With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (business and risk – public session)
Tuesday 27 January 2015 at 12:30
Small conference room, Learning and Development Centre, Fieldhead, Wakefield, WF1 3SP

AGENDA

1. Welcome, introduction and apologies

2. Declaration of interests

3. Minutes and matters arising from previous Trust Board meeting held on 16 December 2014

4. Chair and Chief Executive's remarks (verbal item)

5. Quality performance reports month 9 2014/15

5.1 Quality performance report month 9 2014/15 (to follow)

5.2 Customer services/patient experience report quarter 3 2014/15

5.3 Exception reporting and action plans

(i) Independent investigation report
(ii) Child and adolescent mental health services Tier 4 development
(iii) Monitor well-led framework and governance review
(iv) Wakefield integration programme – business rules for partners

6. Strategies for approval

6.1 Risk Management Strategy
6.2 Treasury Management Strategy and Policy

7. Monitor quarterly return quarter 3 2014/15

8. Assurance framework and risk register

9. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 31 March 2015 in the Boardroom, Kendray, Doncaster Road, Barnsley.

Minutes of Trust Board meeting held on 16 December 2014

Present:	Ian Black	Chair
	Peter Aspinall	Non-Executive Director
	Julie Fox	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Helen Wollaston	Deputy Chair
	Steven Michael	Chief Executive
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Alan Davis	Director of Human Resources and Workforce Development
	Alex Farrell	Deputy Chief Executive/Director of Finance
Apologies:	Laurence Campbell	Non-Executive Director
In attendance:	Diane Smith	Interim Director of Service Innovation and Health Intelligence
	Dawn Stephenson	Director of Corporate Development
	Bernie Cherriman-Sykes	Board Secretary (author)

TB/14/71 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. The apology, as above, was noted.

TB/14/72 Declaration of interests (agenda item 2)

There were no declarations made over and above those made in March 2014 and subsequently.

TB/14/73 Minutes of and matters arising from the Trust Board meeting held on 21 October 2014 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 21 October 2014 as a true and accurate record of the meeting. There was one matter arising.

TB/14/56b Quarterly serious incidents report – independent investigation report

Tim Breedon (TB) confirmed that the delegated authority given to the Chair, Deputy Chair, Chief Executive, Director of Nursing and Medical Director to formally agree the independent investigation report on behalf of Trust Board was used on 25 November 2014 and the report approved. The report should be published by NHS England early in January 2015 and will be formally presented to Trust Board in the public session at its January 2015 meeting.

TB/14/74 Assurance from Trust Board Committees (agenda item 4)

TB/14/74a Audit Committee 7 October 2014 (agenda item 4.1)

Peter Aspinall (PA) alerted Trust Board to the internal audit on patients' property arrangements. This was discussed at length at the meeting and there was some debate on the level of assurance given; however, it was agreed to focus on the remedial action agreed and to ask Alex Farrell (AF) to take back to the Executive Management Team (EMT) for agreement of responsibility and accountability.

The Committee also considered the arrangements for internal and external audit as both services come to an end of the current contracts in 2015. The Committee agreed that it would provide unnecessary organisational stress to run two tender processes at the same

time. It was agreed, therefore, to undertake a tender exercise for external audit services as there was no ability to extend the contract further and to extend the contract for internal audit services for a further year. The Chair asked that the Members' Council was made aware of the Committee's decision and the timetable for both the tender and extension processes.

TB/14/74b Clinical Governance and Clinical Safety Committee 17 September and 11 November 2014 (agenda item 4.2)
Helen Wollaston (HW) highlighted the following from 11 November 2014.

- A key item for the Committee was an update on the recovery plan for child and adolescent mental health services (CAMHS), which was not as advanced as the Committee had planned.
- The Committee received a report from BDU Directors on the level of vacancies held by BDUs and the impact on services. The Committee took assurance from the report.
- The Committee received a presentation on tissue viability from Margaret Kitching, Director of Nursing and Quality, NHS England (South Yorkshire and Bassetlaw). A key point emerging was that the Trust appears to have a lower threshold for reporting incidents than other Trusts and this will be reviewed by the Trust. Margaret Kitching was very complimentary of the tissue viability services provided by the Trust.

TB/14/74c Mental Health Act Committee 21 November 2014 (agenda item 4.3)
Julie Fox (JF) raised the following.

- The Committee received a presentation on UnITED (understanding and interpreting trends with ethnic diversity), which analysed data in relation to ethnic groups within in-patient wards. The Committee found the presentation very useful, particularly in terms of the actions taken and asked whether these could be replicated elsewhere in the Trust.
- Section 136 suites and their use within the Trust, which has been the subject of increased focus nationally and a review by the Care Quality Commission (CQC). TB confirmed that the Trust would review its service in two areas:
  - liaison with the Police regarding the use of the services; and
  - funding of the suites.

  He also commented that there is scrutiny currently on progress of organisations to sign-up to the Mental Health Crisis Concordat. TB assured Trust Board that the Trust is fully supportive and has signed up to both the West and South Yorkshire Concordats.

  IB asked whether the issue with Section 136 suites relates to having two police forces covering the Trust. TB responded that, to some degree, it does create issues, particularly that the Trust has three suites to cover four BDUs and for transfer across police boundaries. SM added that this also links to the future configuration of crisis and acute services. The Trust needs to be able to articulate what constitutes acute and emergency mental health services and how these should be funded. The time may be right to look at opportunities to work on a network basis, particularly in West Yorkshire. IB asked whether the issue is that it is part of one system in West Yorkshire and one in South Yorkshire. TB responded that there is one protocol across both areas; however, issues arise in implementation. The Concordat compels organisations to work together and further development may involve networks.
- Ethnicity recording and the level of 'unknown' or not declared.
- Consent to treatment audit, which indicates a deterioration in recording of capacity. The Committee was clear that 100% of records should be complete and accurate and the Trust needs to address performance.

TB/14/74d Remuneration and Terms of Service Committee 14 October 2014 (agenda item 4.4)

There were no issues raised from the meeting on 14 October 2014; however, IB did comment on the Committee's ratification of the substantive appointment of Diane Smith (DCS) as Director of Health Intelligence and Innovation from 1 January 2015 at its meeting prior to Trust Board.

TB/14/75 Chair and Chief Executive's remarks (agenda item 5)

IB took Trust Board through a summary of staff successes and achievements, and highlighted:

- what the Trust has done well, in particular Creative Minds, which won the Health Service Journal award for compassionate care, which was presented by Jeremy Hunt;
- Values into Excellence, which will culminate in a celebration event in March 2015 where a panel of judges will select a 'winner of winners';
- Governor reviews in January/February 2015; feedback is welcome from members of Trust Board to him as Chair; and
- appointment of two new non-executive directors to replace PA and HW starting with an initial event on 15 January 2015.

Under his remarks, the Chief Executive (SM) commented on the following.

- Calderdale and Huddersfield NHS Foundation Trust position.
- Dalton Review, which links very closely to the Five-year Forward View for the NHS produced by Simon Stephens. Jonathan Jones (JJ) asked if there was anything the Trust needed to do. SM responded that the Trust is in active dialogue and positioning with commissioners and GPs in each district.
- All Party Policy Group on creativity.

He ended by informing Trust Board that the successful appointment of Adrian Berry (ABe) as Medical Director has left an operational gap in forensic services, which, coupled with sickness absence at a senior level in CAMHS, led him to seek and identify interim cover at Director-level from the first week in January 2015.

TB/14/76 Performance reports months 7 and 8 2014/15 (agenda item 6)

TB/14/76a Performance reports (agenda item 6.1)

AF commented that there were no major changes from month 6 and highlighted the following.

- Mental health currency and clustering – a robust change management process was agreed by the EMT last week.
- The financial forecast is on plan for the end-of-year outturn; however, the current significant underspend driven by the underspend on staffing should be eroded in the next quarter bringing performance in line with forecast.
- There are two capital schemes that will not proceed in 2014/15 in relation to the Wakefield hub and the Fieldhead masterplan. A capital programme of £8.5 million will be spent, which is a significant investment. The issue was flagged with Monitor at quarter 2.

TB commented on the take-up of mandatory training, where there are a number of areas of potential concern. Activity is underway to ensure action is in place to address. Alan Davis (AGD) commented that the performance report provides a global position but provides no

assessment of risk. Work has begun to make a risk-based assessment of take-up. TB also confirmed that the planned review of the impact of changes to shift patterns and reduction in mandatory training headroom has begun. JF commented on two issues raised in services regarding mandatory training in relation to cancelled training due to lack of participants and services unable to release staff at the last minute. The Trust needs to be able to find ways to address both.

IB commented that he would like to see measures and 'traffic lights' on the dashboard to demonstrate performance and progress in future reports.

AGD commented that national benchmarking of sickness absence demonstrates that the Trust is performing well and that there is a clear North/South divide. The Trust will use internal audit to try to understand its position and the outcome will be presented to the Remuneration and Terms of Service Committee in due course. SM commented that it would be useful to get comparative data and metrics, and understand factors behind the figures. PA commented that the Trust's performance against the sickness absence rate of 4% is now going backwards. His continued challenge to the EMT is whether it has the skills and expertise to address what is such a high cost area. One clear example is following and interpreting human resources policies and whether such policies are appropriate for the Trust. IB responded that sickness absence is discussed in detail at the Remuneration and Terms of Service Committee. The 4% target is set and is achieved in some parts of the Trust. He accepted the Trust's comparative position but Trust Board wants to see an absence rate consistent with the financial plan and the setting of next year's budget. He will ensure this is discussed in detail at the Committee's next meeting. AF added that consultation has begun with KPMG on the internal audit plan for 2015/16 and she will ensure sickness absence benchmarking is included.

TB/14/76b Exception reports and action plans – Data breaches (agenda item 6.2(i))

Dawn Stephenson (DS) explained the context and the Trust's response to a Freedom of Information request. SM commented that the organisation, Big Brother, seeks to identify areas where there is over-intervention or excessive bureaucracy on the part of 'the state'. It was unclear what the motivation was behind the Freedom of Information request given the subsequent medial reporting.

PA was supportive of the Trust's position and commented that continued learning must surely result in a decrease in incidents. DS responded that the principle is to learn from incidents and this should result in a decrease. IB commented that it also demonstrates how seriously the Trust takes such breaches and he was assured by the commitment to learning. JF suggested a reinforcing message for the weekly staff briefing.

It was RESOLVED to NOTE the Trust's approach to release of information in response to a Freedom of Information request.

TB/14/76c Exception reports and action plans – Customer Services Policy (agenda item 6.2(ii))

It was RESOLVED to APPROVE the amended policy.

TB/14/76d Exception reports and action plans – Care Quality Commission – Duty of Candour (agenda item 6.2(iii))

HW asked how the duty of candour will be met through engagement with relevant people. TB responded that this will be managed through professional networks and individual briefings for staff through appraisal and clinical supervision arrangements. It was agreed to bring a report back to the Clinical Governance and Clinical Safety Committee. In relation to learning lessons, AF commented that the key is effectiveness of dissemination of learning. TB concurred and, with the Medical Director, he will review 'closing the loop' on learning

through BDU governance groups, which will be reported through to the Clinical Governance and Clinical Safety Committee in April 2015.

PA asked whether the criminal offence was corporate or individual and how this fits with the Trust's human resources policies. TB agreed to clarify; however, AGD commented that it would usually be organisational liability although a wilful or deliberate act would be individual as currently observed by the Health and Safety Executive.

It was RESOLVED to NOTE the CQC Duty of Candour and the action taken/planned by the Trust in response.

TB/14/77 Use of the Trust seal (agenda item 7)

It was RESOLVED to NOTE use of the Trust's seal since the last report in September 2014.

TB/14/78 Date and time of next meeting (agenda item 8)

The next meeting of Trust Board will be held on Tuesday 27 January 2015 in the small conference room, Learning and Development Centre, Fieldhead, Wakefield. There is also a joint meeting with the Members' Council on Friday 30 January 2015.

Signed …… Date ……

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 27 January 2015
Agenda item 5.2

Title:	**Customer services report – Q3 2014/15**
Paper prepared by:	Director of Corporate Development
Purpose:	To note the service user experience feedback received via the Trust's Customer Services function, the themes arising, learning, and action taken in response to feedback.
Mission/values:	A positive service user experience underpins the Trust's mission and all values. Ensuring people have access and opportunity to feedback their views and experiences of care is essential to delivering the Trust's values and is part of how we ensure people have a say in public services.
Any background papers/ previously considered by:	Trust Board approved a revised Customer Services policy and procedure in December 2014. The revised policy reflects CQC essential standards, the duty of candour and Trust action following an internal audit report. The KPMG review indicated that Trust policy is robust and in line with best practice in NHS complaints management, and recommended only minor amendment to policy wording to reflect existing practice. The Trust-wide Patient Experience Group, which has been established for some time, is currently reviewing its role and function, in part informed by the audit. The Group is proposing a revised reporting and governance framework to enable more robust triangulation of service user experience data. Membership of the group is also subject to review to ensure representation aligns with the new 'trio' structure in BDUs (clinical lead, general manager and practice governance coach).
Executive summary:	A range of key performance indicators are being developed to evidence patient experience. Reporting on these KPIs will be used as a tool to change behaviours, influence improvement and will evidence improved customer care. The agreed indicators will be measured in the same way each quarter to ensure consistency. Reporting on these indicators will begin in 2015/16. **Customer Services Report – quarter 3 2014/15** This report provides information on feedback received, the themes indicated, lessons learned and action taken in response to feedback. In quarter 3: • 426 issues were responded to; • 57 formal complaints were received and 267 compliments; • care and treatment, staff attitude, admission, discharge and assessment issues, waiting times, delays and cancellations were the most common themes; • two complainants asked the Parliamentary and Health Service Ombudsman to review their complaint; • over 135 public enquiries were responded to and just over 350 staff enquiries; • 57 requests for information under the Freedom of Information Act were actioned.
Recommendation:	**Trust Board is asked to REVIEW and NOTE the feedback received through customer services in quarter 3 of financial year 2014/15.**
Private session:	Not applicable

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South West Yorkshire Partnership NHS
NHS Foundation Trust

CUSTOMER SERVICES - REPORT FOR THE PERIOD 01 OCTOBER 2014 – 31 DECEMBER 2014 (QTR. 3 14/15)

TRUST WIDE

INTRODUCTION

This report covers all feedback received by the Trust's Customer Services Team - comments, compliments, concerns and complaints, which are managed in accordance with policy approved by Trust Board. The policy is subject to annual review and was most recently reviewed by the Board in December 2014. It takes account of relevant regulation and best practice and emphasises the importance of using insight from service user experience to influence and improve services.

The Customer Services function provides one point of contact at the Trust for a range of enquiries and feedback and offers accessible support to encourage feedback about the Trust and its services.

The report includes:

- the number of issues raised and the themes arising
- equality data
- external scrutiny and partnering
- Customer Service standards
- actions taken and changes made as a consequence of service user and carer feedback
- compliments received
- the number and type of requests processed under the Freedom of Information Act

From Qtr. 3, each Business Delivery Unit (BDU) will receive a more detailed report showing a breakdown of issues at service line.

FEEDBACK RECEIVED

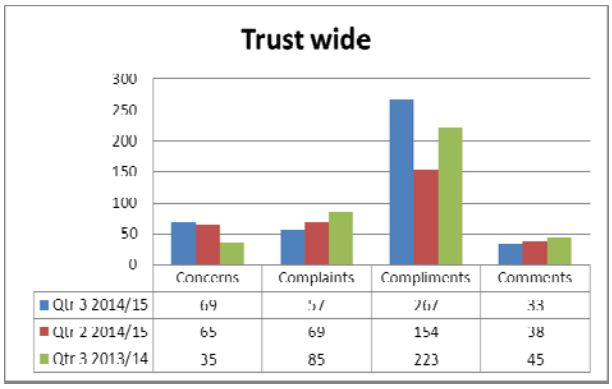
The tables below illustrate Customer Services activity in Qtr. 3. The Customer Services team responded to 426 issues; 57 formal complaints were received and 267 compliments. This compares to 321 issues, 67 formal complaints and 153 compliments in the previous quarter.

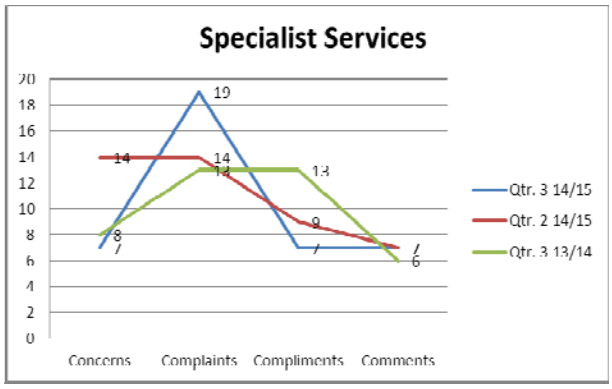
Complaint numbers were down overall on the previous quarter.

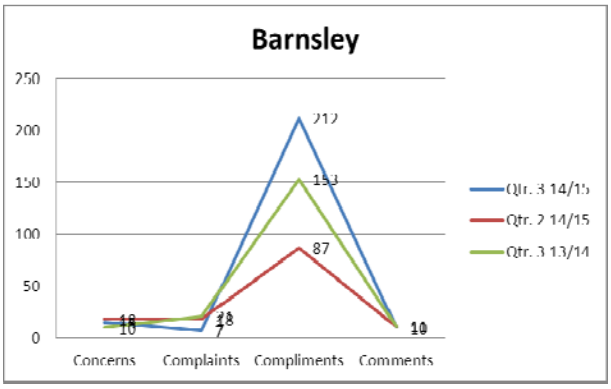
In Specialist Services, all the complaints received related to CAMHS services, with Calderdale and Kirklees CAMHS having the most complaints (12), Barnsley CAMHS 7 and Wakefield 1. Access to services and waiting times (including the wait time from the initial 'Choice' appointment to treatment) were the most common issues raised in regards to CAMHS services. Administrative errors, in particular poor or no communication regarding appointment cancelled by the service and lack of timely processing of referrals impacting on wait times. There was also an information governance breach in Kirklees services relating to the release of healthcare records without consent.

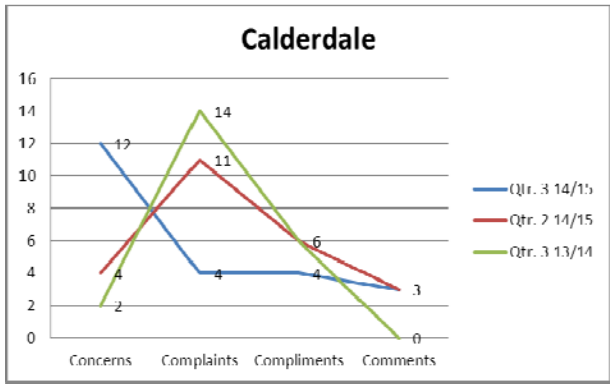
There was an increase in compliment in the quarter, with Barnsley BDU continuing to alert Customer Services to all compliments received, in particular in general community services.

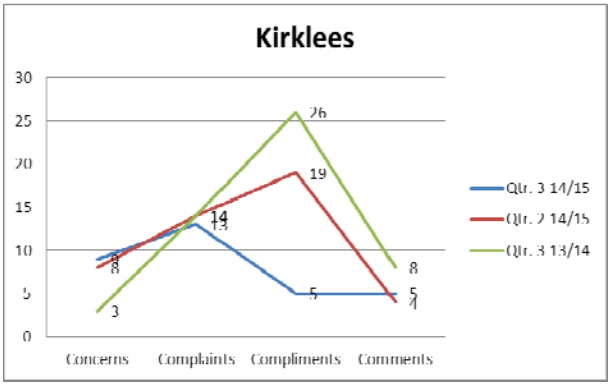
CUSTOMER SERVICES ACTIVITY QTR.3

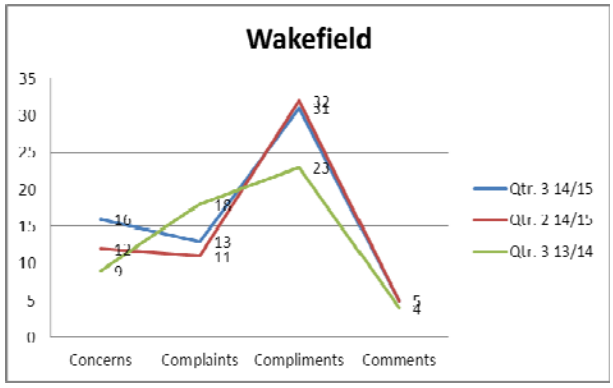


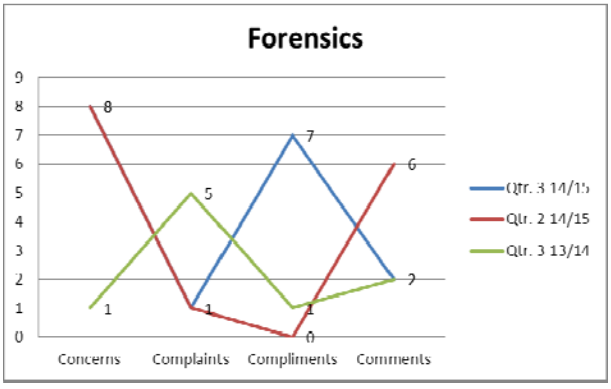












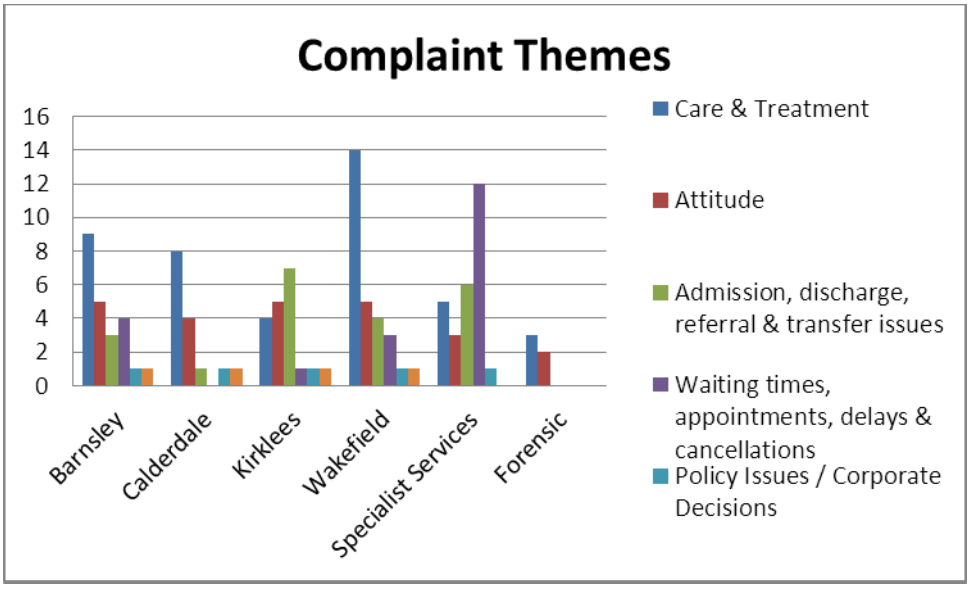
NUMBER OF ISSUES RAISED INFORMALLY

During Qtr. 3, Trust services responded to 69 issues of concern at local level. The Customer Services team worked with service lines to ensure the recording of issues raised informally and to capture action taken in response to this feedback. This promotes a default position of putting things right as and when they happen wherever possible and supports shared learning about service user and carer experience.

THEMES

Consistent with past reporting, care and treatment was the most frequently raised negative issue (43). This was followed by staff attitude (24), admission, discharge and assessment issues (21), waiting times, delays and cancellations (20), policy issues and corporate decisions (6), and mental health act/detention issues (4). Most complaints contained a number of themes.

The Customer Services function connects to a weekly risk scan which brings together intelligence from the Patients Safety Support Team and the Legal Services Team to triangulate any issues of concern and assess the impact on service quality.

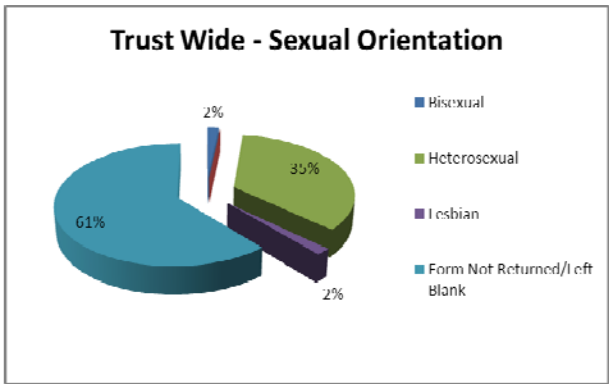


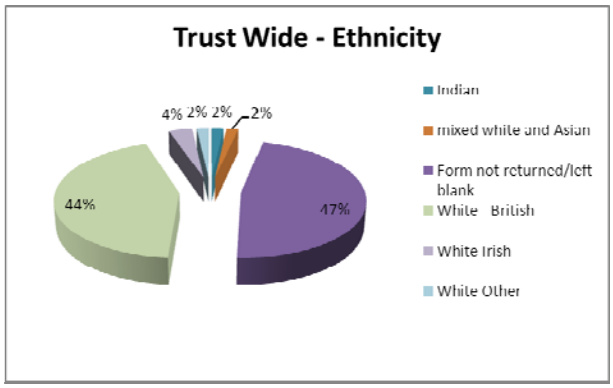
TRUST WIDE EQUALITY DATA

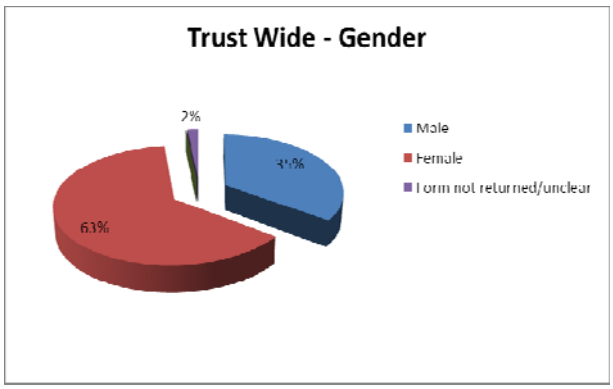
Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. Additional information is now also shared explaining why collection of this data is important to the Trust and that it is essential to ensure equality of access to Trust services.

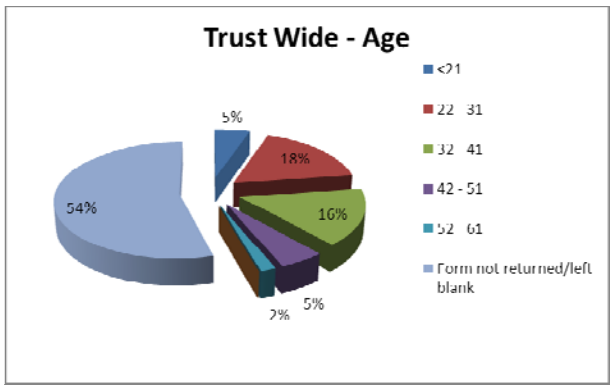
The Team is participating in a project with the Partnerships Team to review best practice in equality data collection in other organisations and will incorporate any learning into routine processes.

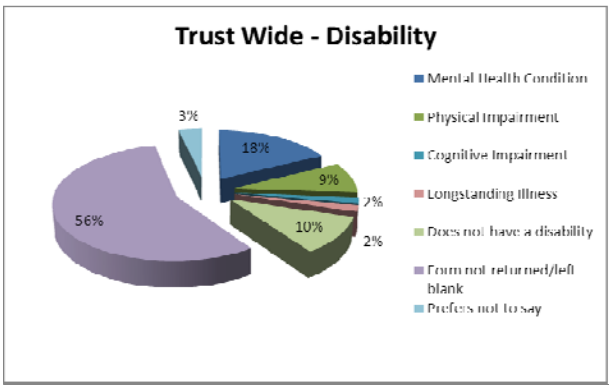
The response rate for forms in Qtr. 3 was 56%. The charts that follow show, where information was provided, the breakdown in respect of gender, age, disability and ethnicity trust wide. The return rate of information is shown underneath the tables.











