With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (business and risk)
Friday 29 January 2016 at 9:45
Seminar room 1, Textile Centre of Excellence, Textile House, Red Doles Lane, Huddersfield, HD2 1YF

AGENDA

1. Welcome, introduction and apologies (verbal item)

2. Declaration of interests

3. Minutes and matters arising from previous Trust Board meeting held on 22 December 2015

4. Assurance from Trust Board committees

4.1 Feedback from Trust Board Forums – Information Management and Technology Forum

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

6. Strategic overview of business and associated risks (to follow)

7. Performance reports month 9 2015/16

7.1 Quality performance report month 9 2015/16

7.2 Finance report month 9 2015/16

7.3 Customer services report quarter 3 2015/16

7.4 Exception reporting and action plans

(i) Potential implications for the Trust arising from Southern Health concerns

(ii) Care Quality Commission inspection

(iii) Governance arrangements for arm's length organisations

8. Items for approval

8.1 Risk Management Strategy

8.2 Customer Services Policy

9. Board self-assessment of operational, clinical and quality risks

10. Assurance framework and risk register

11. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 29 March 2016 in rooms 3 and 4, Laura Mitchell House, Great Albion Street, Halifax, HX1 1YR.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 January 2016
Agenda item 2

Title:	**Declaration of interests by the Chair and Directors of the Trust**
Paper prepared by:	Director of Corporate Development on behalf of the Chair of the Trust
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Mission/values:	The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process undertaken annually supports this.
Any background papers/ previously considered by:	Annual declaration made by the Chair and Directors of the Trust April 2015 and subsequent declarations made.
Executive summary:	The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise, received in April 2015, and the requirement for the Chair and Directors to consider and declare any interests at each meeting. There are no legal implications; however, the requirement for the Chair and Directors of the Trust to declare interests on an annual basis and for Non-Executive Directors to declare their independence is enshrined in the Health and Social Care Act 2012 in terms of the content of the Trust's Constitution. There is also a requirement for the Trust to assure itself that members of its Board meeting the fit and proper person requirements. Declarations made by new and existing Directors are as follows. <u>Executive Director – Jon Cooke</u> No interests declared although on secondment as Chief Finance Officer, Yorkshire and Humber Commissioning Support Unit. Jon has also made a declaration that he meets the fit and proper person requirements.
Recommendation:	**Trust Board is asked to CONSIDER the declaration, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.**
Private session:	Not applicable

Minutes of Trust Board meeting held on 22 December 2015

Present:	Ian Black	Chair
	Laurence Campbell	Non-Executive Director
	Rachel Court	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Julie Fox	Deputy Chair
	Chris Jones	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	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:	None	
In attendance:	Jon Cooke	Interim Director of Finance (designate)
	Kate Henry	Director, Marketing, Engagement and Commercial Devel.
	Dawn Stephenson	Director of Corporate Development (Company Secretary)
	Bernie Cherriman-Sykes	Board Secretary (author)
Guests:	Peter Adu	Member of the public
	Dave Himmelfield	Huddersfield Examiner
	Bob Mortimer	Publicly elected governor (Kirklees), Members' Council

TB/15/77 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting, in particular, Jon Cooke (JC), who will take up post as Interim Director of Finance on 4 January 2016. There were no apologies.

Alex Farrell joined the meeting.

TB/15/78 Declaration of interests (agenda item 2)

The following declaration was made over and above those made in April 2015 and subsequently.

Name	Declaration
NON-EXECUTIVE DIRECTORS	
Charlotte Dyson	Member, Local Advisory Committee for Clinical Excellence Awards, Bradford Teaching Hospitals NHS Foundation Trust

There were no comments or remarks made on the Declarations; therefore, **it was RESOLVED to formally NOTE the Declaration.**

TB/15/79 Minutes of and matters arising from the Trust Board meeting held on 23 October 2015 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 23 October 2015 as a true and accurate record of the meeting. There were no matters arising.