Age 26/57 ***Gender 56/57*** ***Disability 25/57*** ***Ethnicity 30/57*** ***Sexual Orientation 22/57***

The team makes every effort to collect equality data, but some people prefer not to share this and indicate that it has no bearing on whether or not they provide feedback to the Trust or want to raise an issue.

MP CONTACT

During Qtr. 3, there were 17 occasions where complaints and feedback were received via local MPs, acting on behalf of constituents. MP enquiries are processed in line with routine practice and contact made direct with individuals wherever possible.

Kirklees BDU: Jason McCartney MP (1) Mike Wood (1)
Further information requested regarding waiting times for talking therapies and how to seek appropriate support for depression.

Specialist Services BDU: Ed Balls (2) John Trickett (1) Yvette Cooper (2) Mike Wood (1)

Jason McCartney (1)
All enquiries related to access to CAMHS services.

Wakefield BDU – Mary Creagh MP (1) Yvette Cooper (2) John Trickett (1)
Enquires related to extent of support available, waiting times for counselling, and a delay in transfer to a low secure facility.

Calderdale BDU – Linda Riordan (1) Jason McCartney (1)
Enquiries related to ward transfer and perceived lack of involvement in care planning.

Trust Wide Corporate Services – Dan Jarvis (1)
Enquiry related to use of estate.

Forensic Service – Patrick McLoughlin (1)
Enquiry regarding level of family contact with individuals living in secure settings and family involvement in clinical decisions about care and treatment.

The Trust makes proactive contact with MPs to keep them informed of news and initiatives on a monthly basis and offers specific briefing about relevant issues.

PARLIAMENTARY HEALTH SERVICE OMBUDSMAN (PHSO)

During Qtr.3, 2 complainants asked the Parliamentary and Health Service Ombudsman to review their complaint. Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. All requested information was provided within the prescribed timeframe.1 related to CAMHS services in Barnsley – the Trust is awaiting a decision regarding investigation. 1 related to crisis services in Wakefield – the PHSO has already completed its review and advised the Trust that no further action is required.

During the quarter, the Trust received feedback from the Ombudsman regarding five cases which had been subject to review – 4 requiring no further action and 1 requesting the Trust to resolve by means of apology and financial redress. Details as below:

Barnsley BDU - Complaint regarding slow response to subject access request. PHSO has asked the Trust to resolve by means of apology and financial redress.

Complaint regarding services provided by the CMHT. PHSO advised no further action required.

Kirklees BDU - Complaint regarding services provided by the CMHT. PHSO advised no further action required.

Forensics BDU - Complaint regarding attitude of consultant. PHSO have advised complaints issue outside its remit – no further action required.

Specialist Services - Complaint regarding CAMHS services in Barnsley. PHSO advised no further action required.

MENTAL HEALTH ACT

3 complaints were made in Qtr. 3 with regards to service user detention under the Mental Health Act. Two of the individuals were White British whilst the third chose not to specify their ethnicity. Information on the numbers of complaints regarding application of the Act is routinely reported to the Mental Health Act Sub Committee of the Trust Board.

CARE QUALITY COMMISSION (CQC)

No issues were referred to the Trust by the CQC in Qtr. 3.

JOINT WORKING

National guidance emphasises the importance of organisations working jointly where a complaint spans more than one health and social care organisation, including providing a single point of contact and a single response.

Joint working protocols are in place with each working partnership. The purpose of these is to simplify the complaints process when this involves more than one agency and improve accessibility for users of health and social care services.

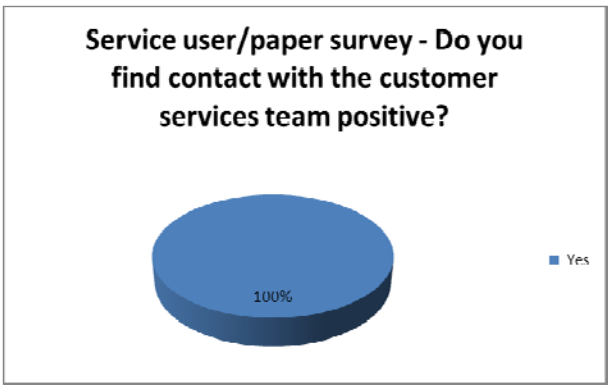
The Customer Service function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information.

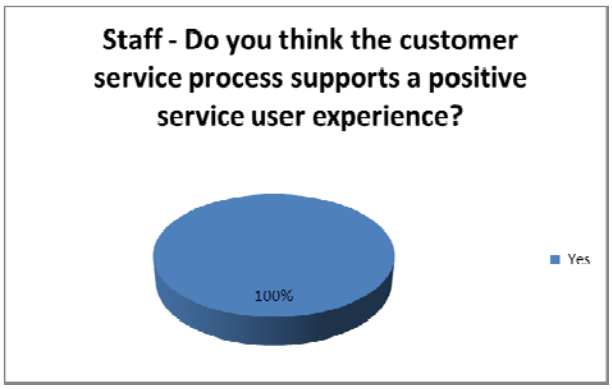
Issues spanning more than one organisation in Qtr.3	Formal Concern (Over 48 Hours) (COMPLAINT)	Informal Concern (Up to 48 Hours) (CONCERN)	Service Issue (COMMENT)	Total
Barnsley Hospital NHS Foundation Trust	1	0	0	1
Barnsley Metropolitan Borough Council	1	0	0	1
NHS Barnsley CCG	0	0	1	1
NHS Calderdale CCG	1	0	1	2
NHS Greater Huddersfield CCG	0	0	2	2
NHS Wakefield CCG	1	0	0	1
Other	1	0	0	1
Wakefield Metropolitan District Council	1	0	0	1
Total	6	0	4	10

CONTACT WITH CUSTOMER SERVICES TEAM

The customer services team processed 135 general enquiries in Qtr. 3, in addition to '4 Cs' management. These included provision of information about Trust Services, signposting to Trust services, providing contact details for staff and information on how to access healthcare records. The team also responded to just over 350 telephone enquiries from staff, offering support and advice in resolving concerns at local level.

In responding to contact of any kind, the team negotiates with individuals regarding the timescales for responding to issues and regular contact is maintained until issues are resolved to the individual's satisfaction. This connection results in positive feedback to the service regarding complaints management. Numbers responding to the request to give feedback are very low (7 service users and 6 staff in the tables below) – but from those who do, the response is entirely positive.





The Trust recognises that it is good practice to offer complainants the opportunity to meet staff to discuss issues. This offer is made early in the process to all complainants, but especially where complaints relate to more serious issues or complex circumstances. These meetings are ideally attended by both Customer Services and service staff and provide an opportunity for staff to reflect on the experience from the service user's perspective. A small number of complainants take up the offer to meet, with those declining indicating they are satisfied with the contact offered via Customer Services.

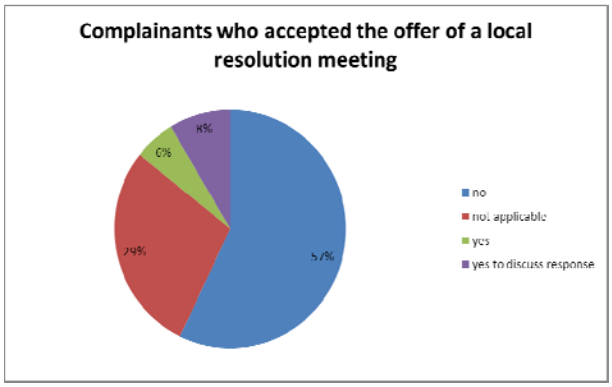
Feedback from staff who participated in meetings indicates that this improves overall understanding of how service users and their families perceive Trust services.

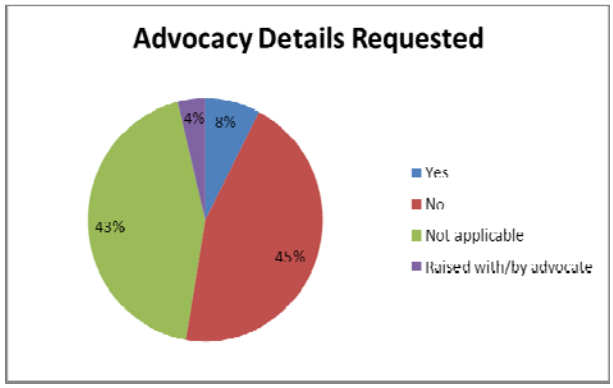
> '*Customer Services listened very well to my concerns. Even though I was unhappy at the time of making my complaint, they kept me updated and informed which made the process much easier and seemed to work very well'*
>
> *Service user*

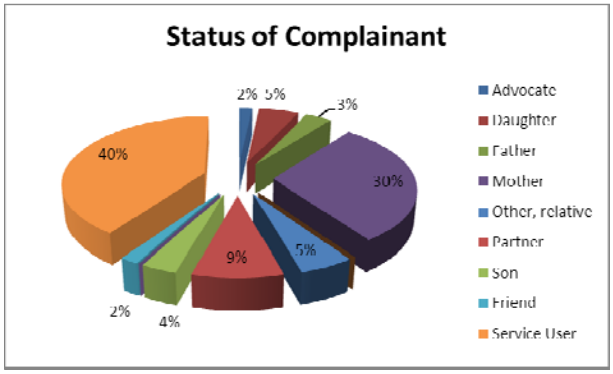
In relation to staff satisfaction (evaluated by questionnaire), 100% of respondents indicated they were happy with the support provided.

> *'The customer services team strive to provide a positive experience for the service user'*
>
> *Staff member*

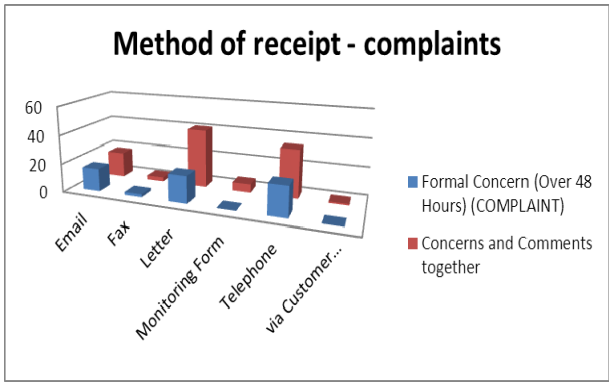
Complainants are also provided with contact details for independent advocacy services and are encouraged to use this support if helpful. A small number of service users are supported by an advocate.







Complainants may wish to communicate in writing (by letter or completion of the Customer services feedback form), by 'phone, email, text message, via the website or through face to face meetings. Ensuring that people have access and opportunities to feedback their views and experiences of care is essential to delivering the Trust's values and is part of how we ensure that people have a say in public services. The Customer Services function is part of a developing framework of activity to facilitate feedback about all aspects of services and ensuring any lessons learned are acted upon.

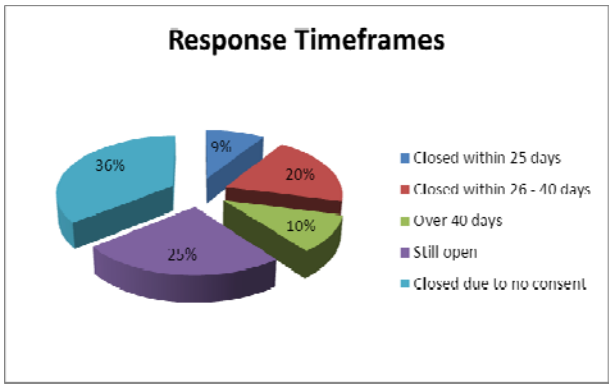


RESPONDING IN A TIMELY MANNER

The customer services standard is for complaints to be acknowledged within three days, with a named case worker assigned. Timescales are negotiated on an individual basis, with each complainant offered regular updates on progress until issues are resolved to their satisfaction or a full explanation has been provided. All complaints are dealt with as speedily as possible. The internal standard is for every complaint to be responded to within 25 days; or 40 days for more complex cases.

In Qtr.3 the majority of complaints were closed within 40 days, but 10% of cases (8) took longer to investigate and offer a response, due to delay in investigation at BDU level and staff absence preventing collection of witness statements. General managers are alerted in such cases.

36% of cases could not progress to investigation. Some individuals change their minds about progressing issues, but in the majority of cases, this related to issues raised by a third party where the individual in receipt of care and treatment refused to give consent.



During Qtr. 3 the team closed 74 complaints.

19 formal complaints remain open. An additional 13 are awaiting consent and 3 are on hold pending further information from the complainant.

COMPLIMENTS

During Qtr. 3, 267 compliments were recorded. These are acknowledged by the Chief Executive and positive feedback is shared with the individual, the team and across the Trust via the intranet to support sharing of positive practice.

Example compliments received in Qtr.3

I would like to convey my thanks to the physiotherapist for her efforts and professional guidance, which has undoubtedly assisted in my recuperations from what, was a most painful operation. She is a credit to the physiotherapy department and I hold her in high regard for the assistance and kindness she has shown me.

Barnsley - Physiotherapy

The staff member was friendly, patient, empathetic, thorough, clear and informative. One of the most useful interactions I have had with the ward. Thank you for your wonderful attitude.

Wakefield – Trinity 2

I have been very impressed with how the staff dealt with a referral and excellent advice was provided. Thank you.

Specialist Services - CAMHS

The CPN has been an invaluable support to both my son and I. We would like to officially acknowledge her unrelenting commitment and professionalism.

Calderdale Insight Team

I am so pleased my GP put me on the health trainer programme. It is now one year since I began my healthy eating and I have lost one stone and 5 pounds. I have changed my eating habits for life. Thank you.

Health Trainers – Wakefield

The speech and language therapist has been fantastic with my son. She made a real difference. She made therapy fun and worked with my son's needs. She has been fantastic and we will miss her. I cannot praise her enough for all her help, she is a real asset.

Barnsley – Children's Speech & Language Therapy

The top 5 words used in compliments to services were:

- Supportive
- Brilliant
- Kindness
- Excellent
- Professionalism.

ACTION TAKEN IN RESPONSE TO FEEDBACK / CHANGES MADE AS A CONSEQUENCE OF FEEDBACK

Not all complaints require action plans to remedy issues, but all provide helpful feedback which is used in services to support service improvement. The responsibility to deliver on action plans is held within the BDUs and monitored through governance processes.

All complainants are offered the opportunity to meet with Trust staff to discuss their concerns, and some take this up. All complainants received a detailed response to the issues raised and an apology that their experience did not meet their expectations.

The Customer Services monitoring form has been shared with all wards and staff are encouraged to capture all feedback at service level. Progress in capturing this additional information is being monitored.

Actions taken by BDUs in response to feedback include:

Barnsley BDU

- Review of the process regarding sharing of information with other agencies is currently underway to ensure appropriate referrals are supported ***(Long Term conditions)***
- Staff have being reminded of the importance of adhering to the confidentiality policy when discussing information with family members ***(Inpatients)***
- Additional training regarding moving and handling have been put in place ***(Primary care and Preventative services)***
- Staff have being reminded of the importance of involving and updating service users in regards to decisions made in respect of care and treatment and also to involve families and carers where possible. ***(Inpatients)***
- Monitoring of administrative tasks is underway to ensure they are carried out in a timely manner. (***Children's business unit)***

Calderdale BDU

- Staff have being reminded of the importance of involving and updating service users in regards to decisions made in respect of care and treatment and also to involve families and carers where possible. ***(Inpatients – OPS)***
- Additional processes have been implemented to ensure support is provided to patients in the community. ***(Community Services – WAA)***

Kirklees BDU

- Clear processes have being implemented between services to reduce referral delays. ***(Community services WAA)***
- the importance of involving and listening to families and carers during ward rounds has been reiterated to staff members ***(Acute Inpatients – WAA)***

- Staff have been reminded of the importance of carefully explaining medication issues during discharge planning meetings, and also who should be in attendance at discharge meetings. ***(Acute inpatients – WAA)***
- Staff are to ensure that carers/families viewpoints/observations are incorporated within service user care plans. ***(Acute inpatients – WAA)***

Wakefield BDU

- Staff from an inpatient ward have been reminded of the importance of sharing care plans. ***(Acute inpatients – WAA)***
- Staff have been reminded of the policies in place regarding the right to appeal under the Mental Health Act. ***(Inpatient services OPS)***
- Staff on an inpatient ward have received additional training and have been reminded of the importance of ensuring medication records are updated and that communication between staff and patients/carers has also been reviewed ***(Acute inpatients – WAA)***
- Staff on an inpatient ward are to receive additional customer services training and additional supervision ***(Inpatient services OPS)***
- A full review of communication pathways and care standards is currently under review ***(Inpatient services OPS)***

Specialist services BDU

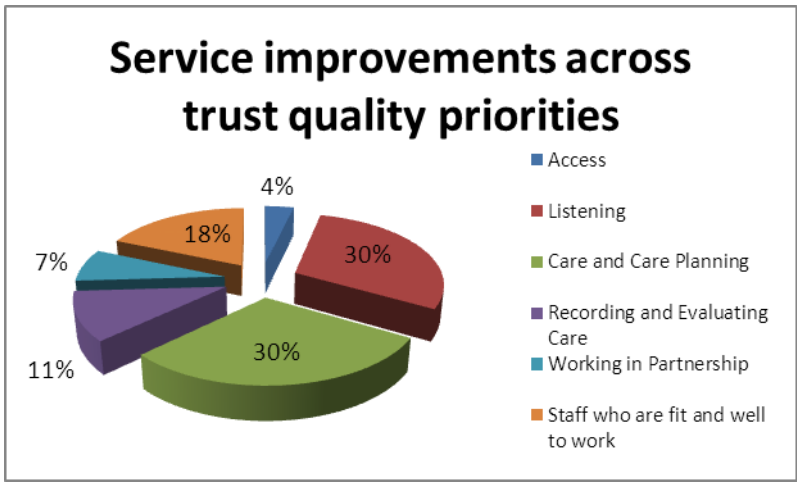
The following improvements have been made in Calderdale and Kirklees CAMHS services in response to feedback; all of which support the recovery plan agreed with commissioners:

- The way assessments are conducted has been subject to review and practitioners will ensure format appropriate to individual and that service users / families are given the opportunity to ask questions / express concerns.
- The need to accurately documenting all communications with families and/carers and to follow up on agreed actions as speedily as possible.
- The importance of clearly communicating the rationale behind the decision to discharge

The following improvements have been made in the Barnsley CAMHS service in response to feedback:

- The service has put a process in place to ensure that when key workers are absent from work, family members are regularly updated regarding the impact on services.
- A revised system has been implemented to ensure all correspondence/telephone contacts are recorded and responded to in a timely manner
- A review of the current multi–agency ASD pathway has been commissioned to improve waiting times
- Improvements to administrative processes to ensure clients receive good customer service.

Improvements made as a result of feedback as shown against Trust quality priorities:



EXAMPLES OF SERVICE USER AND CARER EXPERIENCE

Judith advised the Trust that her family had changed address. This was 11 months ago. Judith's daughter, Daisy, is in receipt of CAMHS services. Judith subsequently enquired about the wait time Daisy was experiencing and it was apparent the contact information had not been updated.

This administrative error led to a missed appointment, and Daisy was placed back on the waiting list.

This complaint highlighted inconsistency in admin practice in updating records. Records are now subject to regular review.

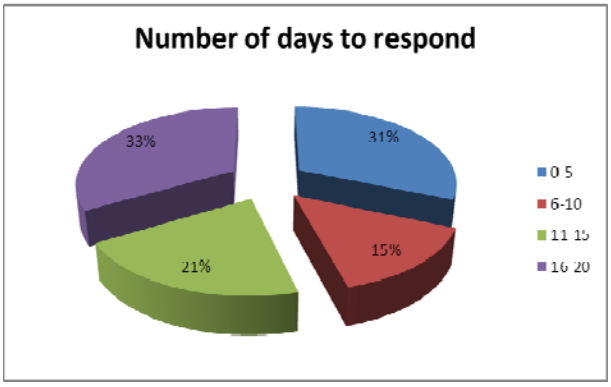
Jonathan raised concerns regarding the care and treatment his father, Eric, received whilst he was cared for on an inpatient ward. Jonathan explained that it felt like there was no communication between the family and staff members, and that they had been excluded from ward rounds and received no information regarding medication issues.

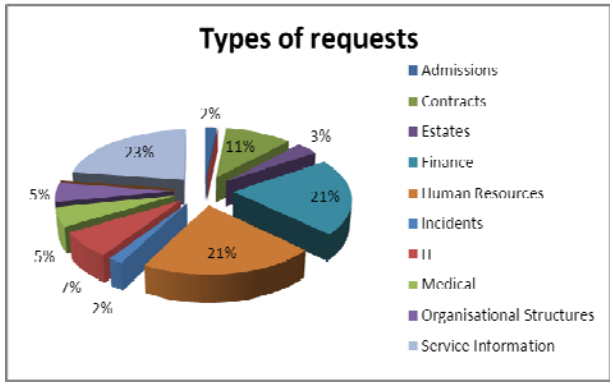
In response to the concerns raised, the General Manager and a Customer Services representative met with Jonathan to discuss his concerns and review his father's care. The General Manager has used feedback from this case to review procedures on the ward and as learning for staff in ensuring improved communication and a customer service focus.

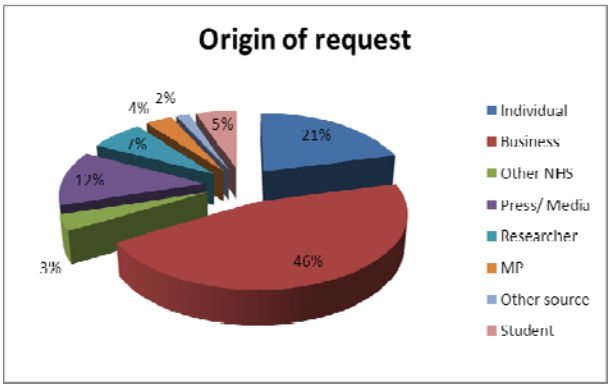
FREEDOM OF INFORMATION REQUESTS

57 requests to access information under the Freedom of Information Act were processed in Qtr. 3, an increase on the previous quarter when 43 requests were processed. Many requests were detailed and complex in nature and required significant time to collate an appropriate response working with services and quality academy functions.

The Customer Services team works with information owners in the Trust to respond to requests as promptly as possible, but within the 20 working day requirement.







During Qtr. 3, there were 2 exemptions applied under section 40 the Act (personal information).

There were no complaints or appeals against decisions made in respect of management of requests under the Act during the quarter.

LOOKING FORWARD

Customer Services efforts continue to focus on gathering insight into service user experience and to support teams to develop action plans to change and improve services as a consequence of feedback.

The move to service line reporting and subsequent update of the Datixweb feedback module has enabled the introduction of revised reporting for BDUs. This will help services (in particular practice governance coaches) to review feedback and issues raised and ensure an appropriate service response.

During the quarter, the Customer Services policy was updated taking account of the CQC essential standards, the duty of candour and the internal audit report reviewing service user experience. Ongoing horizon scanning of best practice publications from regulatory bodies and patients associations continues with review against Trust procedures to promote ongoing learning and improvement.

The Patient Experience Group, which has been established for some time, is currently reviewing its role and function, informed by the KPMG audit. The Group has identified that not all the mechanisms and processes in place to capture feedback are joined up and is proposing a single reporting and governance framework to enable more robust triangulation of experience data. Membership of the group is also subject to review to ensure representation aligns with the new 'trio' structure in BDUs (clinical lead, general manager and practice governance coach).

The proposed remit for the group, subject to approval of the EISTAG, is to:

- Maintain oversight of all initiatives to gather feedback about service user and carer experience and ensure high level co-ordination
- Triangulate feedback and commentary from service users, carers and volunteers, identifying themes and trends
- Ensure services are supported to make appropriate and timely response to feedback
- Ensure linkages with CQC and other regulatory bodies
- To identify and commission the top 5 task and finish development projects as a follow up to customer feedback.
- Ensure progress reports to Equality and Inclusion Strategy Trust Action Group (EISTAG).

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 27 January 2015
Agenda item 5.3(i)

Title:	**Independent investigation report (executive summary)**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	To advise Trust Board on action taken in response to the Independent Investigation into homicides involving Trust service users.
Vision/goals:	The paper demonstrates the Trust's commitment to learning lessons and implementing remedial action following serious untoward incidents.
Any background papers/ previously considered by:	A summary was presented to the Clinical Governance and Clinical Safety Committee and the Executive Management Team.
Executive summary:	In line with Department of Health requirements, an Independent Investigation should be undertaken when a homicide has been committed by a person in receipt of specialist mental health services under the Care Programme Approach in the six months prior to the event. All investigations should build on the Trust/provider's internal investigation, be proportional to the incident and avoid duplicating previous investigations. The investigation should be "an external verification and quality assurance review of the internal investigation with limited further investigation" Three investigations were commissioned through NHS England to provide an independent review of three incidents that involved service users who met the criteria above. A fourth report was additionally commissioned to undertake a themed analysis of the three commissioned reports and three previous homicide independent reviews from previous incidents which took place 2007 onwards. An executive summary of the process and the outcome is attached. The final reports and action plans have now been agreed between all parties and formally signed off by NHS England and Clinical Commissioning Groups. Trust Board agreed delegated authority for approval by the Chair, and Chair of Clinical Governance and Clinical Safety Committee, Chief Executive, Director of Nursing, Clinical Governance and Safety and Medical Director. This took place on 25 November 2014. The Trust's communications team has worked with CCGs and NHS England to prepare for publication of the report on 23 January 2015. The reports and action plans will be available on the Trust's website and those of NHS England and Greater Huddersfield and North Kirklees CCGs. The action plan will be monitored internally through the Clinical Governance and Clinical Safety Committee and with commissioners through the Quality Board.

Recommendation:	**Trust Board is asked to NOTE the publication date of the reports and action plans, which will include publication on the Trust website and the monitoring process for the action plans.**
Private session:	Not applicable

Trust Board 27 January 2015
Independent investigation reports – executive summary

1. Background

The Single Operating Model – HSG (94) 27 requirements under Department of Health guidance (HSG (94) 27 and as amended in 2005) states that an independent investigation should be undertaken when a homicide has been committed by a person in receipt of specialist mental health services under the Care Programme Approach in the six months prior to the event. All investigations should build on the Trust/provider's internal investigation, be proportional to the incident and avoid duplicating previous investigations. This investigation should be "an external verification and quality assurance review of the internal investigation with limited further investigation".

The investigation, commissioned through NHS England, is an independent review of three incidents that involved service users who met the above criteria. A fourth report was additionally commissioned to undertake a themed analysis of the three commissioned reports and three previous homicide independent reviews from previous incidents which took place 2007 onwards.

STEIS number	Known in independent investigation report	Incident date	Other reviews
2010.9926	J	28.07.10	
2011.11370	L	09.06.11	Domestic homicide review
2011.11502	M	18.06.11	
Previous cases			
2008.10741	X	23.12.08	
2008.1621	Y	21.02.08	
2007.5748	Z	20.03.07	

2. Process

The independent investigation and reports were commissioned by NHS England. The investigators examined a range of national benchmarks, including NICE guidance and good practice guidance. They also examined Trust documents, including policies and procedures, the serious incident investigation report and supplementary information, such as action plans, implementation and records of meetings with staff. They also conduct interviews with staff. The perpetrators and their families were contacted as well as the families of the victims and the report has been shared with them.

3. Feedback from investigations

3.1 2010.9926

On 29 July 2010 Mr J, aged 29, was arrested for attacking and killing a member of the public. He was found guilty of murder and sentenced to life imprisonment with a minimum term of 16 years. Mr J had received support from a community mental health team at the Trust from July 2005 up until the incident.

3.2 Overall conclusions of the Independent Investigation

There was no evidence from Mr J's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently. Therefore, the review concludes that this incident was not predictable. The homicide would have been preventable if

professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so.

It was noted that Mr J had several previous convictions and had served custodial sentences for violent offences, criminal damage and possession of drugs. Despite this, no evidence was found to indicate that the Trust should have undertaken any actions or specific interventions that would have prevented the incident. It was found that the incident was, therefore, not preventable.

Since this incident, the Trust has undergone a major restructure as part of its transformation programme, which has included implementation of a revised Care Programme Approach (CPA) policy.

The investigation agreed with the Trust's investigation findings that there is insufficient evidence to suggest that Mr J suffered from a mental disorder that needed support from secondary mental health services. His primary problem was cannabis use and this should have been dealt with by Lifeline[1]. He should also have been reviewed by a multidisciplinary team in order to assess if he needed to continue to receive mental health services. A recommendation was made on this issue.

The investigation also commented on the safeguarding elements of this case and noted some good practice. The Trust recognises that the safeguarding agenda shared between itself and the local authority continues to evolve. It was found that significant progress has been made since the date of this incident in improving staff awareness of relevant issues and of joint working with other agencies.

When the investigators met with staff, staff were of the view that further integration of the local authority's electronic record systems with those of the Trust would improve the efficiency of administration and give advance warning of safeguarding issues. A recommendation has been made to develop the work that the Trust has already done in this area.

3.3 Recommendations

- The Trust should take steps to ensure that patients are reviewed by the multidisciplinary team on a regular basis so that timely discharge and relapse plans are put in place.
- The Trust should consider the options available to refine and develop its electronic record systems in order to ensure greater integration of safeguarding, care planning and care delivery systems.

3.4 2011.11370

This case has been subject to an internal investigation and a domestic homicide review overseen by the Home Office.

On 9 June 2011 Mr L stabbed and killed his partner (Ms Y). He was charged with and found guilty of murder.

3.5 Overall conclusions

The care and treatment offered to Mr L were generally of a good standard although there were some missed opportunities. The first was that Mr L was not screened or offered treatment for his substance misuse during the third episode of care. Although it was not thought that not referring Mr L to substance misuse services changed the course of events with respect to the incident, it was felt that Mr L should have had the opportunity to access these services and may have benefited from treatment for his substance misuse.

The Trust was unaware that Mr L had an extensive criminal history. This is significant because Mr L had previously been arrested for assaulting Ms Y and for an earlier assault on a former

[1] Lifeline is an open-access service that offers advice, information and support related to drug and alcohol dependency.

girlfriend. Although staff asked about his criminal history, they did not seek any corroborative evidence from anyone else including his family, girlfriend or the police. If the clinical team had obtained this information as part of the risk assessment process, it might have prompted a discussion about whether there was a need for a safeguarding referral.

These issues were identified in the Trust's internal investigation report. There is evidence that all the recommendations have been put in place and signed off. In view of this, no further recommendations in relation to CPA, risk or referral to substance misuse services were made by the investigators.

When the investigators met with staff, staff were of the view that further integration of the local authority's electronic record systems with those of the Trust would be helpful. This would improve the efficiency of administration and provide the trust with advance warning of safeguarding issues. In view of this, a recommendation for improvement has been made.

3.6 Recommendation

The Trust should consider the options available to refine and develop its electronic record systems and thereby ensure greater integration of systems in regard to safeguarding, care planning and care delivery.

3.7 2011.11502

On 18 June 2011 Mr N robbed and assaulted an 89-year-old woman who died from the injuries sustained in the attack. He was convicted of manslaughter and two counts of robbery. At the time of the offence, Mr N had been discharged from the early intervention in psychosis (EIP) team and other mental services. Discharge from services occurred on 4th April 2011.

3.8 Overall conclusions

Overall, Mr N received a comprehensive service from the Trust. He was assessed by a range of professionals and received risk assessments and a plan of care. He had a named CPA co-ordinator who consistently attempted to engage with Mr N.

Mr N presented with potential substance misuse issues and mental health issues, a dual diagnosis (mental illness and comorbid substance misuse problem). The EIP team was cognisant of Mr N's substance misuse history and deployed suitably experienced clinicians to treat him; however, he was not subject to routine drug screening or a referral to substance misuse services by the Trust.

Mr N may also have benefited from access to psychological therapies and a psychological assessment.

The Trust worked closely with local authority agencies to ensure that safeguarding issues were addressed and policies and procedures adhered to; however, Mr N and his family would have benefited from closer multi-agency working. The Trust acknowledged this in its internal review. Further integration of the Trust's electronic records and systems would produce closer cooperation between the agencies responsible for safeguarding.

The investigators found there was no evidence from Mr N's words, actions or behaviour prior to the fatal incident that could have alerted professionals that he might engage in criminal activity involving violence. Therefore, no evidence was found to indicate that the incident was predictable and there was no specific intervention or set of actions that should have taken place to prevent the incident. It was found, therefore, that the incident was not preventable.

3.9 Recommendations

1. To ensure the efficacy of the EIP team and the appropriateness of care delivery to patients, the Trust should routinely audit case files to ensure that the EIP team is focused on those patients with psychosis, or at risk of psychosis. Those patients with a presentation

suggestive of personality disorder should be transferred to other trust services such as the CMHT or psychological therapies.

2. The Trust should seek further to refine and develop its electronic record systems to ensure greater integration of systems in regard to safeguarding, care planning and care delivery.

3. The Trust should review its dual diagnosis policy and capacity to ensure appropriate access to specialist knowledge and drug screening when services are responding to presentations that include both a mental disorder and active substance misuse.

4. The Trust should seek to provide assurance to commissioning bodies of compliance with NICE *Guidance in the treatment and management of personality disorder* (appendix C) through an audit process.

5. The Trust should maintain and improve on current performance in delivery of psychological therapies to ensure that 18 weeks is the maximum waiting time rather than, as at present, the average.

6. Commissioning bodies should ensure the Trust to adequately resourced to meet population demand to enable it to comprehensively achieve the 18 week target.

3.10 Thematic report

During the period March 2007 to June 2011, there have been six homicides committed by service users who had received care and treatment from the Trust. Three are described in brief above. The remaining three are described below.

Mr X and his wife were found dead at their home, in 2008. The Coroner's inquest found that Mr X had taken his own life while the balance of his mind was disturbed and was responsible for the unlawful killing of his wife.

Mr Y was convicted, in 2008, of manslaughter on the grounds of diminished responsibility.

Mr Z was convicted alongside two others, in 2007, of the murder of a vulnerable man.

3.11 Common Themes

The report identified common themes as being those that fell below good practice arising in two or more of the case investigated:

- diagnosis and treatment;
- pathway of care;
- non-compliance with care programme approach policy;
- lack of risk assessment and management;
- personality disorder/NICE guidelines;
- safeguarding of adults and children;
- working with people with substance misuse problems (not dual diagnosis); and
- record keeping.

The report goes on to describe the Trust's current position and conclusion. No additional recommendations were made.

4. Next Steps

The final reports and action plans have now been agreed between all parties. The reports have been formally signed off by NHS England and the boards of both Clinical Commissioning Groups (CCGs). Trust Board agreed delegated authority for sign of by the Chair, Chair of Clinical

Governance and Clinical Safety Committee, Chief Executive, Director of Nursing, Governance and Clinical Safety and the Medical Director. This took place on 25 November 2014.

The communications teams from the Trust, CCGs and NHS England have prepared for publication of the report on 23 January 2015. The reports and action plans will be available on NHS England, CCGs and Trust websites.

The action plan will be monitored internally through the Clinical Governance and Clinical Safety Committee and with CCGs through the Quality Board.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 27 January 2015
Agenda item 5.3(ii)

Title:	**Potential development of Tier 4 child and adolescent mental health service (CAMHS)**
Paper prepared by:	Medical Director
Purpose:	To inform Trust Board of progress in developing a business case to provide new in-patient CAMHS facilities within the Trust catchment area.
Mission/values:	Consolidation of care pathways for young people in the local area and expansion of the specialised services provided by the Trust.
Any background papers/ previously considered by:	Previous papers have been presented as commercial and in confidence at private sessions of Trust Board.
Executive summary:	The shortage of specialised mental health inpatient facilities for those under eighteen years, known as Tier 4 CAMHS, has been recognised nationally both in the media and in a NHS England report published in 2014. This has resulted in significant difficulties in locating facilities for young people in crisis and admission to units remote from their family and social networks. Yorkshire was identified as an area of particular under provision in the NHS England review and this is a view supported by local commissioners. Although the Trust now provides community mental health services for young people across all localities, there is no inpatient provision within the Trust catchment area resulting in all young people who require Tier 4 CAMHS being treated out of area, often at considerable distance from their homes. This has a number of adverse impacts including loss of continuity of care team, dislocation from family and social networks and transitions of care occurring at times of high clinical risk. The development of Tier 4 CAMHS in parallel with the community services currently provided forms a compelling clinical and service user/carer based case. The Trust was approached by the largest current provider of Tier 4 CAMHS in the country to explore the potential of a partnership approach to service development locally. The independent provider has an existing contract with NHS England, the only commissioner of such services, for multiple sites across England. The potential benefits of such a partnership include synergistic expertise in development of infrastructure, commissioner engagement, new service model development and care pathway management. A number of work streams have been established to test out the clinical and business case viability of the potential development, these include: • development of a Memorandum of Understanding which can form the basis of a contractual relationship between the two organisations; • development of a clinical service model in which shared clinical and support workforce will manage an inpatient unit providing a number of pathways for young people with a range of mental health needs; and • exploration of an estate solution for service development, which includes design of a potential unit and identification of suitable estate the development. This involves both the appropriate location of service from an access and clinical perspective and the effective use of land which the Trust is not currently utilising or planning to use for clinical services.
Recommendation:	**Trust Board is asked to NOTE the ongoing development work and APPROVE the preparation of a formal business case to be presented for**

	subsequent Board consideration.
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board – 27 January 2015
Agenda item 5.3(iii)

Title:	**Monitor well-led framework governance review**
Paper prepared by:	Director of Corporate Development
Purpose:	To ensure Trust Board is aware of the requirement to undertake a review of the Trust's governance arrangements, what this entails and the Trust's proposed timescales.
Mission/values:	Ensuring the Trust has good and appropriate governance arrangements in place provides the framework for the Trust to meet its mission and adhere to its values.
Any background papers/ previously considered by:	None
Executive summary:	Background In 2014, Monitor stated its expectation that all foundation trusts boards would carry out an external review of their governance arrangements every three years as: - good governance is essential in addressing the challenges the sector faces; - oversight of the Trust's governance arrangements is the responsibility of Trust Board; - governance issues are increasing across the sector; and - regular reviews can provide assurance that governance arrangements are fit for purpose. As a result, Monitor issued guidance (the framework) to support Trusts in ensuring they are 'well-led'. The framework is intended to support the NHS's response to the Francis Report and is aligned with the assessment the Care Quality Commission will make on whether a foundation trust is well-led as part of its revised inspection regime. Monitor is very clear that this is a Trust Board-led process and is not a 'tick-box' exercise undertaken by Trust officers. The framework is similar to the existing 'Quality Governance Framework' with four domains, ten high-level questions and a description of 'good practice' that can be used to assess governance. The four domains cover: - strategy and planning – how well is the Board setting direction for the organisation? - capability and culture – is the Board taking steps to ensure it has the appropriate experience and ability, now and into the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way? - process and structures – do reporting lines and accountabilities support the effective oversight of the organisation? - measurement – does the Board receive appropriate, robust and timely information and does this support the leadership of the Trust? Each domain has specific questions and associated outcomes and Monitor has provided examples of good practice against each outcome.

	Process All foundation trusts have to undertake a review every three years. The Trust can do this when it wants within a three-year window; however, reviews can be no longer than three years apart. The Trust is required to inform Monitor when it has scheduled its review and who will carry it out (see below). Monitor guidance must be used as basis for review and trusts are expected to add to the scope or change the emphasis to reflect Trust Board knowledge of organisation. Monitor "considers" that independent reviewers should be used to ensure objectivity; however, it is of the view that reviewers should not have carried out audit or governance-related work for the Trust during the previous three years. Reviewers must be independent of Trust Board, should be multi-skilled and bring different disciplines (experience of evaluating board leadership and governance arrangements, knowledge of the healthcare sector and specialist expertise, particularly clinical, leadership experience and management information systems). Review steps The steps in the review are set out at appendix 1. Timescales In consultation with the Chair and Chief Executive, the Director of Corporate Development is considering the timescales for the review with a view to presentation of the final report at Trust Board in July 2015. The review, therefore, would take place in May, June and July 2015 with a presentation of the Trust's self-assessment to the strategy session at the beginning of March 2015. A tender exercise would, therefore, be undertaken to select the independent reviewer in February 2015. Outcome Monitor suggests use of a 'RAG' rating approach as follows. - GREEN – meets or exceeds expectations (many elements of good practice and no major omissions). - AMBER-GREEN – partially meets expectations but confident in management's capacity to deliver GREEN performance within a reasonable timeframe (some elements of good practice, some minor omissions and robust action plans to address perceived gaps with proven track record of delivery). - AMBER-RED – partially meets expectations but with some concerns on capacity to deliver within a reasonable timeframe (some elements of good practice with no major omissions. Action plans to address perceived gaps are in early stage development with limited evidence of track record of delivery). - RED – does not meet expectations (major omissions in governance identified. Significant volume of action plans required with concerns regarding management's capacity to deliver). Monitor will consider any material governance concerns identified and the Trust's response and what, if any, steps it will then take.
Recommendation:	**Trust Board is asked to NOTE the Monitor well-led framework for governance reviews and to SUPPORT the timescales proposed.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Appendix 1

Monitor well-led framework for governance reviews – review steps

Stage	Steps	Activity	Lead	Timescales
Preliminary	Chair and CE briefing		DS	23.12.14
	Trust Board briefing		Chair/DS	January 2015
	First stage assessment	- Project established with Director briefing and project group established - Table top assessment exercise - Identification of any additional areas Trust would like included	DS BC-S EMT	
	Scope, tender and appoint reviewer	- Trust Board to agree scope, identify any additional areas Trust would like to include and agree tender process - Appoint reviewer - Inform Monitor		
Review activities	Step 1 – Initial review	- Board self-assessment - Initial investigation against Monitor's questions	Trust Board Reviewer	
	Step 2 – Scope	- Using the inputs from initial investigation, agreement of scope of in-depth review with reviewer and methods to be used	Trust Board/ reviewer	
	Step 3 – Detailed review	Such as - Board observations - Focus groups - Interviews with key staff - Interviews with key internal and external stakeholders	Reviewer	
Action plan	Step 4 – Board report and action planning	- Production of report setting out findings of the review - Review team present to and discuss with Trust Board - Agreement of action plan to address any issues and risks	Reviewer/ Trust Board	
	Step 5 – Letter to Monitor	- Chair writes to Monitor to advise review has taken place, setting out any material issues identified and proposed action plan to address.	Chair/DS	

Trust Board 27 January 2015
Agenda item 5.3(iv)

Title:	**Wakefield integration programme – business rules for partners**
Paper prepared by:	Deputy Chief Executive/Director of Finance
Purpose:	For Trust Board to receive and endorse the business rules for partnership working developed by Wakefield Clinical Commissioning Group.
Mission/values:	The intent of the business rules is to promote the development of 'best service offer' in terms of outcomes and use of resources through effective partnership working. The principles and behaviours outlined are consistent with the Trust's values and mission to enable people to live well in their communities.
Any background papers/ previously considered by:	None
Executive Summary:	**Purpose and Background** The purpose of the paper is to share the business rules developed by Wakefield CCG and endorse them, which will mean, in effect, the Trust and its employees commit to a way of working which is consistent with the principles and behaviours outlined in the document. **Process** All provider and commissioner partners were invited to a series of sessions to develop the document. The sessions were facilitated by an experienced external consultant and the Trust was represented at Director and senior manager level. The final document were circulated autumn 2014 and all partner organisations have been asked present the report to their Boards and endorse the content. **Comments** In terms of the content and commitment to ways of working, the business rules are consistent with the values and strategic direction of the Trust in developing with partners a more integrated local community service offer which puts people in control and has a person centred approach to care. The one area still to be confirmed in the document is the arrangements for the section 75 for the Better Care Fund and the agreement on risk share. This is currently being negotiated and the Trust has been actively involved in brokering a financial risk share which manages risk appropriately across all partners. In terms of involvement of stakeholders, including providers, Wakefield CCG has been probably the most successful in promoting provider partnerships. The Trust role in supporting the Provider Alliance is helpful in continuing to promote solutions through partnerships. The business rules set the parameters for how we will do things which will be helpful in developing 'best integrated service offer' by 'best placed provider'.
Recommendation:	**Trust Board is asked to RECEIVE and SUPPORT the Wakefield CCG**

	Business Rules.
Private session:	Not applicable

BUSINESS RULES

Between Partners in the Wakefield Integration Programme

1. Purpose and Scope of these Business Rules

The integration agenda in Wakefield is responding to consistent messages from our citizens who have told us that they want:

- to be supported to stay well;
- to receive coordinated care designed around them;
- to have care delivered close to home;
- to feel connected to their local community and maintain good social networks; and
- to feel like a valued individual.

A 'whole Life Course' approach will be adopted to address these expectations and to deliver the vision and integration strategy set out in the Wakefield Integration Shared Narrative:

These Business Rules begin to establish a framework for formal collaboration between all the partners in the Wakefield Integration Programme. They will evolve over time and in the light of experience of working together.

The Better Care Fund will be central to our integration work initially but the scope of these Business Rules extends beyond this initiative and it is intended to reflect the shared commitment of partners to **co design and re-shape the way the whole system operates** and the cultural shifts that partners have signed up to; **the way we think and do things in Wakefield**.

2. Our Ambition

Communities in Wakefield District achieve the best possible outcomes for themselves and their families, facilitated by coordinated services provided as close to home as possible.

3. Values and Principles

The principles underpinning our approach to integration are:

Prevention	**Partnerships**	**Personalisation**	**Evidence**	**Innovation**

These principles will **drive the way we think and do things in Wakefield**.

Partners will also sign up to living the following values in their dealings with each other:

Honesty
Integrity
Ambition
Mutual respect
Be bold
Develop unity
Deliver what we say#

#

4. Our Commitments

4.1 Integrating Our Service Models

- A focus on **prevention** and **personalisation**;
- Using **evidence** and **innovating** in the development of medical and social models of care;
- Integrated service models that reflect the intentions of the Wakefield Health and Wellbeing Strategy, the views of the 7 GP Clinical Networks and **evidence** from robust patient and public involvement;
- Providing health and social care services, as close to where people live as possible.

4.2 Creative Use of our Non-Financial Resources

- Valuing our workforce and nurturing a sense of pride in working in Wakefield;
- **Innovation** in the use of technologies to drive improvement and efficiency;
- Being creative in the use of our assets including buildings and facilities;
- Providing space for people to explore together new and innovative ways of working.

4.3 Use of our Financial Resources

- Procuring and commissioning service models that drive integration and improve outcomes;
- Transparent investment decisions that optimise outcomes for Wakefield citizens;
- Citizens and **partner** organisations will be able to see how the Wakefield pound is being spent;
- Creating the flexibility to move our collective resource around the system to optimise outcomes;
- A phased introduction of pooled commissioning budgets, starting with the Better Care Fund and over time, developing a Better Care Fund for Children;
- Developing fair and proportionate risk and reward sharing which reflects the relative characteristics of **partner** organisations;
- Incentivising delivery and improvement rather than penalising under performance.

See appendix __ for specific business rules for the management of Better Care Fund Section 75.

4.4 Performance and Information Sharing

- Openly sharing information between **partners;**
- **Collectively** holding each other to account for performance;
- Developing a shared basket of outcome measures (KPIs);
- Proactive monitoring of outcome measures to ensure early warning of performance challenges;
- Encouraging innovation, risk sharing and learning through an open, honest and mutually supportive approach to performance.

4.5 Leadership and Development of our Organisations / the Whole System

- Delivering **innovative** and transformational change through whole system leadership;
- Providing organisation and system development support across the system, respecting the unique identities of **partner** organisations;
- Supporting our people and those that deliver services in Wakefield, to deliver large scale transformational change within the District; creating a supportive, developmental environment for them to work in;

4.6 Commercial Strategy Development

- Developing our approach to procurement and market development, underpinned by the principles of plurality of provision and respect for the individuality of partner organisations' own brands and commercial strategies;
- Commissioning services to deliver against **evidence** based outcomes and which demonstrate effective **prevention** as well as **personalisation** of services;
- Stimulating and developing the diversity of our provider market including the voluntary sector and small businesses;
- Balancing competition with collaboration;
- Engaging with all providers in the development and transformation of services through activities including provider development days;
- Making investment decisions that make Wakefield a better place to live and work.

5 Parties

The founding parties to these Business Rules are listed as follows but it should be noted that these rules and the Wakefield Integration Programme are inclusive and so this list marks a point in time only and in no way excludes other organisations.

- GP Clinical Networks
- Mid Yorkshire Hospitals NHS Trust
- NHS Wakefield Clinical Commissioning Group
- NOVA
- South West Yorkshire Partnership NHS Foundation Trust
- Spectrum Community Health CIC
- Wakefield Assembly/Age UK
- Wakefield Council
- Wakefield and District Housing
- Yorkshire Ambulance Service NHS Trust

6 Responsibilities

The division of responsibilities will be based on the following guiding principles:

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Accountability	Each partner organisation Board (or equivalent) will be accountable for its actions and the services it delivers;
Transparency	Commissioners, regulatory authorities and the public must know who is responsible for what;
Openness	Each organisation will share clinical, operational, financial and staffing information necessary for the planning and delivery of safe, high quality and sustainable services;
Co-operation	Organisations will work closely with each other and those other stakeholders who are not party to the Business Rules where relationships / interdependencies are relevant to the delivery of the Business Rules.

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Individual Partner Organisations will be individually responsible for:	Jointly the partner organisations will be proportionately responsible and accountable for:
▪ Discharging the responsibilities of their organisation including their service, fiduciary, regulatory, corporate and clinical governance and statutory responsibilities; ▪ Ensuring that the organisation adopts the principles and values set out in section 3; ▪ Reporting on progress to the Health and Well Being Board via the Integration Executive and others as required.	▪ Preparation and delivery of detailed plans for integrated models of service; ▪ Putting in place the programme management arrangements to support robust delivery of agreed plans; ▪ Ensuring strong clinical and professional leadership; ▪ Identifying and securing the resources required to deliver the programme management arrangements; ▪ Reporting on progress to the Health and Well-being Board.

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7 Governance Arrangements

Appendix __ sets out the governance framework showing the key relationships and accountability arrangements including points for escalation (for decision making and issue resolution). This shows the Wakefield Health and Well Being Board having overall responsibility for driving forward integration across Wakefield and holding the system to account for delivery of agreed plans.

The Health and Well Being Board will be supported in their work by an Integration Executive which will be the "engine room" driving integration and ensuring agreed actions are delivered through a robust programme management approach.

Appendices __ and __ include the terms of reference for both the Health and Well Being Board and the Integration Executive are attached to these Business Rules.

8 The Period

These Business Rules will be operative from XXXX and will be reviewed annually as a minimum by the partner organisation CEOs/ Chief Officers.

Progress in the application these rules will be monitored by the Integration Executive and progress will be reported to the Boards (or equivalent) of each partner organisation and the Health and Wellbeing Board.

June 2014

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Business Rules

The following are co-signatories to these Business Rules which support delivery of the Wakefield Integration Programme.

Partner	Title	Signature
NHS England – Area Team		
GP Clinical Networks x 7		
Mid Yorkshire Hospitals NHS Trust		
NHS Wakefield Clinical Commissioning Group		
NOVA		
South West Yorkshire Partnership NHS Foundation Trust		
Spectrum Community Health CIC		
Wakefield Assembly/Age UK		
Wakefield Council		
Wakefield and District Housing		
Yorkshire Ambulance Service NHS Trust		

Date……

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board – 27 January 2015
Agenda item 6.1

Title:	**Risk Management Strategy**
Paper prepared by:	Director of Corporate Development
Purpose:	The Trust's Risk Management Strategy ensures there are appropriate and adequate risk management processes in place within the Trust to manage and mitigate risk and is a key Strategy to support the Accounting Officer's Annual Governance Statement. The Strategy also ensures the Trust complies with Care Quality Commission and Monitor requirements.
Mission/values:	The Risk Management Strategy provides a framework for the continuous development of systems and processes to support assurance, compliance and risk management.
Any background papers/ previously considered by:	None
Executive summary:	The Risk Management Strategy is reviewed annually to reflect changes in the internal and external environment in relation to risk and was last reviewed in December 2013. The Risk Management Strategy enables the Trust to identify key risks in the external environment and in its forward plans. Planned actions to mitigate risks are described in the Trust's Business Plan, and in its Assurance Framework and risk register, which are reviewed by Trust Board on a quarterly basis. The Strategy has been reviewed to ensure it is fit for purpose for a further year and the following minor changes have been made; however, Trust Board should note that most of the content has not been subject to change. ➢ The strategic context has been updated to reflect the current position (page 3). ➢ References to the Trust's leadership and management arrangements have been updated to reflect the changes made during 2014. ➢ The implementation plan at appendix 5 has been updated. ➢ Directors' responsibilities at appendix 4 have been updated to reflect current portfolios. ➢ The revised Equality Impact Assessment has been included at appendix 10. ➢ The review and approval checklist and version control have been added at appendices 8 and 9 respectively.
Recommendation:	**Trust Board is asked to APPROVE the revised Risk Management Strategy.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Document name:	**Risk Management Strategy**
Document type:	**Trust-wide Strategy**
What does this policy replace?	**Update of previous strategy (requirement for annual review by Trust Board)**
Staff group to whom it applies:	**All staff within the Trust**
Distribution:	**The whole of the Trust**
How to access:	**Intranet and internet**
Issue date:	**V1 issued December 2008** **V2 issued October 2010** **V3 issued December 2011** **V4 issued October 2012** **V5 issued December 2013**
Revised date:	**Revised ~~December 2013~~January 2015**
Next review:	**~~December 2014~~January 2016**
Approved by:	**Trust Board 20 December 2011** **Trust Board 30 October 2012** **Trust Board 17 December 2013** **Trust Board 27January 2015**
Developed by:	**Director of Corporate Development**
Director leads:	**Director of Corporate Development**
Contact for advice:	**Director of Corporate Development /Integrated Governance Manager**

Risk Management Strategy
Contents

Pages 3 to 15	Risk Management Strategy 20145
Appendix 1	The process for identification, assessment and management of risk
Appendix 2	Guidelines for completing the Risk Register
Appendix 3	Risk grading matrix
Appendix 4	Directors' responsibilities
Appendix 5	Implementation plan
Appendix 6	Key risk related documents
Appendix 7	Risk Management Training
Appendix 8	Checklist for review and approval
Appendix 9	Version Control
Appendix 10	Equality Impact Assessment

RISK MANAGEMENT STRATEGY

1. Introduction

South West Yorkshire Partnership NHS Foundation Trust is an NHS foundation trust, providing a range of community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield, a population of over 1.2 million. The Trust also provides ~~some~~ specialist medium and low secure services to the whole of Yorkshire and the Humber. ~~In April and May 2011, a range of NHS services transferred to the Trust, including all community and mental health services in Barnsley. This was as a result of the Government's plans to transform the way community health services are provided to improve quality of care and outcomes for patients.~~

Foundation Trusts are required to demonstrate financial viability, sound governance and legality of constitution. The Risk Management Strategy describes the development of internal control systems to enable the organisation to achieve an appropriate focus on both delivery of high quality, safe and effective services and financial sustainability, and make timely decisions in order to develop the business. The Strategy is refreshed annually to ensure it remains responsive to changes in circumstances. Its approval is a matter reserved for Trust Board.

~~The purpose of this strategy is to set out the Trust's strategic approach to the anticipation, prevention, mitigation and management of risk, linked to the Trust's Business Plan. The strategy describes the systems the Trust has in place at a strategic, corporate and operational level to ensure that assurance is provided to Trust Board through its governance arrangements and to external bodies that risk is being effectively managed within the Trust. It also sets out the framework through which Trust Board drives a culture of proactive risk management.~~

2. Strategic context

The Trust was authorised as a Foundation Trust in May 2009. The process leading to authorisation provided assurance that the Trust has effective governance arrangements in place at Board level and throughout the organisation to enable the Trust to remain financially viable and sustainable.