TB/15/80 Assurance from Trust Board committees (agenda item 4)

TB/15/80a Audit Committee 6 October 2015 (agenda item 4.1)

Feedback was taken at the October 2015 meeting and there was no further update.

TB/15/80b Clinical Governance and Clinical Safety Committee 2 November 2015 (agenda item 4.2)

The following areas were raised.

- The Committee proposed that Trust Board undertakes basic managing aggression and violence training, which will be developed as a bespoke package for Directors. This was supported by Trust Board.
- Tim Breedon (TB) commented on the challenge event held in Kirklees, which looked at arrangements in place within agencies with responsibilities for safeguarding children. The Trust was scored highest of the twelve agencies that attended the event, providing assurance of the arrangements in place within the Trust.
- The Committee received a report on nurse revalidation and asked for further detail at the next meeting on what happens if a member of staff was not revalidated.

Jonathan Jones (JJ) asked whether the Committee would review the report on learning disability services provided by Southern Health, on behalf of Trust Board, as he would derive assurance from the Committee that learning points have been considered and addressed. TB provided background for Trust Board and confirmed that the initial, draft report has been reviewed. The Trust does comply with national frameworks as demonstrated in reports such as the quarterly and annual incident management reports to both Trust Board and the Committee, and the learning lessons report (item 7.3(iii) on this agenda). He added that there may be additional work identified when the final report is published and reviewed in detail. A report will come back to Trust Board.

Adrian Berry (ABe) commented that Southern Health was criticised for the processes in place for reporting and recording incidents and that care should be taken in interpretation of data until the full report is published. JJ responded that he appreciated that the Trust has mechanisms in place to report and review incidents; however, he was looking for assurance that recommendations are implemented and lessons learnt. TB responded that assurance is provided through the annual incident management report to Trust Board, independent audits, BDU governance groups, where there is a particular focus on 'closing the loop', and the strengthening of incident management and learning processes undertaken during 2015. ABe added that incident reports submitted to commissioners and are consistently rated highly.

The Chief Executive (SM) made four points.

- The publication of the report will put providers of mental health and learning disability services under greater scrutiny. Trust Board must be prepared for this and offer support to this area of Trust services.
- The Trust needs to ensure that the standard of investigation and reporting is robust and strong and Trust Board should take assurance from the Clinical Governance and Clinical Safety Committee in this regard.
- There will be further scrutiny on what aspects of care for people with learning disabilities should be provided by the NHS and this will impact on the Trust's plans for transformation of its services.
- Trust Board should acknowledge the view of the Trust's commissioners and Coroners of Trust investigations and reporting, and seek assurance through review by the Clinical Governance and Clinical Safety Committee. IB asked that the incident management annual report includes more detail of the external view of Trust reports.

SM added that communication and follow up with families was also highlighted as an issue for Southern Health and this is an area the Trust works hard to ensure is undertaken in a positive, proactive and constructive way.

TB/15/80c Mental Health Act Committee 10 November 2015 (agenda item 4.3)
Julie Fox (JF) raised the following.

- The Committee received a report on the outcome of an audit of the in-depth pathway leading to Mental Health Act admissions in Kirklees (which was also reported to the Equality and Inclusion Forum). A number of recommendations were made and a follow up report will come back to the Committee.
- There were a number of Care Quality Commission (CQC) visits in relation to the Mental Health Act reported to the Committee. A recurring theme from the visits is clinical record keeping and the Committee acknowledged and understood the work within the Trust to improve in this area.

TB/15/80d Remuneration and Terms of Service Committee 17 November 2015 (agenda item 4.4)
IB commented on the recruitment of the Chief Executive and the application process, which closed on 18 December 2015. The current list has some very strong candidates. Interviews will be held on 11 February 2016. The Trust is also recruiting a substantive Director of Finance, which is running in parallel to the Chief Executive's recruitment.