As a Foundation Trust, the organisation operates in a different context to that of an NHS Trust. The autonomy and freedom from central Government control afforded by Foundation Trust status requires the Trust to have skills and systems in place to manage its own business. Trust Board must be assured of the safety and effectiveness of services and the financial sustainability of the organisation and, to this end, is responsible for developing the appetite of the Trust to take risks and the ability of the Trust to manage risk. In turn, Trust Board must be able to provide assurance to its external regulators, Monitor and the Care Quality Commission (CQC). This includes registration with the CQC to be a provider of NHS commissioned services and adherence to Monitor licensing conditions. ~~The Trust has also implemented the changes introduced by the Health and Social Care Act 2012.~~

3. Purpose

The purpose of the strategy is to set out the Trust's strategic approach to the anticipation, prevention, mitigation and management of risk, linked to the Trust's Business Plan. The strategy describes the systems the Trust has in place at a strategic, corporate and operational level to ensure that assurance is provided to Trust Board through its governance arrangements and to external bodies that risk is being effectively managed within the Trust. It also sets out the framework through which Trust Board drives a culture of proactive risk management.

~~3.~~4. Definition of risk

The Trust is a large and complex organisation, operating in an increasingly competitive and contestable health economy and, as such, faces service, political and financial challenges. The Trust is also subject to public scrutiny and providing services to people whose conditions or behaviour may be unpredictable. In this context, risk cannot be completely eliminated and the Trust's approach is to have in place systems and processes that enable it to:

- ~~-~~anticipate where risks might occur;
- ~~-and~~ make sound decisions based on information and intelligence; and
- ~~-to~~ minimise the likelihood or impact of potential risks.

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Risks ~~These~~ can be broadly defined as:

- strategic risks – risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans;
- clinical risks – risks arising as a result of clinical practice or those which are created or exacerbated by the environment, such as cleanliness or ligature risks;
- financial or commercial risks – risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income, inability to recruit or retain an appropriately skilled workforce, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation;
- compliance risks – failure to comply with its licence~~the terms of authorisation~~, CQC registration standards, ~~NHS LARMS,~~ or failure to meet statutory duties, such as compliance with health and safety legislation.

~~4.~~5. Aims of the strategy

The risk management strategy is designed to ensure a systematic and focused approach to clinical and non-clinical risk assessment and management is in place to support the Trust in meeting the needs of decision makers throughout the organisation and to meet all external compliance and legislative requirements, including those set by Monitor. Robust risk management systems, supported by effective training, need to be in place throughout the organisation and to be routinely used to support planning and delivery of services.

The Risk Management Strategy is a key strategy for the organisation and its objectives are to:

- provide a framework for risk management that assures Trust Board that the Trust is delivering against the strategy set out in its plan;
- clarify responsibility and accountability for management of risk throughout the organisation from Trust Board to the point of delivery (from 'board to ward') and support greater devolution of decision-making linked to Business Delivery Units and service line management;
- define the processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust;
- promote a culture of performance monitoring and improvement, which informs the implementation of the Business Plan and ensure risks to the delivery of the Trust's plans and market position are identified and addressed;
- ensure staff are appropriately trained to manage risks within their own work setting and clear processes are in place for managing, analysing and learning from experience, including incidents and complaints;
- ensure approaches to individual risk assessment and management balance the rights of individuals to be treated fairly, the rights of staff to be treated reasonably and the rights of the public in relation to public protection;
- support Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislative responsibilities, including standards of clinical quality, Monitor compliance requirements and the Trust's licence.

~~5.~~6. Monitoring

Monitoring of risk and the effectiveness of the Risk Management Strategy is undertaken through:

- review of the Strategy by Trust Board annually;
- scrutiny of Trust Board Committee minutes on a quarterly basis;
- internal and external audit activity;
- scrutiny of the assurance framework and risk register by Trust Board quarterly and by the Executive Management Team monthly;
- Directors' quarterly reviews with the Chief Executive;
- the Chief Executive's quarterly reviews with the Chair.

~~6.~~7. Current control systems

Trust Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk. This includes responsibility for standards of public behaviour and accountability for monitoring the organisation's performance against the agreed direction, ensuring corrective action where necessary. Trust Board must be confident that systems and processes are in place to support corporate, individual and team decision making and accountability for the delivery of safe and effective, person-centred care within agreed resources.

Trust Board is required to provide assurance to Monitor and to local people through the Members' Council that it is compliant with its licence, which encompasses financial viability, governance and clinical service quality.

The agenda and focus of Trust Board meetings~~, which include a quarterly Business and Risk meeting,~~ is continuously reviewed to ensure attention is given to both strategy and implementation~~ and regular, detailed reports are provided on performance and market assessment~~. Each quarter, there is a business and risk meeting, which is forward looking and risk-based, a general meeting, which provides a detailed retrospective review of performance, and a strategic meeting, which also informs Trust Board development.

There are currently four risk **committees of Trust Board**:

- the Audit Committee;
- the Clinical Governance and Clinical Safety Committee;
- the Mental Health Act Committee; and
- the Remuneration and Terms of Service Committee.
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Each of these committees has clearly defined **terms of reference** which set out the functions that the committee carries out on behalf of the Board. All Committees are chaired by a Non-Executive Director. Minutes are formally presented to Trust Board and assurance is provided to Trust Board by the Committee Chair. The Audit Committee Chair does not routinely attend any other committees to ensure objectivity; however, the Chair of the Audit Committee has the opportunity to attend each committee once a year as part of providing assurance to Trust Board on effectiveness of other risk committees.

Membership of committees is organised to ensure good linkages. The Director of Corporate Development attends all committees in the capacity of Company Secretary (with the exception of the Remuneration and Terms of Service Committee) and oversees the administration of all Committees.

The **Audit Committee** is responsible for assessing the adequacy of systems of controls assurance and governance in the organisation as described in the Annual Governance Statement and that the systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring there is independent verification of the systems in place for risk management. Responsibility for monitoring financial performance is held by Trust Board but the Audit Committee scrutinises the financial management systems through its links to internal and external audit.

The **Clinical Governance and Clinical Safety Committee** provides assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice, and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice. The Committee has a particular focus on ensuring standards of clinical care are improved or maintained in a climate of cost control and efficiency savings.

The **Mental Health Act Committee** is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended

by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty.

The **Remuneration and Terms of Service Committee** has delegated authority~~is responsible~~ for developing and determining appropriate pay and reward packages for the Chief Executive and Executive Directors and a local pay framework for senior managers that actively~~as appropriate, which~~ contribute to the achievement of the Trust's aims and objectives. The Committee also has delegated authority to approve any termination payments for the Chief Executive and Executive Directors and is also responsible for approving Clinical Excellence awards for Consultant Medical staff. The Committee also supports the strategic development of human resources and workforce development and considers issues and risks relating to the broader workforce strategy. On behalf of Trust Board, it reviews in detail key workforce performance issues.

The Trust also has two time-limited Board-level groups, which focus on the development and implementation of the Trust's estates and information and management technology strategies to provide assurance to Trust Board. Both are chaired by a Non-Executive Director.

Trust Board and its Committees are reviewed on an ongoing basis to ensure that Trust Board adds value to the organisation in terms of setting strategy, monitoring performance and managing risk. This includes:

- a development programme based on continuous review of the combined skills and competencies of the Trust Board;
- ongoing review of the format of Board meetings to ensure best use of time and appropriate balance between strategy development and retrospective performance monitoring;
- an annual review of the Committee structure, membership and terms of reference to ensure clarity of role and optimise their effectiveness.

The **Members' Council** plays a key role in the Trust's governance arrangements. It provides a bridge to the community, supporting the Trust to engage with its membership and acting in an advisory role in the development of strategy and plans. Under the Health and Social Care Act 2012, the Members' Council has a duty to hold Non-Executive Directors to account for the performance of Trust Board. Its work programme is specifically designed to reflect this duty.

The Members' Council is also responsible for monitoring the effectiveness of Trust Board including the appraisal of the Chair and appointment and removal of Non Executive Directors. The Members' Council has a **Nominations Committee** to support this role.

Development of the Members' Council focuses on:

- development of the interface between the Trust Board and Members' Council;
- public and staff elections to attract people who represent the diversity of the community served by the Trust and effective induction of new members;

- development of individual and collective skills of the whole Members' Council;
- development of the interface between the Members' Council and the wider membership to optimise the Members' Council's role.

The **Chief Executive** is the Accounting Officer of the Trust and has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding its resources. The Accounting Officer's approach to this is set out in the Annual Governance Statement, which describes the system of internal control within the organisation. This is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The Chief Executive provides leadership to the **Executive Management Team**. The Executive Management Team is made up of Executive and Operational Directors and is responsible for ensuring implementation of the strategy, plans and policies agreed by Trust Board. To ensure alignment with Trust Board meetings, Executive Management Team meetings are organised into transformation (focus on transformation and future vision with overarching scrutiny of the implementation of the transformation programme), strategy and risk (external focus, particularly in relation to stakeholders, partners and competitiveness, risk scanning across the system), and delivery (internal focus on delivery and performance). This also ensures risks to delivery of the Trust's plans are closely monitored and that the Trust remains forward looking.

The Executive Management Tteam reviews the risk register and scans clinical incidents, claims and complaints to ensure they are being effectively managed and action is being taken to minimise the risk of recurrence. The Executive Management Team also reviews the strategic position of the Trust and any potential threats to income or achievement of its plans. ~~Meetings are organised into strategic, business and risk, and performance sessions to ensure risks to delivery of the Trust's plans are closely monitored and that the Trust remains forward looking.~~

The **Extended EMT** meets monthly. The Extended EMT provides an opportunity to engage all first line report staff in transformation and delivery. It comprises all Executive Directors and senior staff, including heads of service and clinical, ~~and~~ general management and practice governance leads from Business Delivery Units. ~~Currently, the role of t~~The Extended EMT ~~is~~ focusses~~d~~ on the Trust's transformation programme, acting as a guiding coalition for the overarching programme, and on the delivery and implementation of the Trust's plans. As part of this role, it will continue to ensure clinical and non-clinical risks are identified within services and that these are recorded on risk registers with appropriate mitigating action taken, taking into account external guidance and intelligence that might affect the Trust's ability to deliver its strategy. Additionally, part of its role is to provide a forum for learning from clinical incidents, complaints and human resources processes and external inquiries and to maintain a focus on compliance with external targets.

Business Delivery Units (BDUs) are responsible for delivering safe and effective services within agreed resources to specific localities and specialist and fForensic sServices, within a framework of devolved responsibility.

The executive functions of the organisation have been reviewed to support the ongoing development of BDUs and devolution of decision-making to service lines. The Executive Management Team has reviewed the way that it works to ensure effective matrix working between the BDUs and the support directorates through a Quality Academy approach designed to ensure capacity in the organisation is prioritised towards delivering high quality, sustainable services.

Each BDU has a deputy district director to support District Directors to deliver services. They also manage the working relationship of the 'trio'-based approach at senior level, encompassing clinical, general management and practice governance to ensure excellence in service quality and delivery in terms of effective clinical engagement and prioritisation, appropriate deployment of resources and effective clinical governance.~~both clinical and managerial leadership at senior level. Where this is not a practising clinician, formal arrangements for clinical leadership are in place. Where this is a practicing clinician, appropriate management and business development arrangements are in place.~~

Business Delivery Unit Directors are responsible for determining the configuration of service lines within the BDU to optimise quality and efficiency.

~~As part of t~~The role of the Quality Academy is to:~~approach, a contracting framework between BDUs and support services has been agreed to ensure that BDUs receive a combined support service offer to enable them to deliver services on a devolved basis at the highest quality and optimum cost. This framework covers the following areas.~~

1. combine the work of the voting executive directors, including corporate development and health intelligence and innovation;~~**Key elements of the support service offer** to cover standards of service linked to key domains and the structure and process to be adopted in terms of devolved support, including people, resources and time.~~
2. ensure key linkages and synergies between all portfolios to provide optimal support to delivery of services in BDUs;~~**Maintaining corporate accountability** to ensure that corporate accountabilities linked to Executive roles are met, in particular, statutory and legal, and to identify the split of resources to be devolved and those that will be held centrally.~~
3. ensure ongoing quality improvement and associated compliance with regulatory requirements; and~~**Delivering synergies and cost improvements** to provide a clear outline of synergies, improvement and efficiency savings.~~
4. ~~e~~Ensur~~eing~~ linkage across key domains of the Quality Academy.

Trust-wide action groups (TAGs) focus on specific issues and ensure these are being properly addressed through the BDUs~~service delivery groups~~. Executive Directors may establish TAGs to support them to discharge their accountability.

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Professional leadership arrangements are in place within the Trust for nursing, allied health professionals, medicine and pharmacy, psychological therapies and social care staff to support the delivery of safe clinical services through development of the knowledge and skills of staff. This is led by the Director of Nursing.

The Trust has a dedicated **Contracting Team** to manage the relationship with commissioners ensuring there are sound systems in place ~~for respond~~to responding~~g~~ to issues which might affect future commissioning intentions and provide a forum for exploring opportunities for service development. These are supported by Director-level Contracting and Quality Boards in each district. Identification of risks to income, opportunities for expansion, and risks to achieving targets and key performance indicators are reported and considered through delivery~~performance~~ EMT meetings where appropriate action is agreed.

Effective management of the Trust's relationships with commissioners is reviewed on a regular basis to ensure it reflects the changing arrangements for commissioning set by the Government and NHS England. Arrangements for managing commissioner relationships and contracts have been developed by and are the responsibility of BDU Directors.

7. Responsibility for implementation of the strategy (duties)

Executive Directors are collectively responsible, as members of Trust Board, for setting the strategic direction of the organisation and ensuring there are sound systems and processes for managing risk.

Individual directors have lead responsibility for specific areas of risk management which are detailed in appendix 4.

Managers in the Trust are responsible for effective risk management including:

- identifying risks within their own service area and ensuring these are appropriately managed or controlled and that risks which cannot be controlled or prevented are recorded on the appropriate risk register at the appropriate level;
- ensuring adherence to Trust policies and procedures to support effective risk management;
- raising staff awareness of the key objectives in the risk management strategy;
- ensuring staff awareness of guidance relating to the identification, recording and management of hazards and incidents, including near misses;
- effective management of clinical and non-clinical risks in their area, including risks to the Trust's reputation;
- management of communications, including adherence to Trust policy;
- staff awareness (including sub-contractors) of risks in the working environment;
- staff awareness of policies and procedures;
- implementation of action plans arising from investigations into complaints or incidents;
- staff training needs are identified and addressed;
- adherence to standing orders, ~~and~~ standing financial instructions and scheme of delegation.

All staff have responsibility for managing risk within their own sphere of responsibility, including:

- awareness of organisational and health and safety risk assessments and of any measures (e.g. policies and procedures) that are in place to mitigate risks;
- identifying and reporting hazards and risks arising out of work-related activities;
- awareness of the requirements to report adverse events and incidents;
- awareness of procedures for dealing with complaints and claims;
- awareness of their responsibilities for implementing any actions arising as a result of incidents or complaints;
- awareness of procedures for dealing with media inquiries;
- working within their area of competence and identify their own training needs;
- following Trust policies and procedures;
- contributing to identification of risks and follow up actions in the risk register.

8. Risk management processes

Risk management is recognised as ~~being~~ integral to good management practice and is~~needs to be~~ the business of everyone in the organisation. Risk management processes are designed to support better decision making by contributing to a greater understanding of risks and their potential impact.

The principal tools upon which Trust Board relies to gain assurance are described in the Chief Executive's **Annual Governance Statement** which is reviewed annually. It shows that the Trust understands its risks, is taking reasonable action to manage those risks and has action plans in place. Systems of internal control are designed to manage risk to a reasonable level rather than to eliminate all risk, through the continuous assessment of the internal and external environment to identify and mitigate risks to the achievement of the Trust's objectives and prioritisation of risk management through assessment of the likelihood and impact of identified risks if they materialise.

Effective management of risk relies on the following processes and systems.

The Trust is required by Monitor, as part of its **Licence,** to have in place a Constitution which is compliant with legislation. The Licence also requires that the organisation is financially viable and sustainable, and well governed, and that it can continue to provide commissioner requested services ~~(as set out in previous mandatory services schedules)~~.

The **Constitution** of the Trust sets out the legal framework in which the Trust operates. The Constitution is based on the model core constitution and defines the powers of both ~~the~~ Trust Board and the Members' Council. The **Standing Orders** of Trust Board and Members' Council form part of the Constitution.

As part of its Standing Orders, Trust Board has approved **Standing Financial Instructions** and a **Scheme of Delegation**, which provide the framework within which responsibility for financial decision making takes place throughout the organisation and is designed to ensure Trust Board has appropriate levels of control over financial decisions and is alerted to financial risks.

Trust Board assurance that its principal objectives are being achieved is summarised and evidenced in the **Assurance Framework.** Where there are gaps in control or Trust Board has received insufficient assurance, these are reflected on the risk register. The Chief Executive uses the Assurance Framework as the template for quarterly performance reviews with each Director. The Assurance Framework is reported to Trust Board on a quarterly basis and provides evidence of actions taken to manage risks.

The Assurance Framework and risk register are reviewed during the year to ensure the process, which is scrutinised by the Audit Committee on an annual basis, and format continue to provide an effective tool for summarising and monitoring assurance and risk management at Board level. The advice of internal audit is sought as part of this review.

The **Risk Register** links closely to the Assurance Framework and enables Trust Board to closely monitor any risks identified in the assurance framework where there are gaps in control (i.e. where there are external factors which the Trust cannot control or where the measures being taken by the Trust are unable to eliminate the risk.) Risk registers are held at Trust Board level, by each BDU and by support services. The r~~R~~isk registers held by BDUs and support services are reviewed regularly and any risk which could have an impact across the Trust is reported to the Executive Management Team monthly to ensure risks which may have a Trust-wide impact are recorded on the Trust's risk register. Individual directors are responsible for ensuring there is a process for identifying risks relating to support services and for adding items to the Trust Board risk register (see section 9). Risk registers held at Trust Board and at service level are designed to be 'live' working documents which support the organisation to identify, assess and manage risks.

The Trust is required by its Regulator, Monitor, to produce an annual ~~rolling three-year~~ **Business Plan** for organisational and service development. The plan describes the key risks to delivery of the plan and how these would be mitigated. It maps the direction of travel, and so supports Trust Board and service managers to identify where it may be deviating from target and take remedial action.

Annual plans are developed within each locality and support directorates and co-ordinated into a Trust plan. Annual plans are agreed with commissioners and support the delivery of the business plan. The plans identify service developments and changes, and the financial and workforce implications of those plans, including any required cost improvements (CIPs). Undertaken by the Director of Nursing and the Medical Director, each cost improvement is subject to a **Quality Risk Assessment**. The assessment covers three aspects of quality (person-centred, safe, effective and efficient). The assessment tool provides a quality impact rating from 'weak' (where a cost improvement will have a detrimental impact on quality of services) to 'excellent' (where it will have a positive impact on the quality of services). The assessment is based on the Trust's seven quality priorities around access, listening to and involving service users and carers, care and care planning, recording and evaluating care, working in partnership, staff fit and well to care, and safeguarding. Where risks are considered to be substantive, plans may be changed or mitigating action put in place to manage the risk.

Reporting of performance against plan enables Trust Board to assess the impact and opportunities of financial decisions on clinical services and the impact of service changes on the financial position of the Trust. The reports also support Trust Board in the early identification of any risks to its strategic position, financial viability or public reputation. High level performance reports are circulated to Trust Board on a monthly basis and each quarter the Board agenda is dedicated to consideration of strategic and business risks, which includes review of performance against plan and compliance.

A range of **strategies, policies and procedures** are in place to support the effective management of risk throughout the organisation and these are located on the Trust's intranet.

The Trust aims to have a whole system approach to risk management where all staff are encouraged to take responsibility for assessing and managing risk within their own sphere of responsibility and the Trust, through its management structure, and staff have a shared responsibility for ensuring ~~staff have~~ the requisite skills are in place to identify and manage risks.

A risk management process based on the Australian/New Zealand Standard (appendix 1) is used within the Trust. The whole system approach is continuously monitored by Trust Board and through the leadership and management framework to support learning and improvement.

The aim of the approach is to support an organisational culture based on prudent ambition in relation to service development and learning from experience to minimise the likelihood of risks manifesting themselves and to enable the Trust to respond positively to mitigate the impact of unavoidable risks and maximise opportunities of doing so.

Challenges in the external environment, combined with both service and structural transformation~~change~~ planned for the year ahead, offer opportunities to develop services but expose the organisation to a degree of risk. The Trust will continue to develop its risk systems in line with the changes to its structure and leadership and management arrangements, and put in place robust plans for managing risk through a period of political and financial instability, and externally and internally driven change.

9. Risk reporting and procedures

The Trust uses Datixweb to support the recording, management and review of risks and production of risk registers across the Trust to ensure consistency of recording. Datix allows control measures to be recorded and actions to be scheduled, with a full audit trail of changes to risk assessment. Information feeds through levels of risk register from 'ward to board'. The system has the ability to report at different levels, look at trends across the organisation and risk areas, such as information governance, or~~and~~ health and safety, and record and manage actions. Identification and prioritisation of risks can be linked to other Datix modules, such as incidents and

complaints. The Trust's has a document "Risk Management Procedure", which sets out the processes for this system and this can beis found on the Trust's intranet.

10. Monitoring compliance with the strategy

Compliance with the strategy will be monitored through established risk processes already in place within the organisation. These are outlined below.

11. Risk Management Training

The Trust's approach to risk management training in respect of Trust Board and the Extended Executive Management Team is set out at Appendix 7.

Monitoring compliance with the strategy

Risk process	Purpose	Frequency	Lead	Outcome
Review of the Risk Management Strategy	To ensure it is appropriate for the Trust, reflects current priorities and the external environment, and is fit for purpose.	Annual	Director of Corporate Development	To ensure Trust Board fulfils its overall accountability and responsibility for risk management in the organisation and thatsets the Trust's approach to risk fits with the Trust's strategic direction.
Annual Governance Statement	Sets out the Trust's systems and processes of internal control	Annual	Chief Executive	Presented to and supported by Trust Board. Included in the Trust's annual report and accounts, scrutinised by the Audit Committee, Trust Board and Monitor.
Trust Board Committees review of their effectiveness	To ensure Trust Board committees are meeting their terms of reference and providing assurance to Trust Board of their effectiveness in scrutinising risk in the organisation.	Annual	Committee Chairs and lead Directors	Annual report presented to each Committee by Committee Chair and lead Director. Committee undertakes a review of its terms of reference to ensure relevance and appropriateness approves its annual work programme and undertakes a self-assessment. The annual report is then presented to the Audit Committee to provide assurance to Trust Board.
Audit Committee review of the effectiveness of risk committees	To ensure Trust Board committees are meeting their terms of reference and providing assurance to Trust Board of their effectiveness in scrutinising risk in the organisation.	Annual	Chair of Audit Committee/ Director of Corporate Governance	Presented to Audit Committee, which provides assurance to Trust Board.
Ongoing work of risk committees	Scrutiny of risk and its management	Committees meet a minimum of four times per year	Non-Executive Chairs/Lead Directors/Director of Corporate Development	Quarterly feedback to Trust Board and annual reports to the Audit Committee and, through the Committee, to Trust Board.
Internal audit programme	This takes a risk-based approach to provide assurance that the Trust's key internal controls are robust, appropriate	Annual work programme	Deputy Chief Executive/Director of Finance	Presentation of reports to the Audit Committee. Head of Internal Audit Opinion forms a key part of the Trust's annual

Risk process	Purpose	Frequency	Lead	Outcome
	and fit for purpose. The programme forms the basis of the Head of Internal Audit Opinion and the Accounting Officer's Annual Governance Statement.			reporting statements.
Internal audit of risk management processes	To provide assurance that the Trust's processes are robust, appropriate (fit for purpose) and are followed.	Annual	Internal audit/ Director of Corporate Development	Presentation of report to Audit Committee.
Review of the Trust's appetite for risk.	To ensure that the Trust's strategic direction, objectives and annual plan reflects its appetite for risk and that this is consistent with the Trust's mission, vision and values.	Annual (as part of annual planning)	Chair and Chief Executive	Agreement of the Trust's strategic direction and annual plan tothat ensures the Trust's meets its objectives and manages risk in an effective way at a level appropriate to the Trust.
Mandatory risk management training	To ensure that the Trust's approach to risk management is embedded at the highest level within the organisation.	Annual	Director of Corporate Development	Trust Board and members of the Extended Executive Management Team undertake mandatory risk management training on an annual basis.

Appendix One

The larger process for identification, assessment and management of risk

Risk management is an iterative process consisting of ~~well-defined~~well-defined steps, which, taken in sequence, support better decision-making by contributing a greater insight into risks and their impacts. The risk management process can be applied to any situation where an undesired or unexpected outcome could be significant or where opportunities are identified.

Risk management is recognised as an integral part of good management practice. To be most effective, risk management should become part of an organisation's culture. It should be integrated into the organisation's philosophy, practices and business plans rather than be viewed or practiced as a separate activity. When this is achieved, risk management becomes the business of everyone in the organisation.

Risk Management may be applied at all stages in the life of an activity, function, project, product or asset. The maximum benefit is usually obtained by applying the risk management process from the beginning.

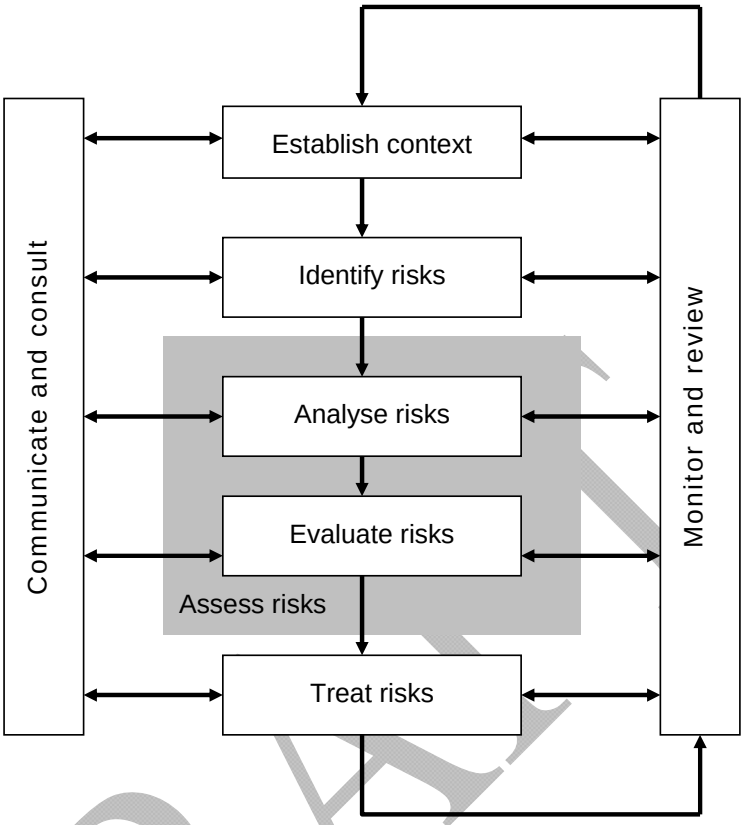
The Trust's whole system approach to risk assessment and management requires the organisation to have in place a systematic process for evaluating and addressing the impact of risk in a cost effective way. In order to achieve this, the Trust is committed to providing staff with the appropriate skills to identify and assess the potential for risk to arise. The system will support the use of professional judgement and decision-making.

The Trust will seek to provide an environment in which people feel comfortable about reporting incidents and risk issues and discussing them in an open, non-accusatory way. It is recognised that staff need to feel that they work in a safe and 'just culture', in which people who report risk or disclose unsafe practice are supported.

Every organisation carries some level of risk, whether associated with clinical care, financial planning, organisational reputation or the recruitment and retention of staff. Risk management is about bringing the risks from those activities together in order to allow risks to be viewed both strategically and operationally. This in turn will allow decision makers to consider the quantity and extent of risk presented and to make some choices about them.

It is important to define the relationship between the organisation and its environment, identifying strengths, weaknesses, opportunities and threats.

The context includes the financial, operational, competitive, political, social, cultural, reputational and legal aspects of the organisation's functions. This needs to be done within the context of both internal and external factors, including understanding key stakeholders and their impact on the organisation.



Risk Management Overview

Step One: Identification of risks

A variety of sources of information, proactive and reactive, are used to identify risks. External sources include national guidance, market analysis, financial and workforce data, benchmarking, feedback from external compliance processes, patient safety notices and communications, external inquiry reports. The Trust also relies on intelligence to identify threats to income, gained through formal processes including ~~the Area Contracting Teams'~~ contact with commissioners, which is fed into the Trust via the appropriate TAG and feedback from other sources such as patient surveys, complaints and compliments and direct communications with GPs.

The Trust's approach to business planning through an annual planning cycle incorporating dialogue and formal agreement with commissioners regarding the range, level and quality of services encourages the early identification of risks and enables the trust to take appropriate mitigating action where risks are identified. Planning processes are also designed to minimise the risk of the organisation incurring costs associated with the development of new services where the source of income is not identified.

Reports commissioned from internal and external audit support identification of risks and provide information about the effectiveness of controls in place to manage or mitigate risks.

Internal intelligence on risks is generated through data collection systems, including the Trust's clinical information system (RiO), which provides information about clinical activity, CQUIN targets, which provide key data relating to the quality of Trust services, and the Datix system, which provides information about adverse events and complaints.

Analysis of media coverage provides information about risks to the Trust's public reputation.

Step two: Analysis of risks
The objective of risk analysis is to separate minor acceptable risks from major risks. Risk analysis involves consideration of the sources of risk, their consequences and the likelihood of the risk manifesting itself. This information enables the Trust to plan action to reduce the likelihood of the risk occurring and to put in place contingencies to reduce the impact if the risk manifests. Sources of information may include:

- past experience;
- intelligence gained from specific sources such analysis of performance information, benchmarking, direct communications with commissioners or other stakeholders;
- published materials;
- specialist and expert judgements.

Step three: Evaluation of risks
Risk evaluation involves applying established criteria to enable the organisation, team or individual to assess the negative impact that could occur if the risk to the organisation or to service users if the risk materialises compared to the opportunity (or positive impact) that could occur as a result of taking the risk. The ability to balance the positive impact of taking risks against the potential negative impact is particularly critical in a complex environment such as the delivery of clinical services, where a no risk culture would detrimentally affect clinical decisions.

The Trust also needs to be able to assess the likely benefits of opportunities that may present to attract new sources of income against the risks. F~~, f~~or example, where there is an opportunity to develop a new service, the Trust needs to be assured that the income will exceed the required investment in buildings or staff or that there are significant benefits in terms of partnerships, reputation or market position from developing new services which offer only a marginal financial contribution.

Evaluation should take account of the following criteria.

- Impact on service delivery and quality of services.
- Financial/value for money issues.
- ~~Impact on service delivery and quality of services.~~
- Reversibility or otherwise of the risk.

- Quality or reliability of evidence surrounding the risk.
- Impact on the organisation, stakeholders of partners.
- Impact on the Ttrust's reputation.
- Whether, on balance, the risk is defensible.

If the resulting risk is low or acceptable, it may be accepted with minimal further treatment but should be regularly and routinely monitored to ensure that it remains acceptable.

If the risk is higher, the Trust should either take action to prevent the risk occurring or develop contingencies (risk treatment).

Step four: Risk treatment
Risk treatment involves identifying the range of options for preventing or dealing with a risk, assessing the options and preparing and implementing 'treatment' plans.

Options, which are not necessarily mutually exclusive, may include the following.

i) Avoid the risk – do not undertake the activity which is likely to generate the risk. Risk avoidance is not always appropriate and may in itself present alternative risks, such as:

- decisions being taken to avoid or ignore risks even where the potential benefits outweigh the risks;
- failure to treat or address risks;
- leaving critical choices or decisions to other parties;
- deferring decisions which the organisation cannot avoid.

ii) Reduce the likelihood of the risk – identify actions which can be taken to reduce the likelihood of the risk occurring and put in place arrangements for monitoring the implementation and effectiveness of those actions.

iii) Reduce the consequences – identify actions that can be taken to lessen the impact should the risk materialise and put in place arrangements for monitoring the implementation and effectiveness of those actions.

iv) Risk control – efforts to reduce the likelihood or consequences of a risk are risk controls. Controls may include policies, procedures or changes to the environment. Controls should be regularly reviewed to ensure they remain relevant and effective.

v) Transfer the risk – put in place arrangements to ensure other parties bear or share the risk and/or its consequences. Contracts, service level agreements, partnerships and joint ventures and insurance provision all form part of the Trust's mechanisms for transferring or sharing risks.

vi) Retain the risk – where the Trust is unable to transfer or eliminate the possibility of a risk materialising, plans should be put in place to manage the consequences of the residual risk. This may include identifying contingencies to offset the risk or to prepare for financial consequences.

A number of options for managing risk may be considered and applied either individually or in combination. Selection of the most appropriate option involves balancing the cost of implementing each option against the benefits derived from it. In general, the cost of managing risks needs to be commensurate with the benefits obtained. Decisions should take account of the need to carefully consider rare but severe risks, which may warrant risk reduction measures that are not justifiable on strictly economic grounds. In general the adverse impact of risks should be made as low as reasonably practicable.

Action planning to manage risks
The action plan for managing risks should identify which of the above approaches is intended. The plan should identify responsibilities, the expected outcome of treatments, budgeting, performance measures and the review process to be set in place. The plan should also include a mechanism for assessing the implementation of the options against performance criteria, individual responsibilities and other objectives, and to monitor critical implementation milestones. Actions to address significant risks are recorded on the risk register.

The Risk Register is a tool used by the Trust to enable the organisation to ~~comprehensively~~ understand and prioritise significant risks to the organisation requiring focus and attention. The Trust is a large and complex organisation that works within a devolved management framework. It is therefore important that the way in which the risk registers are developed reflects these management arrangements. This will ensure that risks are being assessed and managed throughout the Trust with decisions being made as near as practicable to the risk source. In addition, key risks can be monitored at the appropriate level. Risks where either the controls in place to manage the risk or the likelihood and impact score means that it is graded red will be monitored by Trust~~the~~ Board through the organisational risk register. The Trust uses the Datix system to support the recording, management and review of risks and production of risk registers across the Trust to ensure consistency of recording.

The Trust risk register is a 'living document' and as such is reviewed and revised monthly by the Executive Management Team providing a continuous scanning process. The risk register is also audited regularly for its level of accuracy and fitness for purpose and reviewed on a quarterly basis by ~~the~~ Trust Board. It is central to the internal control system~~,~~; provides a focus to support the Trust's review of its systems of internal control and also reflects gaps in control and/or assurance in the Assurance Framework. All directors are set principle objectives linked to the organisation's strategic objectives and, with the r~~R~~isk r~~R~~egister, ~~and these~~ are reviewed quarterly by the Chief Executive. The framework for delivering each objective includes the requirement to describe any risks to achieving the objective and the controls in place to manage the risk.

All BDUs have risk registers, informed by the risks identified through clinical teams, Directors and key stakeholders. The BDU risk registers are used to inform the Trust Risk Register through the Executive Management Team. ~~Where appropriate, i~~Individual Directors hold a register detailing risks that are managed within support services.

Risk registers should be used to inform decision-making processes. Ideally, all decisions, such as changes in policies, procedures or practices, and all resource commitments, should result in reductions to the organisation's highest priority risks. This means that, at all levels, proposals to make changes or commit resources should include reference to the effects that this may have on the risk profile of the organisation. For significant changes, all business plans, bids for funding and proposals are required to include a section which shows how they will help reduce the risks to the organisation and whether any additional risks will arise.

Risk rRegisters should be flexible enough to allow the organisation to respond to unforeseen risks, serious incidents, external events or changes in national policy. A dynamic, comprehensive and effectively used risk register process will not only drive risk management, but will also ensure that the Trust can justify the decisions it has made.

Guidance on completion of the rRisk rRegister and the risk grading matrix applied in the Trust are included in appendix 2 and in the document "Risk Management Procedure".

Monitoring and Review

Risk management systems and are scrutinised by the Audit Committee, supported by internal audit and external audit, and the overall management of risk is monitored by the Trust Board, through the Assurance Framework and risk register.

The role of internal audit is to provide an independent and objective opinion to the Chief Executive and Trust Board on the system of control. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The audit programme is based on a risk assessment of the Trust, using the Assurance Framework and the Trust's risk register. Action plans are agreed to address any identified weaknesses. The Audit Committee relies on internal audit to support it in its role of providing assurance to Trustthe Board on the effectiveness of internal controls. Internal audit is required to identify any areas to the Audit Committee where it is felt that insufficient action is being taken to address risks.

External audit also plays a key part in identifying key risks to the organisation in relation to its work and in the monitoring and review of the Trust's systems and processes, particularly in relation to financial probity and value for money.

Communicate and consult

Effective communication is important to ensure that those responsible for managing risk and those affected understand the basis on which decisions are made and their responsibilities for managing risk. Each step of the risk management process should identify communications activity to take place with internal and external stakeholders. Communications should address issues relating to both the risk itself and the process to manage it. Communication and consultation involve a two-way dialogue between stakeholders. Since stakeholders can have a significant impact on the effectiveness of the arrangements for managing risks, it is important that their

perception of risk, as well as their perception of benefits, are~~be~~ identified and documented and the underlying reasons for them understood and addressed.

Documentation

Each stage of the risk management process should be documented to:

- ~~to~~ provide those responsible for managing the risk with a clear plan for approval and subsequent implementation;
- ~~to~~ facilitate effective monitoring of the management plan;
- ~~to~~ provide a record of risks and lessons learned;
- ~~to~~ facilitate sharing and communication of information;
- ~~to~~ provide evidence of a systematic approach to risk identification and analysis.

Risk Management Database and Incident Reporting System

The Trust uses the Datix electronic risk management database, which has modules for managing complaints, incidents, claims, Customer Services and coroners' inquests to support the retrospective review of clinical risk and facilitate learning from experience.

Trust-wide reports about incidents, complaints and claims are provided on a quarterly basis to the Clinical Governance and Clinical Safety Committee on behalf of Trust Board. Relevant information about incidents and complaints are also provided on a regular basis to BDUs, Trust-wide Action Groups, and professional groups. Specialist Advisers have direct access to the system and are able to scan the system and produce statistical incident reports.

The Trust works with the NPSA Patient Safety Manager, and patient safety incidents have been reported directly into the NRLS (National Reporting and Learning System) in line with national requirements, since December 2004.

The project to develop and implement the Datix risk module across the Trust to enable it~~the Trust~~ to manage the identification of risk and risk registers at all levels of the organisation has been completed. Ongoing work ~~will~~ focuses on embedding this system at all levels, ensuring staff have the appropriate skills to identify and assess risk, the use of Datix in monitoring and managing risks, and embedding the role of risk co-ordinators with BDUs and support services, particularly the relationship with Practice Governance Coaches.

Guidelines for Completion of Risk Register

Appendix 2

	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
3 Negligible	1	2	3	4	5

Green	1 – 3	Low risk
Yellow	4 – 6	Moderate risk
Amber	8 – 12	High risk
Red	15 – 25	Extreme risk

Document Control	
Authors	
Version	
Circulation	
Date	
Status	

Risk ID	Hist. Ref	Source	Risk Responsibility	BDU/Directorate	Service	Specialty	Description of risk	Current control measures	Consequence (Current)	Likelihood (Current)	Rating (current)	Risk level (current)	Summary of risk action plan	Fin cost (£)	Risk Owner	Expected date of completion	Monitoring & Reporting Requirements	Risk level (Target)	Is this rating acceptable?	Comments	Risk Review Date

Appendix 3

Risk registers: guidance on use of the risk grading matrix

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 to determine the likelihood score(s) (L) for those adverse outcomes.

4 Calculate the risk score, multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

Appendix 4

Directors' Responsibilities

Trust Board has overall responsibility for setting the strategic direction of the organisation, ensuring the Trust meets all external compliance duties and promoting a culture of effective risk and performance management. Individual Executive Directors have specific responsibilities in relation to risk management.

Chief Executive	As Accounting Officer, has overall accountability for risk within the organisation, in particular, internal control systems and organisational governance, Risk Management Strategy and ~~Integrated~~ Business Plan.
Director of Finance	Executive Director with accountability for strategic financial planning and management, demonstrating probity, including counter fraud, and value for money. Overall responsibility for coordination of the transformation programme to redesign services. Responsibility for performance management and information management and technology, including implementation of RiO, and information governance. Also holds director lead for business planning, including securing a strong market position for the organisation through integrated business and annual planning processes, and service level agreements and contracting. Holds the role of Senior Information Risk Officer.
Medical Director	Executive Director with accountability for medical leadership, including professional development and practice effectiveness, medicines management, public health, research and development, professional leadership (with the Director of Nursing), and shared accountability for clinical quality with the Director of Nursing.
Director of Human Resources and Workforce Development	Executive Director with accountability for strategic Human Resource management, workforce development, facilities and estates maintenance, catering and food hygiene, environmental management, fire safety, health and safety, security management, and waste management. Director lead for the strategic approach to the Trust's estate. Also lead director for emergency and business continuity planning.
Director of Nursing, Clinical Governance and Safety	Executive director with accountability for clinical governance and clinical safety, and compliance, including safeguarding children and vulnerable adults, system for reporting, managing, analysing and learning from incidents, including Serious Incidents, managing violence and aggression, infection prevention and control, medical devices, clinical records management, professional leadership for non-medical clinical staff, and the Mental Health Act. Has shared accountability for clinical quality with the Medical Director. Holds the role of Caldicott Guardian.
Director of Corporate Development and Constitutional Affairs	Lead Director for co-ordination of the risk agenda and with overall responsibility for the Risk Management Strategy. Director role has accountability for corporate governance, communications and public relations, public involvement, diversity and inclusion, system for managing complaints, claims and litigation, supporting the Chief Executive in maintaining the Trust Risk Register and Assurance Framework and other corporate systems. Company Secretary portfolio contained in the role.
Director of Health Intelligence and Innovation	Lead Director for research and development.
Business Delivery Unit Directors	Directors with strategic and operational accountability for service delivery across Barnsley and Wakefield, Calderdale, Kirklees and Specialist Services, and Forensic services.

There are also a number of statutory and regulatory responsibilities across the Trust relating to risk as follows.

Function	Lead
Accounting Officer	Chief Executive
Caldicott Guardian	Director of Nursing, Clinical Governance and Safety
Company Secretary	Director of Corporate Development
Controlled Drugs	Chief Pharmacist
Counter Fraud	Director of Finance
Director for security	Director of Human Resources and Workforce Development
Emergency planning	Director of Human Resources and Workforce Development
Fire	Director of Human Resources and Workforce Development
Health and Safety	Director of Human Resources and Workforce Development
Income from overseas	Business Delivery Unit Directors
Lead Governor	Governor (Members' Council)
Registration Authority Manager	Director of Finance
Senior Independent Director	Non-Executive Director
Senior Information Risk Officer	Director of Finance
Whistleblowing (Non-Exec)	Deputy Chair/Senior Independent Director

Appendix 5

Implementation plan

Action required	Action plan	Review date	Lead	Training implications
Review Board meeting cycle, agenda setting process and committee functions to ensure focus of each meeting is clear and ensure adequate focus on strategy, risk and performance.	Review agenda setting to ensure balance of focus on strategy and retrospective performance monitoring. Review terms of reference and membership of committees to ensure clarity of function and effective Board assurance.	Ongoing	Chair, Chief Executive and Director of Corporate Development	Board development sessions and strategy sessions built into cycle
Continue improved performance reporting to Trust Board to ensure information is well integrated, timely and accessible.	Review Board approach to performance monitoring to ensure the information meets Board requirements.	Ongoing	Chief Executive and Director of Finance	Individual and whole Board development to support effective governance
Each committee to undertake an annual self assessment exercise and produce an annual report to ~~the~~ Trust Board demonstrating how it has met its terms of reference.	Self assessment exercise to be undertaken by each committee to review performance against annual plan and interface with other committees and reported to Trust Board by the Audit Committee	April 2015~~4~~	Chair of Audit Committee, other Committee Chairs and lead director for each committee	None
Work programmes to be developed annually and reviewed regularly for each Committee to ensure efforts are focused on management and monitoring of risks identified in the assurance framework, risk register and annual~~business~~ plan.	Annual work programme to be developed for each committee and reported to Trust Board. Work programmes to be amended in the light of changes to risk register	February to April 2015~~4~~ Ongoing	Committee chair and lead director	To be identified as part of work programme
Assessment of effectiveness of Board and individual directors	External facilitated assessment of Trust Board effectiveness. Chair's appraisal.	During 2015~~4~~ April 2015~~4~~	Chair/CE led	None

Action required	Action plan	Review date	Lead	Training implications
	Chair's quarterly reviews with Non-Executive Directors. Chief Executive's quarterly reviews with Directors. Assessment of skills and experience of Trust Board to ensure remains fit for purpose as a Foundation Trust Board.	Quarterly Quarterly As part of role of Nominations Committee	SID with Members' Council Chair Chief Executive Chair	None None None Access to training as appropriate
Assessment of effectiveness of Members' Council and individual governors	Annual evaluation session Individual reviews with Chair Individual induction meetings with the Chair Trust responsibility to ensure development and maintenance of skills and knowledge of governors	September 2015~~4~~ January/February 2015~~4~~ On joining Ongoing	Chair Chair Chair Chair	Access to NHS Providers~~FTN~~ GovernWell training modules and other training (both internal and external) as appropriate
Assurance provided by Committees specifically reported to Trust Board	Chairs of committees to provide specific assurance to Board where they have responsibility for scrutiny of an issue	Ongoing	Chairs and lead directors	None
Ensure effectiveness and accessibility of approaches used by Trust Board to monitor risks and receive assurance	Continued embedding of risk register management through Datix and assurance framework to support the overall system of internal control.	During 2015~~4~~	Chair of Audit Committee, Chief Executive and Director of Corporate Development	

Action required	Action plan	Review date	Lead	Training implications
Develop internal control systems to support effective risk management in the context of devolved decision making	Develop and implement internal governance arrangements to support service line management and to support the introduction of payment by results.	~~By April 2014~~During 2015	Chief Executive, Deputy Chief Executive and~~&~~ Director of Corporate Development	
	Review Standing Orders, Standing Financial Instructions and Scheme of Delegation ~~(as part of review of Constitution and Standing Orders)~~.	~~Annual~~April 2015	Chief Executive, Director of Corporate Development and Director of Finance ~~& Director of Corporate Development~~ Audit Committee and Trust Board	
Risk management training relevant to individual roles to be undertaken	Trust Board to receive training in risk analysis and risk management relating to the role of a corporate board as part of Board development programme. Extended EMT to receive training on risk management. E-learning module to be developed for Trust Board, Extended EMT and risk co-ordinators.	~~December 2013~~January 2015 March 2015~~4~~ During 2015~~4~~	Director of Corporate development Director of Corporate Development Director of Corporate Development	
All staff to be briefed about amendments to risk management strategy	Include in weekly staff news and reference to intranet	~~January 2014~~February 2015	Director of Corporate Development	As appropriate
Key policies and procedures on the intranet to be brought up-to-date to enable document store to support information governance	~~Business critical policies identified and integrated~~	~~Completed during 2013 Phase II during 2014~~	~~All directors~~	Training relevant to roll out of individual policies as and when they are revised.

Action required	Action plan	Review date	Lead	Training implications
requirements in relation to non-clinical records.	Complete work to update the document store.	~~June 2014~~September 2015	Director of Corporate Development	

Appendix 6

Risk-Related Trust Documents - Policies, Procedures, Protocols and Guidelines

All Trust policies and procedures have a role in proactively managing risk by putting in place systems and processes to effectively control and reduce identified risks.

A full list of current Trust policies, procedures and guidelines is available on the Trust intranet system. This is a constantly changing list as policies, procedures and related documents are developed and updated to ensure that they reflect current legislation, guidelines, good practice and learning.

The following documents are key to risk management.

- Trust Constitution
- Trust Board Committees' Terms of Reference
- Standing Orders, Standing Financial Instructions and Scheme of Delegation
- Business Plan
- Annual Planning Guidance
- Integrated Performance Strategy
- Emergency planning and business continuity policy
- Serious Incident management Procedures
- Incident Management Policy and Procedures
- Being Open – Policy and Guidelines
- Complaints policy and procedure (Customer Services Policy)
- Claims policy and procedure
- Communications strategy
- Media policy
- Care Programme Approach (CPA) Policy
- Health and Safety - Policies and Procedures
- Human Resources – various related policies, procedures, protocols and guidelines
- Infection Control Policies and Procedures
- Information Governance
- Medicines Management - related policies, procedures, protocols and guidelines
- Clinical and operational policies including Mental Health Act, Consent, Safeguarding Children, Vulnerable Adults and other related policies, procedures, protocols and guidelines

Appendix 7

Risk management training arrangements

The mandatory training policy for the Trust identifies risk management training as mandatory for Trust Board and senior managers across the organisation in line with the Trust's training needs analysis. Senior managers are defined in this context as members of the Extended Executive Management Team, which comprises senior staff across the Trust in both operational and support service roles.

Risk management training is undertaken annually and, as a minimum, covers the Trust's strategic and operational approach to the identification and recording of risk.

Attendance at both ~~the~~ Trust Board and ~~the~~ Extended EMT sessions is formally recorded and non-attenders identified. In the case of Trust Board, the Director of Corporate Development ensures a separate briefing is undertaken as appropriate and that this is recorded. For members of Extended EMT who do not attend, Directors will be responsible for ensuring that these individuals are briefed appropriately. The Director of Corporate Development is responsible for ensuring that all members of the unitary Board receive risk management training and, through the Executive Management Team, is responsible for monitoring compliance by the Extended Executive Management Team.

An e-learning package will be developed by during 2015~~4~~, which will be mandatory for Trust Board, members of Extended EMT and risk co-ordinators. The package will also be available for other staff.

Appendix 8

Checklist for review and approval~~Equality Impact Assessment Tool~~

Date:~~Date of Assessment:~~ ~~December 2013~~ January 2015

	~~Equality Impact Assessment Questions:~~		~~Evidence based Answers & Actions:~~
~~1~~	~~Name of the document that you are Equality Impact Assessing~~		~~Policy for the development, approval and dissemination of policy and procedural documents~~
~~2~~	~~Describe the overall aim of your document and context?~~ ~~Who will benefit from this policy/procedure/strategy?~~		~~The overall aim of the policy is to describe the Trust's approach to the development and approval of policies and procedural documents.~~ ~~All staff~~
~~3~~	~~Who is the overall lead for this assessment?~~		~~Director of Corporate Development~~
~~4~~	~~Who else was involved in conducting this assessment?~~		~~Integrated Governance Manager~~
~~5~~	~~Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?~~ ~~What did you find out and how have you used this information?~~		~~The Executive Management Team was consulted on the original development of the policy. Feedback from the NHS LARMS assessment has also been considered in developing the policy.~~ ~~N/A~~
~~6~~	~~What equality data have you used to inform this equality impact assessment?~~		~~N/A~~
~~7~~	~~What does this data say?~~		~~N/A~~
~~8~~	~~Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:~~	~~Yes/No~~	~~Evidence based Answers & Actions. Where Negative impact has been identified please explain what action you will take to remove or mitigate this impact.~~
~~8.1~~	~~Race~~	~~No~~	~~N/A~~
~~8.2~~	~~Disability~~	~~No~~	~~N/A~~
~~8.3~~	~~Gender~~	~~No~~	~~N/A~~
~~8.4~~	~~Age~~	~~No~~	~~N/A~~
~~8.5~~	~~Sexual Orientation~~	~~No~~	~~N/A~~

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.6	Religion or Belief	No	N/A
8.7	Transgender	No	N/A
8.8	Maternity & Pregnancy	No	N/A
8.9	Marriage & Civil partnerships	No	N/A
8.10	Carers*Our Trust requirement*	No	N/A
9	What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-		This policy aims to standardise the approach to policy development, approval and dissemination and requires adoption of the Equality Impact Assessment throughout the organisation.
9a	Promotes equality of opportunity for people who share the above protected characteristics;		
9b	Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;		
9c	Promotes good relations between different equality groups;		
9d	Public Sector Equality Duty – "Due Regard"		
10	Have you developed an Action Plan arising from this assessment?		No
11	Assessment/Action Plan approved by		**Signed:** Dawn Stephenson **Date:** 17 December 2013 **Title:** Director of Corporate Development

	Risk Management Strategy	Yes/No/ Unsure	Comments
1.	Title		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous	YES	

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	Risk Management Strategy	Yes/No/ Unsure	Comments
	document?		
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	N/A	
	Are people involved in the development identified?	N/A	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	N/A	
	Is there evidence of consultation with stakeholders and users?	Trust Board	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	N/A	
	Are the references cited in full?	N/A	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		

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	Risk Management Strategy	Yes/No/ Unsure	Comments
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

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Appendix 9 - Version Control Sheet

Version	Date	Author	Status	Comment / changes
1	December 2008	Integrated Governance Manager	Final	Final version approved by Trust Board
2	October 2010	Integrated Governance Manager		Changes made to reflect transfer of services from NHS Barnsley. Approved by Trust Board
3	December 2011	Integrated Governance Manager	Final	Annual review approved by Trust Board
4	October 2012	Integrated Governance Manager	Final	Inclusion of Datix processes approved by Trust Board
5	December 2013	Integrated Governance Manager	Final	Annual review approved by Trust Board
6	January 2015	Integrated Governance Manager	Final	Annual review approved by Trust Board

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Appendix 10 - Equality Impact Assessment Tool

Date of Assessment: January 2015

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	Name of the document that you are Equality Impact Assessing		Risk Management Strategy
2	Describe the overall aim of your document and context? Who will benefit from this policy/procedure/strategy?		The overall aim of the policy is to describe the Trust's approach to risk management All staff
3	Who is the overall lead for this assessment?		Director of Corporate Development
4	Who else was involved in conducting this assessment?		Integrated Governance Manager
5	Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy? What did you find out and how have you used this information?		Trust Board is responsible for approving the Strategy. N/A
6	What equality data have you used to inform this equality impact assessment?		N/A
7	What does this data say?		N/A
8	Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:	~~Yes~~/No	The strategy aims to reduce risk to all service users, carers and staff from the nine protected characteristics.
8.1	Race	No	N/A
8.2	Disability	No	N/A
8.3	Gender	No	N/A
8.4	Age	No	N/A
8.5	Sexual Orientation	No	N/A

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.6	Religion or Belief	No	N/A
8.7	Transgender	No	N/A
8.8	Maternity & Pregnancy	No	N/A
8.9	Marriage & Civil partnerships	No	N/A
8.10	Carers*Our Trust requirement*	No	N/A
9	What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-		
9a	Promotes equality of opportunity for people who share the above protected characteristics;		N/A
9b	Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;		N/A
9c	Promotes good relations between different equality groups;		N/A
9d	Public Sector Equality Duty – "Due Regard"		N/A
10	Have you developed an Action Plan arising from this assessment?		No
11	Assessment/Action Plan approved by		**Signed:** Dawn Stephenson **Date: January** 2015 **Title:** Director of Corporate Development

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With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board – 27 January 2015
Agenda item 6.2

Title:	**Treasury Management Strategy and Policy**
Paper prepared by:	Deputy Chief Executive/Director of Finance
Purpose:	As part of its governance arrangements, the Trust is required to formally outline its approach to treasury management.
Mission/values:	The Strategy and Policy link to the mission and values by ensuring that the Trust adheres to governance requirements, makes the best use of its resources and supports financial probity, reporting and transparency.
Any background papers/ previously considered by:	This policy was reviewed by the Executive Management Team on 15 January 2015 and the Audit Committee on 20 January 2015. No amendments or revisions were suggested. The Audit Committee recommends approval to Trust Board.
Executive summary:	The purpose of the policy is to provide a clearly defined risk management framework for those responsible for treasury operations. The approach and policy are reviewed annually. For this iteration, a review of guidance has been undertaken as well as a review of a number of other NHS Trust policies. There is no new guidance available and other Trusts' policies are similar with a similar format and key headings, which reflect guidance. There are no significant changes to the Strategy; however, two minor changes have been made to the required signatories (section 8.2) and to reflect the changes to Monitor's risk assessment of foundation trusts (section 7.1) and the subsequent quarterly reporting to the Audit Committee. Trust Board is also asked to note that: ➢ the policy looks to minimise risks and provide a clear framework for investment decisions; ➢ whilst minimising risk, the policy looks to maximise Trust financial performance; and ➢ Trust Board should note that currently all material funds are held within the UK Government Banking System hence sovereign (minimal) risk of default.
Recommendation:	**Trust Board is asked to APPROVE the Strategy and Policy to support the overall financial strategy**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Document name:	Treasury Management Strategy & Policy
Document type:	Policy
Staff group to whom it applies:	All staff within the Trust who can action transfers within Trust bank Accounts
Distribution:	Executive management Team & Finance Department.
How to access:	Intranet
Issue date:	November 2009 First revision June 2010 Second Revision December 2013 Third Revision December 2014
Next review:	December 20154
Approved by:	Original - Trust Board 29 June 2010 Reviewed – Trust Board December 2013
Developed by:	Head of Finance R Adamson
Director leads:	Deputy Chief Executive / Director of Finance A. Farrell
Contact for advice:	Head of Finance R Adamson

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1 SCOPE OF THIS STRATEGY & POLICY

The Trust's mission is 'Enabling people to reach their potential and live well in their community.'

This strategy and policy exists to support this mission and provides part of the Trust's overall financial strategy which is determined by the Trust Board.

As a consequence this strategy does not determine the Trust's approach to surplus, capital expenditure or cash and working capital management, rather the cash balances available for investment under this strategy are determined by the Board's strategy on surplus, capital expenditure and cash & working capital.

2 TREASURY OBJECTIVES

2.1 Introduction

Written in conjunction with the guidance contained within 'Managing Operating Cash in NHS Foundation Trusts' (December 2005) issued by Monitor. [This document describes guidelines that are intended to ensure adequate safety (i.e. manageable risk profile) and liquidity (i.e. accessibility of funds at short notice), of such investments, while generating a competitive return]. This policy puts in place formal and comprehensive objectives, policies and practices, strategies and reporting arrangements for the effective management and control of their Treasury Management activities.

"Under Section 17 of the Health and Social Care (Community Health and Standards) Act 2003, NHS Foundation Trusts have a wide discretion to invest money (other than money held by them as Trustee) for the purposes of, or in connection with, their functions. Whilst this freedom offers greater opportunity to improve patient care, it should be managed carefully to avoid financial and/or reputational risks" (Monitor- Managing Operating Cash in NHS Foundation Trusts).

2.2 Treasury Management Strategy

The Trust's Treasury Management Strategy is to hold appropriate levels of short-term liquid investments whilst maintaining a competitive rate of interest for the Trust. The Trust will pursue best value in Treasury Management and through the use of suitable performance measures ensure that the Trust works within the context of effective risk management.

2.3 Scope of the Treasury Function

This Trust defines its Treasury Management activities as:

"the management of the organisation's cash flows, its banking, money market and capital market transactions; the effective control of the risks associated with those activities; and the pursuit of optimum performance consistent with those risks".

The objective of the treasury function is to support the Trust's development by

- ensuring a competitive rate of return on surplus funds with a minimal risk profile;
- ensuring the availability of cash to meet operational requirements; and
- ensuring the availability of flexible, competitively priced funding at all times.

This Trust acknowledges that effective Treasury Management will provide support towards the achievement of its business and service objectives. It is therefore committed to the principles of achieving best value in Treasury Management, and to employing suitable performance measurement techniques, within the context of effective risk management.

2.4 Approved Activities of the Treasury Management Operation

The Treasury Management operation will encompass all of the following techniques and procedures.

- Working capital management (including all matters relating to debtors, creditors and cash);
- Investment of surplus funds in permitted institutions and the assessment of the creditworthiness of these organisations;
- Interest rate exposure management;
- Dealing procedures (i.e. using brokers, banks);
- The interpretation and analysis of external information from various sources, including market analysts and technicians;
- The production, analysis and interpretation of internal information and reports;
- Financing of cash deficits via approved borrowing instruments.

In addition, it incorporates the formulation, monitoring and review of Treasury Management objectives, strategies, operational policies, authority limits and exception reporting criteria.

Given the nature of the activity and the size of the transactions involved, Treasury Management security controls are of paramount importance. Liaison will be required with both internal and external audit and internal controls, separation of duties, authorisation levels and responsibilities should be reviewed regularly. All banking arrangements will fall within the scope of Treasury Management (i.e. services, costs and tendering procedures). It is the responsibility of the Audit Committee to review and approve a Treasury Management Strategy and Policy (this document) on a periodic basis, which will be at least annually after the production of a revised financial plan for the Trust.

2.5 Treasury Controls

The wide range of complex financial instruments available to organisations can significantly reduce financial risk when used wisely. Equally, they can lead to financial distress when used unwisely.

The following treasury controls proposed in this document are designed to ensure the Foundation Trust treasury activities are undertaken in a controlled and properly reported manner.

The key components of the overall treasury-operating environment include

- clearly defined roles and responsibilities, as laid out in section 4;
- regular reporting of treasury activities;

- controls on who can operate bank accounts and authorisation limits; and
- segregation of duties across the treasury function.

2.6 Conclusion

Treasury Management is the efficient management of liquidity and financial risks in a business and the actions to manage these risks will vary as their nature changes over time.

This policy provides a clearly defined risk management framework for those responsible for treasury operations. In order to fully realise the benefits, it is essential that the policy is kept up to date to reflect any changes in the Trust's operation.

3 ATTITUDES TO RISK

3.1 Funding

The principal role of the Treasury Management function is to maintain liquidity and ensure a competitive return on surplus funds while maintaining a minimal risk profile.

Due to regulation changes from Monitor and the Department of Health to the calculation of Financial Risk Ratings (under the revised Risk Assessment – April 2014) and the methodology of the Public Dividend Capital (PDC) interest payment calculation the Trust will conduct a monthly review on the best approach to ensuring a competitive return on surplus funds while maintaining a minimal risk profile.

The outcome of this review will be either:

- Cash remains within the Government Banking Service (GBS) and is used to offset the calculation of PDC interest payable.
- Investment, as outlined below, of surplus funds if this return is greater than the impact within the PDC calculation.

Any surplus funds to be invested will be with recognised "safe harbour" investments with a maturity date of no more than 95 days. This approach should be reviewed on an annual basis depending on the level of cash balances. Any changes in approach would require prior agreement of the Trust Board.

The key-funding objective is to ensure the Trust has sufficient liquidity to cover its business cash flows and provide reasonable flexibility for seasonal cash flow fluctuations and capital programme expenditure.

The Trust's approach to funding is that the majority of surplus funds should be available to the Trust on short notice of up to 95 days, and if the Trust holds a committed working capital facility the Trust should not aim to use it.

3.2 Safe Harbour Investments

In line with the Monitor guidance; 'Managing Operating Cash in NHS Foundation Trusts'; it is proposed that the Trust does not invest outside of safe harbour investments. This approach ensures that NHS Foundation Trust Boards do not need to undertake individual investment reviews. In addition, Monitor will not require a report on investments as part of its risk assessment process as safe harbour investments are deemed to have sufficiently low risk and high liquidity. As an

illustration of this assessment Safe Harbour Investments are treated as cash within Financial Risk Rating calculations.

There should be no circumstances for the Trust to invest surplus operating cash outside of the safe harbour.

Monitor's guidance defines a safe harbour as follows:
"Securities that are considered sufficiently safe and liquid to be in the safe harbour meet all of the following criteria:

- Meet permitted rating requirement issued by a recognised rating agency;
- Are held at a permitted institution;
- Have a defined maximum maturity date;
- Are denominated in sterling, with any payments or repayments for the investment payable in sterling;
- Pay interest at a fixed, floating or discount rate;
- Are within the preferred concentration limit.

These investments include (but are not limited to) money market deposits, money market funds, Government and Local Authority Bonds and debt obligations, certificates of deposit, and sterling commercial paper, providing they meet the following criteria. The following definitions elaborate on the criteria above and are consistent with the guidance *"Managing Operating Cash in NHS Foundation Trusts"* issued by Monitor:

Term	Advice
Recognised Rating Agency	Only the following are recognised rating agencies • Standard & Poors; • Moodys; and • FitchRatings.
Permitted Rating Requirement	The short term rating should be at least • A-1 Standard & Poors rating; or • P-1 Moodys rating; or • F1 Fitch Ratings *See note**
Permitted Institutions	Permitted institutions include: Institutions that have been granted permission, or any European institution that has been granted a passport, by the Financial Services Authority, to do business with UK institutions provided it has an investment grade credit rating of A1/A+ issued by a recognised rating agency; and The UK Government, or an executive agency of the UK Government, that is legally and constitutionally part of any department of the UK Government, including the UK Debt Management Agency Deposit Facility.
Maximum Maturity Date	• The maximum maturity date for all

	investments should be 95 days • The maturity date for any investment should be before or on the date when the invested funds are needed
Preferred Concentration Limit	• Cash surpluses below £750k may be invested with one institution • Cash surpluses above £750k should be invested across a number of permitted institutions to spread the investment risk • Investment limits should be set for permitted institutions based on their credit rating and net worth. These limits should be reviewed annually and reset if there is a change in either the credit rating or the net worth of the financial institution. If an institution is either downgraded or put on credit watch by a recognised rating agency, the decision to invest with them should be reviewed • Investments with permitted institutions should not exceed the set limit at any time

** Moodys, Standard & Poors and FitchRatings are the three top agencies that deal with credit ratings for the investment world.*
Due to the current financial climate, the application of long term ratings have been removed as per Monitor guidance.

3.3 Investments

In accordance with the above table, all cash balances should remain in a comparatively liquid form and all investments resulting from them should be realisable and have maturity not exceeding 12 months.

Cash deposits should only be placed with banks in line with deposit limits agreed by the Trust Board and based on the preferred recognised rating agency agreed by the Trust Board.

The Trust can invest upto one month's working capital with any one institution (currently £13.2m).

Cash deposit must be placed in Banks that are at last rated A-1, P-1 or F1 on their Short Term ratings.

These limits should be reviewed annually by the Trust Board and a review of the investment ratings must be undertaken on a quarterly basis for institutions investments are held with. See **APPENDIX 1 - Ratings Guide** for details of credit ratings.

3.4 Foreign Exchange Management

The Trust's current policy is not to cover any foreign exchange risk. This is due to the

low volume and value of the Trust's foreign exchange exposure, and will be re-evaluated if foreign trading transactions become more significant.

3.5 Bank Relationships

The Trust's approach is to develop long-term relationships with a core group of quality banks. A transactional approach, without the development of relationships, may result in the Foundation Trust being unable to rely on the support of banks in any unforeseen circumstances that may arise, such as a crisis in the banking market, or a sudden decrease in surplus funds.

The aim of the Trust is to establish a high degree of confidence and commitment between the parties so that the banks are prepared to meet funding requirements at crucial times, and at short notice.

4 SUMMARY OF KEY RESPONSIBILITIES

4.1 Trust Board

- Approve external funding arrangements;
- Approve the banking arrangements;
- Approve and monitor an appropriate Treasury Management policy and strategy.

4.2 Audit Committee

- The Committee shall review the establishment and maintenance of an effective system of internal control and risk management for its treasury function;
- The Committee shall consider external funding arrangements and recommend to the Board for approval;
- The Committee shall consider and recommend for approval the banking arrangements.

4.3 Director of Finance

- Responsible for maintaining the Trust's banking arrangements and for advising the Board on the provision of banking services and operation of accounts;
- Approve cash management/forecasting systems;
- Ensure approved bank mandates are in place for all accounts and that they are updated regularly for any changes in signatories and authority levels;
- Hold regular meetings with the Deputy Director of Finance and Head of Financial Accounting to discuss issues and consider any points that should be brought to the attention of the Audit Committee.

4.4 Deputy Director of Finance / Head of Financial Accounting

- Draft the Trust's Treasury strategy and policy for consideration by the Director of Finance;
- Report on the Treasury activities on an accurate and timely basis;
- Manage key banking relationships;
- Manage Treasury activities within agreed policies and procedures.

The Trust's Treasury procedures will be subject to periodic review by both the internal and external auditors as part of their audit undertakings and any significant deviations from agreed policies and procedures will be reported, where appropriate, to the Audit Committee.

5 BANK RELATIONSHIPS AND CASH MANAGEMENT

The development and maintenance of strong banking relationships is an important factor in the Trust's cash management policy. The provision of efficient cash management systems throughout the Trust ensures that banking requirements are serviced at optimal cost. This section details the Trust's objectives in these areas of Treasury Management.

5.1 Objectives

- To ensure the cost paid for banking services is competitive;
- To minimise the cost of borrowings and maximise the return on cash surpluses within acceptable risk parameters by maintaining efficient cash management procedures within the Trust;
- To develop and maintain strong relationships with a number of key banks;
- To monitor and ensure compliance with banking covenants.

5.2 Banking Relationships

The Deputy Director of Finance, with the support of the Head of Financial Accounting, will be responsible for managing all banking relationships across different banking services to achieve the optimum benefit to the Trust.

The Deputy Director of Finance and the Head of Financial Accounting, along with other members of the Financial Accounts Team, will meet with banks on a regular basis to discuss services provided and any new or improved products of potential interest to the Trust.

6 TREASURY REPORTING

The regular reporting of treasury activities is crucial in allowing all relevant parties to be aware of transactions undertaken, appreciate the Trust's financial position, and assess the on-going appropriateness of Treasury objectives. The following reports are produced to meet these criteria.

6.1 Daily Movement Reports

This report is completed daily by the Senior Financial Accountant for review by the Head of Financial Accounting. This details all payments to / receipts from the operational accounts (Paymaster General and the Trust nominated clearing bank) as well as the forecast closing positions.

This is used by the Head of Financial Accounting to decide on proposed appropriate levels of investments to ensure a competitive rate of return by not carrying excess funds in operational accounts.

All proposed investments are approved by the Deputy Director of Finance and / or the Head of Finance consistent with agreed delegated limits.

6.2 Monthly Reports

Monthly Reconciliation

A monthly cash flow reconciliation is produced by the Head of Financial Accounting using the daily movement report breaking down monthly payments / receipts into various headings. This is used to monitor the actual income / expenditure against the forecast, which highlights any variances, and to produce forecast cash balances.

This reconciliation includes an analysis of the interest receivable by the Trust for the month. This report is available to the Director of Finance / Deputy Director of Finance.

Monthly Board Report

Included in the monthly Board Report is a ~~twelve month~~ forecast of the Trust's cash balances for the current financial year, together with the Balance Sheet which incorporates the month's closing cash balance. This is based on the current Trust Annual Plan ~~Long Term Finance Model~~ as submitted to Monitor.

The Income and Expenditure Account shows the interest receivable during the financial year. The monthly Board Reports also provide evidence of the calculations of Monitor's Risk Ratings and compliance with banking covenants.

Audit Committee

The Audit Committee will be provided with a Quarterly Treasury Performance Report which will include a position statement ~~analysis~~ of cash / borrowings and details of the performance of all cash investments and interest earned in the period together with the current risk ratings of all banking relationships (if appropriate).

Budget Setting for Interest Receivable

The Head of Financial Accounting will propose and agree with the Deputy Director of Finance the budgeted Interest Receivable based on projected interest rates, funds to be invested, and projected costs of investments.

7 TREASURY PERFORMANCE MANAGEMENT

Performance management is an important part of the control environment from a corporate governance perspective. A performance management framework is a mechanism for the Audit Committee and the Board to approve policy and to monitor the effectiveness of that policy. The metrics used to measure performance may be quantitative and qualitative. It is important that any quantitative measures are simple to compute and market related.

7.1 Quarterly Performance Reports

Quarterly Reports submitted to Monitor

Reports are required by Monitor to assess the financial risk of each Foundation Trust as part of the compliance framework. The report consists of a Balance Sheet, Income and Expenditure Account and Cash Flow Statement detailing planned, actual and

variance figures. A commentary is also required to explain any significant variances from plan.

Financial Risk Ratings (currently identified as the Continuity of Service Risk Rating encompassing Capital Service Cover {a measure of how well the Trust can cover debt} and Liquidity {as driven by cash balances})~~Various ratios such as liquidity, return on assets, stock days, trade debtor days etc~~ are included to ensure the Trust is maintaining its minimal risk approach and remains a going concern.

The quarterly performance reports required by Monitor will be produced by the Head of Finance and the Deputy Director of Finance. The reports will be checked and signed off by the Director of Finance and copies circulated to Trust Board.

Quarterly Treasury Performance Report

The Head of Financial Accounting will prepare a quarterly treasury performance report for circulation to Director of Finance and Audit Committee.

The report will detail:

- Analysis of cash / borrowings;
- Details of the performance of all cash investments and interest earned in the period;
- Current risk ratings of all banking relationships (if appropriate);
- Performance of the borrowing portfolio versus the benchmark of 3 month Libor* + 1/8th % at the start of each quarter.
- Current Authorisation schedules

*Libor = London Interbank Offered Rate

8 TREASURY CONTROLS

8.1 Summary

The overall objective of the controls set out below is to ensure treasury activities are undertaken in a controlled manner, thereby ensuring that the Trust is not exposed to undue operational risks. In particular as follows:

- Segregation of Duties is specified between those who initiate and those who authorise transactions;
- All transactions are recorded and supported by an instruction/confirmation;
- All payment instructions/confirmations will require two authorised signatories in accordance with approved bank mandates;
- Mandates will be reviewed regularly;
- The Head of Financial Accounting will ensure that there is absence cover and that current procedures are maintained in accordance with the Treasury Management Policy;
- The Trust will ensure that all the relevant people involved in Treasury Management have the relevant training required;
- This Trust is committed to the pursuit of proper corporate governance throughout its businesses and services, and to establishing the principles and practices by which this can be achieved. Accordingly, the Treasury Management function and its activities will be undertaken with openness and transparency, honesty, integrity and accountability;

- The Head of Financial Accounting will review periodically the investments to ensure that the investment Banks are appropriate.

8.2 Operational Procedures

Undertaking Transactions

- The Director of Finance will maintain schedules of those authorised to make investments where the cash is not on overnight deposit or repayable on demand, or where the amount invested is in excess of £5,000,000. In these circumstances the required ~~one~~ signator~~y~~ies will be :
  - List 1 - Senior Finance Team
  - Deputy Chief Executive / Director of Finance
  - List 2 - Directors ~~must be drawn from each of two lists. The first list will be senior members of the finance team. The second list will be Executive Directors of the Trust, excluding the Director of Finance~~. The Director of Finance will ensure that all staff on these schedules are fully briefed as to their responsibilities. The Director of Finance will submit any revisions to these lists to the next Audit Committee for their information;
- Investment of less than £5,000,000 ***and*** which are either overnight deposit or are repayable on demand, may be made by two signatories from the senior finance team;
- All transfers are signed by two authorised signatories as per bank mandate, and recorded by the ~~Chief~~Senior Financial Accountant;
- Transfer initiation forms are sequentially numbered.

Verification of Transactions

All confirmations will be received and signed by the Senior Financial Accountant. Bank Mandates are maintained by the Head of Financial Accounting.

Prepared by Head of Finance
R Adamson
~~November 2013~~December 2014

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APPENDIX 1 - Ratings Guide

Long-Term Debt Ratings - Measure of the borrower's ability to pay back longer term debt.

All the ratings agencies use similar classifications ranging from the very best, Aaa or AAA, downwards to the lowest rating of "Junk".

The top categories from Aaa/AAA down to Baa3/BBB are generally described as "investment grade".

Very few banks are rated higher than Aa2/AA and many fall much lower down the scale.

Moodys	**Standard & Poor's**	**Fitch Rating**
Aaa	AAA	AAA
Aa1	AA+	AA+
Aa2	AA	AA
Aa3	AA-	AA-
A1	A+	A+
A2	A	A
A3	A-	A-
Baa1	BBB+	BBB+
Baa2	BBB	BBB
Baa3	BBB-	BBB-

Short-Term Ratings - Measure of the strength of the borrower to repay short-term obligations of up to 12 months.

It is, of course easier to get a high short-term rating than a high long-term rating. Short–term ratings use a slightly different scale.

Moodys	**Standard & Poor's**	**Fitch Rating**
Prime-1 P1	A-1+	F1+
Prime-1 P1	A-1	F1
Prime-2 P2	A-2	F2
Prime-3 P3	A-3	F3
No Prime	B	B
	C	C
	D	D

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 27 January 2015
Agenda item 7

Title:	**Trust Board self-certification – Monitor Quarter 3 return 2014/15**
Paper prepared by:	Director of Corporate Development
Purpose:	To enable Trust Board to be assured that sound systems of control are in place including mechanisms to identify potential risks to delivery of key objectives.
Mission/values:	Compliance with Monitor's Risk Assessment Framework supports the Trust to meet the terms of its Licence and supports governance and performance management enabling the Trust to fulfil its mission and adhere to its values.
Any background papers/ previously considered by:	The exception report to Monitor highlights issues previously reported to Trust Board through performance and compliance reports.
Executive summary:	Quarter 3 assessment Based on the evidence received by Trust Board through performance reports and compliance reports, the Trust is reporting a governance risk rating of **green** under Monitor's Risk Assessment Framework. Based on performance information set out in reports presented to Trust Board, the Trust is reporting a continuity of services/finance risk rating of **green** with a score of **4**. Self-certification Monitor authorises NHS foundation trusts on the basis that they are well-governed, financially robust, legally constituted and meet the required quality threshold. Monitor's Risk Assessment Framework is designed to: - show when there is a significant risk to the financial sustainability of a provider of key NHS services, which endangers the continuity of those services through the continuity of services risk rating; and/or - show where there is poor governance at an NHS Foundation Trust through the governance rating. Trust Board is required to provide board statements certifying ongoing compliance with its Licence and other legal requirements to enable Monitor to operate a compliance regime that combines the principles of self-regulation and limited information requirements. The statements are as follows. - For continuity of services, that the Trust will continue to maintain a risk rating of at least 3 over the next twelve months. - For governance, that the board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the Framework and a commitment to comply with all known targets going forward. - And that Trust Board can confirm there are no matters arising in the quarter requiring an exception report to Monitor, which have not already been reported. The Framework also uses an in-year quality governance metric, which is currently the same as that used since quarter 3 of 2013/14, of executive team turnover as this is seen as one of the potential indicators of quality governance concerns. The Trust is required to provide information on the

total number of executive (voting) posts on the Board, the number of these posts that are vacant, the number of these posts that are filled on an interim basis, and the number of resignations and appointments from and to these posts in the quarter.

Subject to any changes required by Trust Board as a result of earlier board papers and the resultant discussion, the attached report will be submitted to Monitor in respect of Quarter 3 and the in-year governance declaration on behalf of the board will be made to confirm compliance with governance and performance targets.

Capital programme

The total Capital Programme for 2014/15 is £11.78 million. As part of the Q1 Monitor return, there was a requirement to issue a revised capital plan. The overall capital programme remains unchanged as £11.78 million; however, the profile has been revised. Capital spend to December 2014 is £3.53 million, which is £3.24 million (48%) behind the revised Trust capital plan. The overall deliverability of the capital programme continues to be assessed on a regular basis. The current forecast expenditure is £8.76 million, which is £3.02 million (26%) behind plan. Most of the forecast underspend relates to:

- delays in Calderdale, Wakefield and Barnsley community hub developments;
- delays in discharging planning conditions in Calderdale, which have led to a delay in demolition and will increase the risk of disruption due to weather;
- delays due to acquisition of a suitable lease property in Wakefield and in-year expenditure will be on design and legal costs with £1.2 million forecast to be spent in 2014/15;
- the current Fieldhead hospital development, including establishing a decant facility, is on hold pending continued internal discussions and it is not anticipated that any construction activity will take place in year.

The Trust's position in relation to sexual health services in Barnsley has implications for the Trust's capital programme in terms of development of its community hub in Barnsley. There is £350,000 set aside in the capital programme to extend the New Street premises, which will not now proceed, instead undertaking the planned refurbishment only.

In its financial return for Q3, Trust Board will need to make a declaration to Monitor as its year-to-date capital expenditure is less than 85% of levels in its capital expenditure forecast and that it is providing re-forecast details in the Q3 return.

Foundation Trust sector comparison

At the end of Q2 2014/15, Monitor issued a press release commenting on the following issues to come out of its analysis of Q2 returns.

- The sector reported a deficit of £254 million compared with a planned deficit of £59 million.
- 81 foundation trusts reported a deficit of which 80% were acute trusts.
- The combined deficit of the 81 trusts was £396 million, offset by 66 trusts making a surplus of £142 million.
- Trusts spent £831 million on contract and agency staff, double the £377

	million they had planned. ➢ Trusts made £492 million worth of cost savings, which is £126 million less than planned. ➢ Trusts spent £854 million on items such as new facilities and estates, which is £357 million less than planned. ➢ 27 trusts (18% of the sector) were subject to enforcement action by Monitor because of governance and performance concerns. All Foundation Trusts Mental Health Trusts The Trust remains in the upper quartile of foundation trusts.
Recommendation:	**Trust Board is asked to:** - **APPROVE the submission and exception report to Monitor, subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance; and** - **to make the declaration with regard to the Trust's capital programme.**
Private session:	Not applicable

All Foundation Trusts

		Governance rating			
		No evident concerns	Issues identified	Enforcement action	Total
Continuity	4	**71**	1	2	**74**
	3	32	9	4	**45**
	2	8	3	4	**15**
	1	0	7	8	**15**
	Total	**111**	**20**	**18**	**149**

Mental Health Trusts

		Governance rating			
		No evident concerns	Issues identified	Enforcement action	Total
Continuity	4	**30**	0	1	**31**
	3	7	1	1	**9**
	2	1	0	0	**1**
	1	0	0	0	**0**
	Total	**38**	**1**	**2**	**41**

Trust Board self-certification - Monitor Quarter 3 return 2014/15
Trust Board 27 January 2015

Compliance with the Trust's Licence

The Trust continues to comply with the conditions of its Licence. There have been no changes to commissioner requested services in Quarter 3.

Trust Board

The Trust has two Non-Executive Directors whose terms of office come to an end in 2015 (Peter Aspinall on 30 April 2015 and Helen Wollaston on 31 July 2015). The recruitment process to appoint to the two vacancies has been agreed with the Nominations Committee and will formally begin on 8 February 2015 for both posts. The Trust has engaged the services of an external recruitment agency to ensure transparency and openness in the process. The recruitment process will conclude with a recommendation to the Members' Council on 29 April 2015.

The Trust has appointed interim operational support at Director level to cover the child and adolescent mental health services and the forensic services portfolio. Nette Carder, who has significant experience at senior management level in this and other sectors, has been appointed for an initial three months to provide Director-level support.

Members' Council

The election process for the Members' Council will begin at the end of January 2015 and elections held for the following seats.

Barnsley – one seat (due to resignation at end of April 2015)
Kirklees – three seats (two retirements by rotation with both eligible for re-election and one vacant seat following a resignation in-year)
Wakefield – two seats (two retirements by rotation with both eligible for re-election)
Rest of South and West Yorkshire – one seat vacant
Staff – six seats (allied health professionals, medicine and pharmacy, non-clinical support staff, nursing and nursing support come to the end of their terms of office and are eligible for re-election. There is also a vacancy for social care staff working in integrated teams.)

Care Quality Commission (CQC)

- The two compliance actions from the Fieldhead inspection visit (Trinity 2, Newton Lodge and Bretton) against outcomes 7 (safeguarding) and 10 (safety and suitability of premises) remain open. As previously reported the Trust has formally notified CQC of completion of the action plan. .
- The CQC continues to monitor the Trust in regard to admission of patients to wards when no beds are available.
- There were seven CQC Mental Health Act visits in Q3 to Newhaven (Wakefield), Gaskell (Newton Lodge, Wakefield), Bronte (Newton Lodge, Wakefield), Johnson (Newton Lodge, Wakefield), Beamshaw (Kendray, Barnsley), Ward 18 (Dewsbury, Kirklees) and Lyndhurst (Calderdale).
- Within the quarter, five MHA monitoring summary reports have been received relating to visits made to Poplars, Ryburn, Bronte, Johnson and Beamshaw. Most aspects of the monitoring visits were positive in terms of practice and implementation of actions

identified from previous visits; however, recurring issues related to the recording of Section 132 rights, recording of Section 17 leave and recording relating to seclusion. In addition, concerns were raised regarding mental health staff access to physical health care records.

- Both the recent CQC MHA visits to forensic units have raised questions regarding seclusion recording described as not adhering to the Code of Practice. Following a seclusion thematic review report, the Trust introduced new seclusion records which it is believed do fully meet the Code of Practice standards. It is of concern that the CQC has continued to raise this issue. One possible cause could be the CQC commenting on historical records used prior to the introduction of new seclusion records; however, the concerns raised are being fully reviewed with intervention and support being provided within the BDU to address any practice issues. This matter will continue to be closely monitored internally through the Management of Aggression and Violence Trust Action Group.

Mental Health Crisis Concordat

The Trust is committed to working with partner agencies to make sure people always get the help they need in crisis. Partners in CCGs in Barnsley, Calderdale, Kirklees and Wakefield have responsibility to lead on the Concordat and co-ordinate all agencies involved. Since December 2014, the Trust and partner agencies have been signed up to the Concordat and action plans are currently being developed in each area with input from Trust staff. A number of crisis initiatives are already led by Trust services, including pilots of street triage in Barnsley and Wakefield, and a pilot education programme for police officers in Calderdale and Kirklees.

Norman Lamb, Minister of State for Care and Support, and Mike Penning, Minister for Policing, Criminal Justice and Victims, wrote to Trusts and partners in South and West Yorkshire highlighting concerns about the use of police stations as a place of safety for under 18's. The Chief Executive has responded to Mr Lamb and Mr Penning and has confirmed the Trust's commitment to the Mental Health Crisis Concordat and to working with partners to maximise the opportunities the Concordat offers. The Trust, with Leeds and York Partnership NHS Foundation Trust and Bradford District Care Trust, is also seeking a meeting with the interim Chief Constable of West Yorkshire Police.

Absent without Leave (AWOL)

There were no CQC reportable cases during Q3.

Eliminating Mixed Sex Accommodation (EMSA)

There have been no reported breaches in Q3. The Trust continues to monitor where service users are placed in an individual room on a corridor occupied by members of the opposite sex. In Q3, there were six reported incidents. All incidents have been appropriately care-managed with required levels of observation and support implemented.

Health and Safety Executive (HSE)

There were no unannounced visits received during Q3.

Infection prevention and control

In Q3, there have been no cases of Clostridium Difficile in Barnsley. The cumulative total for 2014/15 is two against a year-end position of eight. There have been no MRSA bacteraemia cases.

Information Governance
The Trust currently has two incidents with the Information Commissioner and has provided responses to all enquiries from the Information Commissioner's Office. No further incidents have been reported in quarter 3.

Safeguarding Children
- In Q3, there were twelve recorded incidents directly relating to issues of child protection. This represents a decrease on Q2. Increasingly, referrals to children social care are being reflected in Trust reporting which should be viewed positively. All of the incidents were reviewed by the Named Nurses and were assessed to have been appropriately reported and managed.
- A CQC review of services for 'Looked After Children' and Safeguarding was undertaken in Barnsley 2014. Areas inspected relating to the Trust include adult mental health, early intervention in psychosis, substance misuse (community team), health visiting, school nurses and CASH. The final report has not yet been published; however, overall the feedback has not suggested concerns and there was consistency with the recent findings from the OfSTED Inspection (2014) that Barnsley "knows itself well" in strengths and areas for improvement.
- An inspection by CQC in Wakefield and Kirklees is widely anticipated in Q3. Ten cases per locality have been identified in preparation for the visit and supporting documents have been distributed to support staff. Also anticipated is an OfSTED inspection in Calderdale with preparation work well under way.

Safeguarding Vulnerable Service Users
No referrals have been made to the Disclosure and Barring Service this quarter and no red incidents reported through the Trust's reporting system, DATIX.

Serious Incidents
- During the course of Q3 there have been 30 SIs reported to the Commissioners (twelve in Barnsley (general community), three in Barnsley (mental health), three in Kirklees, four in Wakefield, six in Calderdale, one in specialist services and one in corporate services. Q3 reporting is similar to the same period last year.
- SI investigations and reports are being completed within timeframes agreed with commissioners; however, there is continued pressure to complete reports within timescales.
- No 'Never Events' occurred in the Trust during this quarter.
- The independent review process in relation to three homicides in Kirklees (one in 2010 and two in 2011) and a thematic analysis report to cover the learning outcomes from three previous homicides in Kirklees that took place in 2007/08 has been completed. The report and action plan will be published by NHS England, Greater Huddersfield and North Kirklees CCGs and the Trust on 23 January 2015.

Customer Services
- The Trust received a total of 57 formal complaints in quarter 3. The breakdown across is as follows:
  - Barnsley – 7;
  - Calderdale – 4;
  - Kirklees – 13;
  - Wakefield – 13;
  - Specialist services – 19;
  - Forensic – 1.

- The majority of complaints related to adult services with the following themes being most evident:
  - care and treatment;
  - staff attitude;
  - admission, discharge and assessment issues;
  - waiting times, delays and cancellations.

  Most complaints contain a number of themes.
- During Q3, two complainants asked the Parliamentary and Health Service Ombudsman to review their complaint. Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. All requested information was provided within the prescribed timeframe. One case related to child and adolescent mental health services in Barnsley and the Trust is awaiting a decision regarding investigation. The other related to crisis services in Wakefield and the PHSO has already completed its review and advised the Trust that no further action is required. During the quarter, the Trust received feedback from the Ombudsman regarding five cases which had been subject to review. Four require no further action and one has resulted in a request to the Trust to resolve by means of apology and financial redress.

Summary Performance Position
Based on the evidence received by the Trust Board through performance reports and compliance reports, the Trust is reporting the achievement of all relevant targets.

<u>Gatekept admissions</u>

Capital programme
The total Capital Programme for 2014/15 is £11.78 million. As part of the Q1 Monitor return, there was a requirement to issue a revised capital plan. The overall capital programme remains unchanged as £11.78 million; however, the profile has been revised. Capital spend to December 2014 is £3.53 million, which is £3.24 million (48%) behind the revised Trust capital plan. The overall deliverability of the capital programme continues to be assessed on a regular basis. The current forecast expenditure is £8.76 million, which is £3.02 million (26%) behind plan. Most of the forecast underspend relates to:

- delays in Calderdale, Wakefield and Barnsley community hub developments;
- delays in discharging planning conditions in Calderdale, which have led to a delay in demolition and will increase the risk of disruption due to weather;
- delays due to acquisition of a suitable lease property in Wakefield and in-year expenditure will be on design and legal costs with £1.2 million forecast to be spent in 2014/15;
- the current Fieldhead hospital development, including establishing a decant facility, is on hold pending continued internal discussions and it is not anticipated that any construction activity will take place in year.

The Trust's position in relation to sexual health services in Barnsley (see below under contracting) has implications for the Trust's capital programme in terms of development of its community hub in Barnsley. There is £350,000 set aside in the capital programme to extend the New Street premises, which will not now proceed, instead undertaking the planned refurbishment only.

In its financial return for Q3, Trust Board has made a declaration as its year-to-date capital expenditure is less than 85% of levels in its capital expenditure forecast and that it is providing re-forecast details in its Q3 return.

Third party reports

The Trust has received one internal audit report with partial (formerly limited) assurance during the quarter in relation to information governance. This was received by the Audit Committee at its meeting on 20 January 2015. The recommendations from the Trust's internal auditor focus on information governance training, reporting procedures with third party contracts, Registration Authority Policy, business continuity planning, and agile working guidance and training. Management action has been agreed with internal audit with timescales for completion to ensure the Trust meets the required level for its submission of the Toolkit at the end of March 2015. As part of this process, internal audit will follow up the action taken against the recommendations March 2015 and it is expected that the assurance rating will increase.

The partial assurance report presented to the Audit Committee in October 2014 in relation to patients' property has been revised with further management response to the recommendations. This was presented to the Committee in January 2015.

Children's and adolescents' mental health services (CAMHS)

The Trust has updated Monitor on the position with the Calderdale and Kirklees Tier 3 CAMHS, which transferred to the Trust on 1 April 2013. In view of the service and reputational risk, the Trust commissioned an independent review of the services, which took place at the end of August 2014. The reviewers fed back to Chief Executive, Medical Director, Director of Nursing and the District Director on 12 September 2014.

The recommendations support the areas of development identified locally and useful suggestions were made to enable the service to continue to improve. After discussion with the external reviewers, it was agreed to invite them to return in six months to undertake a further review and advise on any further action needed. Senior managers and clinicians are also intending to visit the service in Norfolk/Suffolk to learn from best practice in that organisation. The outcome of the review will also be shared with commissioners and Trust Board has asked that the review is shared with staff. An overarching recovery plan has been developed to address the recommendations, which will be reviewed by the Executive Management Team and by the Clinical Governance and Clinical Safety Committee on behalf of Trust Board.

On presentation of the report to Trust Board and the Committee, a number of actions taken by the Trust were highlighted as a demonstration of how the recovery plan is beginning to take effect. These included:

- the strengthening of leadership and management arrangements and the appointment of a clinical lead for CAMHS across the Trust;
- the secondment of the Deputy Director of specialist services for six months on a full-time basis to the service to deliver on transformation and the recovery plan;
- dedicated Quality Academy support, particularly around information management and technology, and HR;
- engagement and listening events for staff, led and facilitated by the Chief Executive; and
- improved engagement with families who use the services with the result that the clinical recovery team is starting to receive positive feedback from families.

The Chief Executive has strengthened leadership and management at a senior level with the appointment of Nette Carder as interim District Service Director for child and adolescent mental health services and forensic services.

Following a review at Trust Board, the Chief Executive has also written to commissioners to request an urgent meeting to review the current position. He has also held a meeting with the Chief Operating Office at Calderdale CCG, which was helpful.

Contracting/commissioning intentions

Barnsley CASH/GUM services

The Trust updated Monitor of the position with sexual health services in Barnsley following the Council's decision to tender for these services. The Trust submitted a bid in partnership with Barnsley Hospital NHS Foundation Trust and was informed on 16 December 2014 that its bid had been unsuccessful. This is a £2.1 million contract over three years with the Trust's element at £1.7 million.

The Trust understands that the contract has now been awarded and there has been initial dialogue between the Trust and the new provider regarding the safe, effective and efficient transfer of services. However, the Trust has a number of outstanding concerns regarding the process undertaken by Barnsley Council and, through legal channels, the Trust has sought a response from the Council to its concerns. To date this has not been forthcoming. A dialogue has taken place between the Chief Executive of the Trust and the Chief Executive of Barnsley Council with a view to identifying a way forward.

The position also has implications for the Trust's capital programme in terms of development of its community hub in Barnsley. There is £350,000 set aside in the capital programme to extend the New Street premises, which will not now proceed, instead undertaking the planned refurbishment only.

Kirklees Care Closer to Home

The governing bodies of North Kirklees and Greater Huddersfield Clinical Commissioning Groups approved at their meetings in September 2014 to proceed with a tender for integrated community services. Older people's liaison, memory assessment, diagnosis and monitoring services are included to a value of £500,000. Notice has been served although will remain part of main block contract with Kirklees commissioners to October 2015.

Quarter 2 2014/15 Financial monitoring
TO GO HERE

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 27 January 2015
Agenda item 8

Title:	**Assurance framework and organisational risk register Q3 2014/15**
Paper prepared by:	Director of Corporate Development
Purpose:	Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives.
Mission/values:	The Assurance Framework and risk register are part of the Trust's governance arrangements and integral elements of the Trust's system of internal control, supporting the Trust in meeting its mission and adhere to its values.
Any background papers/ previously considered by:	Previous quarterly reports to Trust Board.
Executive summary:	**Background** Trust Board has a duty to ensure that the organisation delivers healthcare and health improvements, and promotes good health within a system of effective controls and within the Government's objectives for the NHS. Trust Board needs to be confident that the systems, policies and people in place are operating in a way that is effective in driving the delivery of objectives by focusing on minimising risk. This paper and supporting papers set out the systems and processes in place and the assurances derived. This report provides an update as at Quarter 3 covering the Assurance Framework and Organisational Risk Register. **Assurance framework 2014/15** Trust Board needs to evidence that it has systematically identified the organisation's objectives and managed the principal risks to achieving them. The Trust's Assurance Framework is designed as a tool for Trust Board to fulfil this objective. Trust Board provides leadership, sets values and standards, sets the organisation's strategic objectives, monitors and reviews management performance, and ensures that obligations to stakeholders are met. To ensure that these obligations are met there must be a sound system of internal controls and Trust Board is required, at least annually, to conduct a review of these internal controls. Whilst the risks to achieving the organisation's strategic objectives should be reduced through these internal controls, they can rarely be eliminated. The Assurance Framework provides Trust Board with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It simplifies Trust Board reporting and the prioritisation of action plans allowing more effective performance management. It sketches an outline of the controls and where assurances can be sought. Lead Directors are responsible for identifying the controls that are in place or need to be in place for managing the principle risks and providing assurance to Trust Board. An Annual Governance Statement (AGS) is produced by the Chief Executive every year and is based on the systems in place, particularly the Assurance

	Framework. The AGS forms part of the annual report and accounts and, without this, the neither can be approved. The Assurance Framework informs the appropriate declarations made in the AGS, including any significant control issues in line with current guidance where appropriate. The AGS for 2013/14 was approved as part of the annual report and accounts in May 2014. The strategic corporate objectives for 2014/15 were approved by Trust Board and form the basis of the assurance Framework for 2014/15. In respect of the Assurance Framework for 2014/15, the Director of Corporate Development has worked with each lead Director to identify the principle high level risks to delivery of our principle objectives. For each of these, the Framework then sets out: - key controls and/or systems the Trust has in place to support the delivery of objectives; - assurance on controls where Trust Board will obtain assurance; - positive assurances received by Trust Board, its Committees or the Executive Management Team confirming that controls are in place to manage the identified risks and these are working effectively to enable objectives to be met; - gaps in control (if the assurance is found not to be effective or in place); - gaps in assurance (if the assurance does not specifically control the specified risks or no form of assurance has yet been received or identified), which are reflected on the risk register. The Chief Executive uses the Assurance Framework to support his quarterly review meetings with Directors to ensure Directors are delivering against agreed objectives and action plans are in place to address any areas of risk identified. For the Q3 report, an initial 'RAG' rating of the Assurance Framework has been undertaken to support the Chief Executive's discussions with Directors as part of their Q4 appraisal. **Organisational risk register** The organisational risk register records high level risks in the organisation and the controls in place to manage and mitigate the risks. The risk register is reviewed by the Executive Management Team on a monthly basis, risks are re-assessed based on current knowledge and proposals made in relation to this assessment, including the addition of any high level risks from BDUs, corporate or project specific risks and the removal of risks from the register. The risk register contains the following risks: - issues around data quality; - the Care Packages and Pathways project for mental health; - impact on services as a result of continued local authority spending cuts and changes to the benefits system; - transformational service change programme; - changes to national funding arrangements; - bed pressures; - child and adolescent mental health services; - industrial action; and - Trust sustainability declaration

	The risk around substance misuse services in Calderdale has been removed as action is in place to mitigate the risk below the Trust Board reporting threshold of 15. **Internal audit report** The Trust's assurance framework and risk register arrangements are reviewed by internal audit on an annual basis. The review undertaken in Autumn 2014 (and reported to the Audit Committee on 20 January 2015) provided an opinion of significant assurance. This review assessed the risk management arrangements in Barnsley BDU and the Trust Board Assurance Framework (BAF) in place at the Trust. In addition, the review assessed wider risk management arrangements, focussed on the effectiveness of reporting in the risk register, and reviewed the controls and assurances which are in place to support it. Testing involved consideration of the local risk register for Barnsley BDU, the way in which it is collated, monitored and reported, and how well this local risk register links with the corporate register, and any changes to the BAF and associated arrangements since the previous review. Overall, there were very few issues identified and only a small number of low risk recommendations have been made to help further strengthen the arrangements already in place. The previous year review made four recommendations (one medium priority and three low priority). Due to the date on which the final report for that review was issued (October 2014), none of these recommendations were due to be completed prior to completion of the current year review. These will, therefore, be followed up through the recommendation tracker and as part of the next review of risk management and BAF.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the assurances provided for Q3 of 2014/15;** ➢ **NOTE those areas where gaps in assurance have been identified, through the Trust wide risk register and are being addressed through specific action plans as appropriate led by the lead Director;** ➢ **NOTE the key risks for the organisation subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**
Private session:	Not applicable

ASSURANCE FRAMEWORK 2014/15 Q3

Principal delivery objective 1 Quality:

- **Create a person-centred delivery system**
- **Deliver safe services**
- **Ensure efficient and effective delivery**

Principal risks (including potential risks)	Lead Direct	Key controls * (Systems/processes)	Assurance on controls * (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurance	Gaps in control	Gaps in assurance
1. Unexplainable variation in clinical practice resulting in differential patient experience and outcomes and impact on Trust reputation.	▪ MD ▪ DN ▪ DDs	▪ C4, C23, C24, C25, C26, C43	▪ A1, A8, A33, A36, A46, A52			ORR ref: 267, 270
2. Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation.	▪ ▪ DoN	▪ C23, C41, C50, C51	▪ A15, A19, A24, A27, A46, A48			
3. Failing to achieve devolution and local autonomy for BDUs within the new leadership and management arrangements impacting on ability to deliver safe, effective and efficient services.	▪ DDs	▪ C1, C3, C33, C52, C53, C54, C55	▪ A1, A5, A26, A33, A35,			
4. No clear lines of accountability and responsibility within Directorates and between BDUs and Quality Academy impacting on ability to deliver safe, effective and efficient services.	▪ DDs ▪ CDs	▪ C17, C23, C33, C53	▪ A12, A15, A16, A23, A35			
5. Trust plans for service transformation are not aligned to the multiplicity of stakeholder requirements leading to inability to create a person-centred delivery system.	▪ DDs ▪ QA dirs.	▪ C3, C17, C18, C30, C32, C35, C45, C52	▪ A1, A4, A5, A8, A15, A16, A26, A40, A53			ORR ref: 463
6. Failure of transformation plans to reach appropriate quality improvement thresholds leading to development of a service offer that does not meet service user/carer needs.	▪ DDs ▪ QA dirs.	▪ C3, C17, C18, C30, C32, C35, C45, C52	▪ A1, A4, A5, A8, A15, A16, A26, A40, A53			ORR ref: 463

Principal delivery objective 2 Finance:

- **Financial stability now and in the future**
- **Embed service line reporting and internal benchmarking in everyday practice**
- **Create surplus for re-investment in new models of care**

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurance	Gaps in control	Gaps in assurance
7. Changing service demands and external financial pressures in local health and social care economies have an adverse impact on achieving local and national performance targets and ability to manage within available resources.	▪ DDs	▪ C4, C5, C20, C22, C27, C28	▪ A1, A8, A9, A10, A11, A15, A16, A23, A30			ORR ref: 275, 522, 695
8. Lack of capacity and resources not prioritised leading to non-delivery of key organisational priorities and objectives.	▪ DDs ▪ CDs	▪ C17, C18, C23, C33, C35,	▪ A1, A3, A4, A5, A42			
9. Lack of resources to support development and pump prime innovation to support delivery of plan	▪ DDs, CDs,	▪ C44, C54, C63,	▪ A5, A34, A35			ORR ref: 522, 463, 695
10. Failure to deliver level of transformational change required impacting on ability to deliver resources to support delivery of the annual plan.	▪ DSD ▪ DoF	▪ C17, C18, C30	▪ A1, A2, A4, A5, A35, A37			ORR ref: 463

Principal delivery objective 3 Workforce:

- **Development of workforce plan linked to service and financial objectives**
- **Development of values-based human resources management to enhance service quality**
- **Improve organisational performance through strong workforce engagement**

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
11. Staff and other key stakeholders not fully engaged in process around redesign of service offer as needed for change leading to lack of engagement and benefits not being realised through delivery of revised models and ability to deliver best possible outcome through changing clinical practice	▪ DDs	▪ C4, C7, C11, C12	▪ A1, A4, A39			
12. Lack of clear service model(s) to support a workforce plan to identify, recruit and retain suitably competent and qualified staff with relevant skills and experience to deliver the service offer and meet	▪ DoH	▪ C1, C12, C29, C35, C67	▪ A1, A10, A20, A21, A22, A24, A47			ORR ref: 463

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
national and local targets and standards.						
13. Failure to motivate and engage clinical staff through culture of quality improvement, benchmarking and changing clinical practice, impacting on ability to deliver best possible outcomes.	▪ MD ▪ DoN	▪ C31, C32, C34, C44, C45, C46	▪ A1, A11,A21, A29, A35, A49, A52			
14. Failure to create and communicate a coherent articulation of Trust Mission, Vision and Values leading to inability to identify and deliver against strategic objectives.	▪ CE	▪ C31, C33, C44, C48, C49, C68	▪ A1, A7, A35, A42			
15. Failure to articulate leadership requirements to identify, harness and support talent to drive effective leadership and succession planning.	▪ DDs ▪ CDs ▪ AGD	▪ C26, C44, C65	▪ A3, A22, A35,			

Principal delivery objective 4 Estate

- **Development of community hubs to support service transformation and agile working in line with approved capital programme**
- **Develop, agree and implement programme for disposal of surplus estate linked to service transformation, including scoping of options for key hospital sites**
- **Development of master plan for Fieldhead underpinned by agreed capital schemes which optimise effective and efficient utilisation of the site**

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
16. Not having clearly defined service model(s) to enable estate to be reviewed and configured to support the transformation agenda.	▪ DoH ▪ DDs	▪ C1, C17, C32, C36, C37, C38	▪ A1, A4, A5, A6A18, A26, A27, A44			ORR ref: 463
17. Failure to dispose of capital assets in line with capital programme, leading to underfunding of capital programme.	▪ AGD	▪ C3, C17, C18, C36, C37, C38, C70	▪ A4, A5, A6, A8, A15, A16, A26			
18. Failure to deliver capital programme in line with timescales resulting in inability to transform and deliver services.	▪ AGD	▪ C3, C17, C18, C36, C37, C38, C70	▪ A4, A5, A6, A8, A15, A16, A26			
19. Failure of services to adopt agile working approaches, which could compromise the future estate model.	▪ AF ▪ DDs	▪ C3, C17, C18, C36, C37, C38, C70	▪ A4, A5, A6, A8, A15, A16, A26			

Principal delivery objective 5 IM&T

- **Implementation of agile working and communications technology to support efficiency and re-design of services**

- **Optimisation and integration of key clinical systems**
- **Performance framework in place, which supports service line management and reporting**

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
20. Inadequate capture of data resulting in poor data quality impacting on ability to deliver against care pathways and packages and evidence delivery against performance targets and potential failure regarding Monitor Compliance Framework.	▪ DoF	▪ C17, C19, C20, C21, C22	▪ A1, A9, A10, A11,A13, A15, A16, A17, A43			ORR ref: 267, 270
21. Lack of suitable technology and infrastructure to support delivery of revised service offer leading to lack of support for services to deliver revised service offers.	▪ DoF	▪ C1, C17, C32, C39	▪ A1, A4, A5, A14, A26			
22. Failure to deliver new IT contract in line with IM&T Strategy, impacting on delivery of services.	▪ DoF	▪ C3, C39	▪ A54			

Principal delivery objective 6 Commissioning

- **Evidence 'value' to commissioners through the implementation of new currency models, which support service delivery**
- **Key partners in systems transformation programmes in all BDUs to safeguard quality in core services**
- **Commercial strategy for development of business**

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
23. Failure to understand and respond to changing market forces leading to loss of market share and possible de-commissioning of services.	▪ DSD ▪ DDs	▪ C1, C2, C3, C4, C32 ▪	▪ A4, A5, A40			ORR ref: 522
24. Failure to develop required relationships or commissioner support to develop new services/expand existing services leading to contracts being awarded to other providers.	▪ DoF ▪ DDs	▪ C1, C4, C5	▪ A1, A36, A40			
25. Failure to respond to market forces and on-going development of new partnerships leading to loss of market share and possible de-commissioning of services.	▪ DDs ▪ DoCD	▪ C1, C2, C3, C6, C30	▪ A26, A29, A40, A39			

Principal delivery objective 7 Partnerships

- **Partner with acute and community trusts within the Trust's area to increase collective ability to deliver integrated care, access Better Care Funds and enhance social and economic wellbeing**
- **Partner with the third sector to develop and deliver 'alternative service offers' increasing capacity, reducing costs and increasing quality**
- **Partner with existing and new partners to develop new business opportunities to create affordable, effective and efficient services, leveraging the resources and capabilities of all partners**

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
26. Lack of engagement and ownership to manage risk in the local economy impacting on available resources.	▪ DoC ▪ DDs	▪ C4, C5, C6, C7, C9	▪ A28, A29, A35, A39			ORR ref: 275, 522
27. Failure to listen and respond to our service users and, as a consequence, service offer is not patient-centred, impacting on reputation and leading to loss of market share.	▪ DDs	▪ C7, C13, C15, C40, C42, C43	▪ A2, A20, A21, A29, A45, A51			
28. Risk of lack of stakeholder engagement needed to drive innovation resulting in key stakeholders not fully engaged in process around redesign of service offer.	• MD, • DoN, • DDs • DoCD,	▪ C11, C17, C18, C30, C32	• A1, A4, A35, A39			
29. Failure to deliver relationships with the third sector to delivery alternative community capacity leading to loss of market share and Trust inability to optimise business opportunities.	• DoCD	▪ C3, C6, C7, C11, C40, C59, C62	• A4, A39, A40			
30. Partners unclear of the intent and purpose of relationships leading to misunderstanding and conflict.	• DoF • DoCS • CE	▪ C4, C5, C9, C13, C28, C40, C59	• A4, A39, A40, A42			

Abbreviations:

DoN		Director of Nursing	DSD	-	Director of Service Development
DDs	-	District Directors	MC	-	Members Council
DoF	-	Director of Finance	AC	-	Audit Committee
DoCD	-	Director of Corporate Development	CGCSC	-	Clinical Governance and Clinical Safety Committee
DoH	-	Director of Human Resources	RC	-	Remuneration Committee
MD	-	Medical Director	MHAC	-	Mental Health Act Committee
CDs	-	Corporate Directors	TAG	-	Trust Action Group

Control (C...)	Key Control (systems/processes)
1.	Executive Management Team ensures alignment of developing strategies with Trust vision and strategic objectives.
2.	Production of market assessment against a number of frameworks including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power.
3.	Production of two-year operational plan and five-year strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks.
4.	Formal contract negotiation meetings established with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services.
5.	Development of joint QIPP plans with commissioners to improve quality and performance, reducing risk of decommissioning, change of provider
6.	Third Sector Strategy and action plan in place approved by Trust Board, promoting and developing key relationships
7.	Involving People Strategy and action plan in place approved by Trust Board, promoting and developing key relationships
8.	No longer used
9.	Care Pathways and personalisation Project Board established with CCG and Local Authority Partners
10.	No longer used
11.	Creative Minds Strategy and action plan in place approved by Trust Board, promoting different ways of working and partnership approach
12.	Partnership Boards established with staff side organisations to manage and facilitate necessary change
13.	Framework in place to ensure feedback from customers, both internal and external, including feedback loop, is collected, analysed and acted upon by through delivery of action plans through Local Action Groups
14.	No longer used
15.	Member Council engagement and involvement in working groups
16.	No longer used
17.	Director leads in place for transformation programme and key change management projects linked to corporate and personal objectives, with resources and deliverables identified.
18.	Project Boards for transformation workstreams established, with appropriate membership skills and competencies, PIDs, Project Plans, project governance, risk registers for key projects in place.
19.	Risk assessment and action plan for data quality assurance in place
20.	Risk assessment and action plan for delivery of CQUIN indicators in place.
21.	Cross-BDU performance meetings established to identify performance issues and learn from good practices in other areas
22.	Performance Management system in place, with KPIs covering national and local priorities
23.	Review of Quality Academy approach and implementation of recommendations
24.	Process in place for systematic use of benchmarking to identify areas for improvement and identifying CIP opportunities.
25.	Peer review and challenge processes in place i.e. Medium Secure Quality Network
26.	Values-based appraisal process in place and monitored through KPI
27.	Internal control processes in place to produce and review monthly budget reports and take mitigating actions as appropriate
28.	CCG/Provider performance monitoring regime of compliance with QIPP plan and CQUIN targets in place.
29.	HR processes in place ensuring defined job description, roles and competencies to meet needs of service, pre-employment checks done re qualifications, DBS, work permits
30.	Project management office in place led at Deputy Director level with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities
31.	Further round of Middleground developed, delivered and evaluated linked to organisational and individual resilience to support staff prepare for change and transition and to support new ways of working
32.	BDU revised service offer through the transformation programme, with workstreams and resources in place, overseen by project boards and EMT
33.	Alignment and cascade of Trust Board-approved corporate objectives supporting delivery of Trust mission, vision and values through appraisal process down through director to team and individual team member
34.	Medical Leadership Programme in place with external facilitation.

Control (C...)	Key Control (systems/processes)
35.	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity.
36.	Estates plan includes outcome of six facet surveys undertaken to identify possible infrastructure and services risks, linked to forward capital programme.
37.	Estates Forum in place with defined Terms of Reference chaired by a NED
38.	Estate TAG in place ensuring alignment of Trust strategic direction, with estates strategy and capital plan
39.	IM&T strategy in place
40.	Public engagement and consultation events gaining insight and feedback, including identification of themes and reporting on how feedback been used.
41.	Weekly serious incident summaries (incident reporting system) to EMT supported by quarterly and annual reports to EMT, Clinical Governance and Clinical Safety Committee and Trust Board
42.	Staff wellbeing survey conducted, with facilitated group forums to review results and produce action plans
43.	Complaints policy and complaints protocol covering integrated teams in place.
44.	OD Framework and plan in place
45.	New leadership and management arrangements established at BDU and service line level with key focus on clinical engagement and delivery of services
46.	Facilitated engagement of clinicians in TAGs
47.	No longer used
48.	Values-based Trust induction policy in place covering mission, vision, values, key policies and procedures.
49.	Communication Strategy in place
50.	Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training
51.	Audit of compliance with policies and procedures co-ordinated through clinical governance team.
52.	Annual Business planning guidance issued standardising process and ensuring consistency of approach
53.	Standing Orders, Standing Financial Systems, scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities
54.	Standardised process in place for producing businesses cases and benefits realisation cards.
55.	Policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval.
56.	No longer used
57.	No longer used
58.	A set of leadership competencies developed as part of Leadership and Management Development Plan supported by coherent and consistent leadership development programme
59.	Member of local partnership boards, building relationships, ensuring transparency of agenda's and risks, facilitating joint working, cohesion of policies and strategies
60.	Staff excellence award schemes in place to encourage and recognise best practice and innovation.
61.	Fostering links to Jonkoping in Sweden as part of on-going development of Quality Academy Approach and learning from best practice.
62.	Investment Appraisal framework including ensuring both a financial and social return on investment providing clarity of approach
63.	Innovation fund established to pump prime investment to deliver service change and innovation
64.	Leadership and Management Development Plan in place covering development framework, talent management and succession planning.
65.	Secondment policy and procedure in place
66.	Board strategic development sessions setting overarching strategy and strategic direction scheduled
67.	Mandatory Training Review Group in place ensuring mandatory training policy and programme linked to delivery of statutory requirements and delivery of corporate objectives.
68.	Achievement of financial targets
69.	Achieve of targets and indicators mandated by Monitor
70.	Approval by Trust Board of business cases for capital developments during 2014/15 and for planned disposals during 2014/15
71.	Continued compliance with CQC registration and Monitor Licence conditions
72.	Deliver year of values programme
73.	Review Scheme of Delegation
74.	Monthly review by EMT of stakeholder and partnership position through rich picture and risk assessment

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
1.	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	➢ CE summary letters to Directors following each quarterly review. ➢ Update reports to each Remuneration and Terms of Service Committee by the Chief Executive
2.	Production of Patient Experience quantitative and qualitative reports, triangulating themes, 'you said, we did' to Trust Board and Members' Council.	➢ Quarterly quality performance report to Trust Board ➢ Quarterly report on customer services to Trust Board ➢ Customer services annual report to Trust Board June 2014
3.	Annual appraisal, objective setting and PDPs to be completed in Q1 of financial year for staff in Bands 6 and above and in Q2 for all other staff, performance managed by EMT.	➢ Performance reports and HR performance reports to Trust Board and EMT (monthly) ➢ HR performance reports to R&TSC ➢ Appraisal records kept by line managers ➢ Values-based appraisal process now used for all staff following a review of the process and revision of policy and supporting documentation
4.	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	➢ Transformational service change reports to EMT (monthly) ➢ Report to Trust Board on progress against transformation plans July and September 2014 ➢ Quarterly investment appraisal report to Trust Board ➢ Transformation business cases present to EMT (acute and community mental health January 2015)
5.	Business cases for expansion/change of services approved by EMT and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework.	➢ Funding for BDU management of Innovation Fund approved by EMT for 2014/15 ➢ Quarterly Investment Appraisal Framework report to Trust Board, which includes investment in specific initiatives ➢ Transactional IT services Trust Board April 2014 ➢ Tier 4 CAMHS Trust Board April, June, July and September 2014 ➢ Newton Lodge service developments Trust Board April 2014 ➢ Calderdale hub Trust Board June 2014 ➢ Strategic outline case Trust Board June 2014 ➢ Technology Fund Trust Board July 2014 ➢ Barnsley hub Trust Board September 2014
6.	Performance management of estates schemes against resources through Estates TAG, deviations identified and remedial plans requested.	➢ Estates TAG minutes and papers ➢ Estates Forum minutes and papers through 2014/15 ➢ Estates Strategy update Trust Board April and December 2014 ➢ Calderdale hub Trust Board June 2014 ➢ Barnsley hub Trust Board September 2014 ➢ Fox View business case EMT July 2014 ➢ Savile Park View business case EMT July 2014 ➢ Fieldhead masterplan EMT December 2014
7.	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives.	➢ Strategy session of Trust Board May and November 2014 ➢ Five-year strategic plan briefing for Trust Board June 2014
8.	Quarterly quality/integrated compliance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	➢ Quarterly quality performance reports to Trust Board ➢ Quarterly compliance reports to EMT to inform presentation to Trust Board
9.	Quarterly Monitor exception report to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken, which includes confirmation that the Trust complies with the conditions of its Licence and, where it does/may not, the risk and mitigating action.	➢ Monitor quarterly exception report return presented to Trust Board, including confirmation that Trust complies and continues to comply with the conditions of the Trust's licence

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
10.	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken. Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	➢ Assurance Framework and risk register presented to and reviewed by Trust Board on quarterly basis ➢ Risk register reviewed monthly by EMT
11.	Assurance reports to Clinical Governance and Clinical Safety Committee covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place.	➢ Clinical Governance and Clinical Safety Committee minutes ➢ Child and adolescent mental health services September and November 2014 (and Trust Board July, September and December 2014) ➢ Children's services April and June 2014 ➢ Hard Truths and Francis Report April, September and November 2014 (and Trust Board June and September 2014) ➢ Impact of cost improvement programme April, June, September and November 2014 ➢ Quality Improvement Plan April 2014 ➢ Patient Safety Strategy September 2014 ➢ Tissue viability November 2014
12.	Annual Governance Statement reviewed and approved by Audit Committee and Trust Board and externally audited.	➢ Approval of annual report and accounts at Audit Committee May 2014 and Trust Board June 2014
13.	Monitor Risk Assessment Framework assurance group review performance before Trust Board on quarterly basis ensuring all exceptions identified and reported to Trust Board and Monitor.	➢ Process in place to review compliance with Monitor targets on quarterly basis ➢ Progress reviewed monthly at EMT evidenced through EMT minutes ➢ Risk assessment of compliance to Trust Board April 2014
14.	Information Governance Toolkit provides assurance and evidence that systems and processes in place at the applicable level, reported through IM&T TAG, deviations identified and remedial plans requested receive, performance monitored against plans.	➢ Information Governance (included in IM&T TAG) papers and minutes ➢ Performance EMT meetings and papers ➢ Monthly performance reports ➢ Report to Clinical Governance and Clinical Safety Committee September 2014
15.	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested.	➢ Performance reports to EMT (which include 'hotspots' and areas for concern) ➢ Minutes from performance EMT meetings ➢ Transformational service change progress reports to EMT (monthly) ➢ Sickness absence included in performance report ➢ Risk assessment of target, CQUINs, etc. Trust Board April 2014 ➢ Detailed analysis in finance report to Trust Board on cost improvement programme (monthly from April to December 2014)
16.	Monthly review and monitoring of integrated and quality performance reports by Trust Board with exception reports requested around risk areas.	➢ Performance reports to Trust Board ➢ Minutes from Trust Board meetings ➢ Risk assessment of performance targets 2014/15 to Trust Board April 2014
17.	Annual report to Trust Board to risk assess changes in compliance requirements and achievement of performance targets.	➢ Risk assessment of performance targets 2014/15 to Trust Board April 2014
18.	Independent PLACE audits undertaken and results and actions to be taken reported to EMT, Members' Council and Trust Board.	➢
19.	CQC registration in place and assurance provided that Trust complies with its registration	➢ Care Quality Commission registration certificates
20.	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board.	➢
21.	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans.	➢ Standing item on CG&CS Committee agenda to reflect rolling programme from 1 April 2014
22.	Remuneration Terms of Service Committee receive HR Performance Reports, monitor compliance against plans and receive assurance from reports around staff development, workforce resilience.	➢ Standing item on Committee agenda
23.	Audit Committee review evidence for compliance with policies, process, standing	➢ Annual report and accounts

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
	orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources.	➢ Standing item on service line reporting ➢ Standing item on payment by results and currency development ➢ Standing item on procurement and review of procurement strategy ➢ Standing item on progress against counter fraud plan ➢ Standing item on progress against internal audit plan ➢ Head of Internal Audit Opinion May 2014
24.	Independent CQC reports to Mental Health Act Committee providing assurance on compliance with Mental Health Act.	➢ Standing item at Mental Health Act Committee meetings
25.	External accreditation against IIP GOLD supported by internal assessors, ensuring consistency of approach in the support of staff development and links with organisational objectives.	The Trust was accredited against the IiP standard in 2009 and re-assessed in 2012, and is working towards achieving GOLD standard in 2014/15.
26.	Annual plan and budget, two-year operational plan and five-year strategic plan approved by Trust Board, externally scrutinised and challenged by Monitor.	➢ Monitor commentary on annual plan ➢ Annual plans, budgets and minor capital programme 2014/15 approved by Trust Board March 2014 ➢ Monitor two-year operational plan approved by Trust Board March 2014 with independent review by Deloitte (April 2014) and update against resulting action plan at each meeting ➢ Follow up review by Deloitte (December 2014) ➢ Monitor five-year strategic plan approved by Trust Board June 2014 ➢ Monitor quarterly returns ➢ Operational Requirement Group established by Chief Executive in April 2014
27.	Health and Safety TAG monitor performance against plans deviations identified and remedial plans requested.	➢ Health and Safety TAG minutes
28.	Staff opinion and wellbeing survey results reported to Trust Board and action plans produced as applicable.	➢
29.	Service user survey results reported annually to Trust Board and action plans produced as applicable.	➢ Quarterly quality performance report to Trust Board
30.	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and director leads to provide assurance against annual plan	➢ Audit Committee annual report to Trust Board 2013/14 April 2014 ➢ Review of other risk Committees' effectiveness and integration Audit Committee April 2014
31.	External and internal audit reports to Audit Committee setting out level of assurance received.	➢ Internal audit update reports to Audit Committee ➢ External audit update reports to Audit Committee ➢ Annual report and accounts to Audit Committee May 2014 ➢ Quality Accounts progress standing item on Clinical Governance and Clinical Safety Committee agenda ➢ Quality Accounts final report to Clinical Governance and Clinical Safety Committee May 2014
32.	External and internal audit reports performance managed through EMT.	➢ Internal audit follow up reports to EMT and consideration of internal audit reports with limited assurance throughout 2014/15 ➢ Quality Accounts external assurance Audit Committee May 2014 and Trust Board June 2014
33.	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities.	➢ Reports to Clinical Governance and Clinical Safety Committee ➢ Limited assurance reports considered by EMT ➢ Internal audit reports on financial management and reporting (including procurement follow up) (substantial), Monitor provider licence (substantial), Francis II (substantial), information governance toolkit (substantial), serious incidents

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
		(substantial), transformation, including service line management (moderate), data quality (moderate), leadership development (moderate), patients' property (partial) and statutory and mandatory training (significant).
34.	Innovation fund allocation approved through EMT with guidance to ensure consistency of approach and alignment with strategic priorities and corporate objectives.	➢ Funding for BDU management of Innovation Fund approved by EMT for 2014/15
35.	Monitoring of organisational development plan through Chief Executive-led group, deviations identified and remedial plans requested.	➢ OD group led by CE established to review OD plan.
36.	QIPP performance monitored through delivery EMT, deviations identified and remedial plans requested.	➢ Performance reports to EMT ➢ Delivery EMT minutes
37.	Sustainability action plans monitored through Sustainability TAG, deviations identified and remedial plans requested.	➢ Sustainability TAG minutes
38.	No longer applicable	
39.	Strategic overview of partnerships and growth in line with Trust vision and objectives provided through EMT and Trust Board.	➢ Stakeholder updates at strategy and risk EMT ➢ Stakeholder analysis and environmental scan Trust Board April, May and November 2014
40.	Market analysis reviewed through EMT, market assessment to Trust Board ensuring identification of opportunities and threats.	➢ Stakeholder analysis and environmental scan Trust Board April, May and November 2014
41.	Production of Corporate Governance Statement to support submission of Trust plans, setting out evidence of compliance/assurance against the statements reviewed by Trust Board	➢ Monitor five-year strategic plan, including Trust Board self-certification, approved by Trust Board June 2014 ➢ Approval by Trust Board of Monitor five-year strategic plan June 2014 ➢ Corporate Governance Statement approved by Trust Board June 2014 ➢ Self-certification on compliance with licence and level of resources Trust Board May 2014
42.	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	➢ Performance reports to Trust Board and EMT ➢ Rolling programme of engagement and listening events for staff
43.	Data quality Improvement plan monitored through EMT deviations identified and remedial plans requested.	➢
44.	Estates Forum monitors delivery against Estates Strategy.	➢ Estates forum minutes and papers outlining development of Estates Strategy
45.	Equality and Involvement Strategy into Action Group established monitoring delivery of equality, involvement and inclusion action plans, reporting into CG&CS Committee.	➢ Equality and Involvement Strategy into Action Group terms of reference and minutes
46.	Serious Incidents from across the organisation reviewed through the Incident Review Panel including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation.	➢ Incident Review Sub-Committee minutes and reports to Clinical Governance and Clinical Safety Committee (NB from November 2014 direct reporting to the Committee) ➢ Serious incidents quarterly reports to EMT, Clinical Governance and Clinical Safety Committee and Trust Board ➢ Annual SI report to Trust Board July 2014
47.	Mandatory training review group in place ensuring consistency of approach across Trust and compliance with legislation.	➢
48.	Assurances received by Committees of Trust Board reported quarterly to Trust Board, providing assurance on systems and controls in place and operating.	➢ Quarterly assurance from Trust Board Committees to Trust Board
49.	Medium secure quality network undertake annual peer reviews providing external assurance on systems and controls in place and operating.	➢
50.	Independent Hospital Managers review detentions providing external assurances of compliance with MH Act.	All detained but non-restricted patients have their renewal of section examined at a formal meeting with independent hospital managers who examine legality and

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
		appropriateness of detention. Also able to identify any concerns voiced by patients/advocates about care given. Feedback given to Mental Health Act Committee through standing item on the agenda (feedback from Hospital Managers' Forum).
51.	HealthWatch undertake unannounced visits to services providing external assurance on standards and quality of care.	➢
52.	Medical staff appraisal and revalidation in place evidenced through annual report to Trust Board and supported through Appraisers forum.	➢ Medical Appraisers' Forum minutes ➢ Annual report to Trust Board June 2014 ➢ Appointment of Responsible Officer Trust Board September 2014
53.	Chief Executive-led Operational Requirement Group established to drive delivery of two-year operational plan.	➢ ORG notes (weekly)
54.	Operational delivery plan to ensure IM&T Strategy is implemented within timescales and within resource envelope monitored through IM&T TAG, EMT and IM&T Forum	➢ IM&T TAG notes and EMT minutes ➢ IM&T Forum papers and minutes

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South West Yorkshire Partnership NHS
NHS Foundation Trust

ORGANISATIONAL LEVEL RISK REPORT

DATE: 27 January 2015 (Trust Board)

	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Green	1 - 3	Low risk
Yellow	4 - 6	Moderate risk
Amber	8 - 12	High risk
Red	15 - 25	Extreme risk

Risk ID	Hist Ref.	Source	Risk Responsibility	BDU / Directorate	Service	Speciality	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Summary of risk action plan	Fin cost (£)	Risk owner	Expected date of completion	Monitoring & reporting requirements		Risk level (target)	Is this rating acceptable?	Comments	Risk review date
267			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Data quality and capture of clinical information on RiO will be insufficient to meet future compliance and operational requirements to support service line reporting and the implementation of the mental health currency leading to reputational and financial risk in negotiation of contracts with commissioners.	➢ Data quality Strategy approved by Board Oct 2011. ➢ Annual report produced for Business and Risk Board to identify risks and actions required in order to comply with regulatory and contract requirements. ➢ Data quality framework is monitored by the Data Quality Steering group which is chaired by the Director of Nursing. ➢ Key issues in relation to data quality and clinical practice to support mental health currency implementation are included in the data quality action plan which is reviewed by the steering group. ➢ All BDUs have individual data quality action plan which is reviewed internally. ➢ Accountability for data quality is held jointly by Director of Nursing and Director of Finance. ➢ Responsibility for data quality is delivered by BDU directors, BDU nominated quality leads and clinical governance. ➢ Key metrics for Data quality are produced monthly in BDU and trust dashboards and reviewed by Performance EMT. ➢ Annual clinical audit programme is planned to reflect data quality priorities.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Progress against data quality action reviewed at Delivery EMT on ongoing basis. ➢ Communication via Team Brief and Extended EMT on key messages. ➢ Performance on Payment by Results metrics reviewed at EMT. Dedicated clinical resource in each BDU as part of PbR project team. ➢ RiO Optimisation – re-focused and linked to PBR roll out with engagement of clinical staff. ➢ Roll out plan reviewed by RiO development Board. ➢ Wider system development network established with clinicians and managers. First set of quick wins to be implemented Q3 2014 ➢ Data quality metrics included in monthly performance reports. ➢ EMT agreed additional resources in October 2014 to be managed by BDU to support clean-up of caseload to prepare for requirements of contracting in 2015/16 ➢ Link of clustering data to mental health transformation work in Mental Health Summit October 2014 to ensure mainstreamed into redesigned services. ➢ Develop implementation plan for RiO system upgrade to be achieved in 2015.	100K est additional capacity	DoF Lead and Director of Nursing	Implementation of national guidance during 2014/15.	EMT and Trust Board monthly review for data quality indicators. Steering group review for ➢ Data quality Board ➢ PbR Project Board ➢ RiO system development Board. Monthly system development board for RiO system. Agreed work plan and prioritisation.	16	Red/extreme /SUI risk (15-25)	Yes		Trust Board January 2015
270			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			The Care Packages and Pathways project will not deliver an improvement in service quality and outcomes through the roll out of clustering and mental health currency.	➢ Accountability arrangements in place for delivery of mental health currency Project - lead Director of Finance. Key project Board members DoN and Medical Director. ➢ Progress reviewed by Audit Committee and Board. ➢ Key issues / risks and progress monitored by EMT through Performance EMT. ➢ Key representation at national level for development of costing by CEO and DoF through CPPP programme.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Re-launch of Project January 2013 with Director of Finance lead. Project Board in place with Medical Director and BDU Director representation. ➢ Steering group arrangements in place with Commissioners to manage implementation. ➢ Project plan in place for 2014/15 contracts proposal to roll over Memorandum of Agreement with Commissioners. ➢ PBR communications and information plan to roll out from April 2014. ➢ Standing item on Performance EMT. ➢ Review by Director of Nursing, Medical Director and Director of Finance of implementation plan October 2014 with report to EMT 23.10.14 and 18.12.14. ➢ Mental health currency and service line reporting standing items on Audit Committee agenda. Has included presentation from BDU Directors on implementation within BDUs.	Included in 267	DoF	As above and included in transformation programme and two-year operational plan	➢ EMT Progress reports ➢ Report on progress to every Audit Committee ➢ Regular Board updates	16	Red/extreme /SUI risk (15-25)	Yes		Trust Board January 2015

275			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Continued reduction in Local Authority funding and changes in benefits system will result in increased demand of health services - due to potential increase in demand for services and reduced capacity in integrated teams - which will create risk of a negative impact on the ability of integrated teams to meet performance targets.	➢ District integrated governance boards established to manage integrated working with good track record of cooperation. ➢ Maintenance of good operational links though BDU teams and leadership. ➢ Monthly review through Performance EMT of key indicators which would indicate if issues arose regarding delivery i.e. delayed transfers of care and service users in settled accommodation.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Continues to be monitored through BDU/commissioner forums. Some evidence in, for example, Kirklees where budgetary pressures have impacted on speed of recruitment.		BDU Directors	Included in two-year operational plan	EMT (monthly) and Trust Board (monthly) EMT review of 2015/16 contracts October / November 2014.	12	Amber/ high (8-12)	Yes		Trust Board January 2015
463			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk that the planning and implementation of transformational change through the transformation programme will increase clinical and reputational risk in in year delivery by imbalance of staff skills and capacity between the "day job" and the "change job".	➢ Scrutiny of performance dashboards and bi-weekly risk reports by BDUs and EMT to ensure performance issues are picked up early. ➢ Weekly risk review by Director of Nursing and Medical Director to ensure any emerging clinical risks are identified and mitigated. ➢ Monthly performance review by Trust Board. ➢ Clear accountability arrangements for leadership and milestones for the transformation programme which are monitored by EMT. ➢ Engagement of extended EMT in managing and shaping transformational change and delivering in year performance.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Ongoing engagement events programme on transformation programme. ➢ Business Case for RAID completed and being implemented Q4 2013/14. ➢ Director objectives linked to deliverables in the transformation programme. ➢ Mental health summit October 2014. Action agreed by EMT and business cases developed and approved January 2015. ➢ Alternative non-recurrent substitutions for shortfall in transformation CIP (£500,000). ➢ Issues relating to Agenda for Change banding of key Project Management Office roles has delayed recruitment to level where there is a critical capacity issue. ➢ Roll-out of mental health acute commissioning implementation starting January 2015.	£500,000	Work stream leads	Two-year operational plan	Monthly transformation and strategy and risk EMT meetings. Trust Board reports as appropriate. Business cases approved by Calderdale, Kirklees and Wakefield commissioners.	20	Red/extreme /SUI risk (15-25)	Yes		Trust Board January 2015
522			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements (such as, CCG allocation and the Better Care Fund) couples with emerging intensified local acute Trust pressures. Risk local re-tendering will increase the risk in the 2015/16 contracting round will increase level of savings required to >5% to maintain financial viability and potential to fragment pathways and increase clinical risk.	➢ Develop a clear service strategy through the internal Transformation Programmes to engage commissioners and service users on the value of services delivered. ➢ Ensure appropriate Trust participation in system transformation programmes. ➢ Robust process of stakeholder engagement and management in place through EMT. ➢ Progress on Transformation reviewed by Board and EMT.	5 Catastrophic	3 Possible	15	Red/extreme /SUI risk (15-25)	➢ SWYPFT proactive in involvement in system transformation programmes which are led by commissioners. ➢ Internal SWYPFT transformation programme linked to CCG commissioning by including schemes within the QIPP element as part of the service development plan in the 2014/15 contract. ➢ Schemes being developed but costs unlikely to be released to commissioners in 2014/15. ➢ RAID scheme being implemented in Calderdale and Huddersfield. ➢ Psychiatric Liaison scheme approved in Wakefield. ➢ Proactive involvement in negotiations regarding implementation of Better Care Fund in each of the localities.	£100,000	Deputy DCE lead & Directors	Two-year operational plan	Monthly at EMT.	12	Amber/ high (8-12)	Yes		Trust Board January 2015
527			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Bed occupancy is above that expected due to an increase in acuity and admissions is causing pressures across all bed-based mental health areas across the Trust.	➢ Revised bed management protocol. ➢ Review of above protocol completed and action plan developed. ➢ Patient flow system established in BDUs with rest to follow. ➢ Linked to Acute Care Transformation Programme.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Actions in place to manage patient flow have had positive impact on numbers of bed days out of area and the level of cost incurred. ➢ Trajectory monitored at delivery EMT. ➢ Internal audit undertaken on implementation of the bed management protocol. ➢ Action plan in place following review with ongoing monitoring.		BDU Director	Reviewed Protocol February 2014	Monthly at EMT	12	Amber/ high (8-12)	Yes		Trust Board January 2015
668			Corporate/ organisation level risk (corporate use only EMT)	Specialist Services	Child and Adolescent Mental Health Services (CAMHS)	Child and Adolescent Mental Health Services - Calderdale and Kirklees	Children potentially at serious risk due to lack of robust systems and processes to ensure safe clinical delivery. Reputation of the organisation if the concerns and issues are not addressed and the service governance aligned with the rest of the organisation	Recovery plan to address the immediate concerns Change Management plan to align delivery to the service specification Trust wide CAMHs transformation programme to be developed	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Dedicated Team in place to deliver the recovery plan. This includes the appointment of interim support at Director-level. ➢ Monitoring of delivery of plans to be undertaken within specific time scales via EMT and BDU ➢ Recovery Plan developed as further concerns/issues have been raised		Interim BDU Director	Timescale for completion 2015/16 and ongoing to ensure the actions in the recovery plan are implemented	EMT Clinical governance Board Meetings Specialist Services BDU meeting - monthly	12	Amber/ high (8-12)	Yes		Trust Board January 2015
683			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	HR		Planned industrial action in the NHS and wider public sector regarding the national pay award for 2014/15. Unions (except for BMA and Royal College of Nursing) are balloting for industrial action in October/November 2014 and into 2015.	A group has been established reporting to the Health and Safety TAG, which includes emergency planning, involving HR, the emergency planning lead and BDU representatives. Contingency plans are being reviewed.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Contingency plans under regular review. ➢ Discussions with Social Partnership Forum representatives regarding the extent and nature of industrial action to enable contingency planning.		BDU Directors / Director of HR		Health and Safety TAG to EMT / Trust Board EMT monthly / Trust Board monthly	9	Amber/ high (8-12)			Trust Board January 2015

695			Corporate/ organisation level risk (corporate use only EMT)	Trust wide			Ongoing requirement to reduce costs and meet commissioner QIPP will result in Trust becoming unsustainable clinically, operationally and financially by year 4 of the 5 year plan (2017-18)	Risk scenario modelled in 5 year plan submitted April 2014, which identified a tiered strategy to achieve sustainability which assumes consolidation of pathways and efficiencies in existing services; substitution of current service models for recovery based alternative service offers at lower cost; and strategic consolidation of key services to drive savings through critical mass.	5	4	20	Red/extreme /SUI risk (15-25)	➢ Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives ➢ Development of preferred partners through Memorandum of understanding and joint tender bids ➢ Quarterly review of strategy by the Board every quarter ➢ Recruitment to key areas of expertise to enable 5 year plan to be realised – Health intelligence, marketing and commercial skills Strategic planning and programme management.		EMT	REVIEW OF PLAN submission to regulator march 2015	Monthly review EMT Transformation Board review Quarterly updates to Board	16	Red/extreme /SUI risk (15-25)			Trust Board January 2015

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Risk profile 27 January 2015

Consequence (impact/severity)	Likelihood (frequency)				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Catastrophic (5)			= Trust's financial viability affected as a result of national funding arrangements (522)	= Data quality and capture of clinical information on RiO (267) = Care packages and pathways project (270) = Transformation programme (463) = Trust sustainability declaration made in five-year strategy plan (695)	
Major (4)				= Reduction in local authority funding (275) = Bed occupancy (527) = CAMHS Calderdale and Kirklees (668) = Industrial action (683)	
Moderate (3)					
Minor (2)					
Negligible (1)					

= same risk assessment as last quarter
! new risk since last quarter
< decreased risk rating since last quarter
> increased risk rating since last quarter