JJ asked if the Executive Management Team (EMT) was satisfied that arrangements are in place to effect an orderly handover between Alex Farrell (AF) and JC. SM confirmed that it was and that the new Chief Executive will be involved in the recruitment of a substantive Director of Finance, particularly in shortlisting and the interviews. He also confirmed that arrangements are in place to ensure responsibility for end-of-year figures and budgets for the coming year. IB added that he was confident that the recruitment process will meet Trust timescales but it will depend on notice periods required. There will undoubtedly be interim arrangements and SM commented that these will depend on the length of the gap between 31 March 2016 and the start date for the new Chief Executive, which will be reviewed when the appointment is made in February 2016. IB was clear that there should only be one interim Chief Executive and who this is will be will reflect the length of interim arrangements needed.

The Committee also supported the Trust's commitment to the Living Wage at its meeting in July 2015 and noted that it had been introduced with a commitment to implement increases on 1 April each year. The Trust's internal auditor, KPMG, has offered support, free of charge, to look at establishing a commitment for the Trust to work only with contractors and suppliers who also implement the Living Wage.

TB/15/80e Estates Forum 9 December 2015 (agenda item 4.5)
JJ reported that there has been much progress on the development of community hubs with the completion of Laura Mitchell House in Halifax and New Street in Barnsley. Work has begun on the hubs in Wakefield and Pontefract. Alan Davis (AGD) added that Laura Mitchell House was handed over to the Trust on 18 December 2016 and that the EMT held its weekly meeting there on 17 December 2015. It is an excellent building and members of Trust Board were welcome to visit.

The Forum noted that the Trust is confident that the receipt from the sale of Aberford Field will be received in this financial year. Laurence Campbell (LC) asked what the implications were if the receipt did not materialise. AGD confirmed the receipt is likely in this financial year as Miller Homes is confident that the option will be exercised. The Trust will then receive its money in 20 working days, which would be within this financial year. AF

commented that Monitor's expectation is that, if the Trust has forecast a surplus, then it must achieve this irrespective of any movements in the financial position and a contingency plan is in place if the £2.7 million receipt does not materialise.

JJ also commented that capital spend is on plan, which represents an excellent effort by all involved.

TB/15/80f Equality and Inclusion Forum 14 December 2015 (agenda item 4.6)
IB commented on a letter the Trust recently received from Touchstone, a charity that provides a number of mental health services, including some specialised services for black and ethnic minority people. The organisation has undertaken some research into NHS Trust recording of the ethnicity of its service users and commended the Trust for reaching a level of 92% over recent months, which puts it into the top half of providers of specialist mental health services nationally on this measure.

Charlotte Dyson (CD) asked if Trust Board receives information on 'service users into employment'. AF responded that it is a public sector outcome measure and is, therefore, reported through Trust Board performance reports. IB added that the report from Sean Rayner (SR) to the Forum related to the pilot in Barnsley to support people back into employment. JF commented that it was heartening to see the extent of the work being undertaken in Barnsley, which the Trust may be able to replicate in other areas.

TB/15/81 Chair and Chief Executive's remarks (agenda item 5)

IB began by congratulating Helen Pye from the Forensic Child and Adolescent Mental Health Service (CAMHS) team who won Mental Health Social Worker of the Year and overall Social Worker of the Year at the national Social Worker of the Year awards. Abdullah Kraam, Consultant Child and Adolescent Forensic Psychiatrist, and Paula Phillips, Service Manager/Nurse Consultant in Forensic CAMHS also won Outstanding Collaborative Leadership of the Year at the Regional Leadership Recognition Awards.

He also commented on the visit on 15 December 2015 by Dame Gill Morgan, Chair of NHS Providers. She visited secure services on the Fieldhead site and the psychiatric liaison services at Pinderfields. She was also very interested in the Trust's position and was candid and helpful with the Chair and Chief Executive on a number of national NHS matters.

Lastly, IB provided feedback from the Members' Council Co-ordination Group, which considered the joint meeting with Trust Board on 12 February 2016. More information will be sent to Directors and support will be needed from Trust Board.

SM covered the following in his remarks.

- The CAMHS 'summit' on 18 December 2015 was positive with recognition from commissioners that the position has moved from one of recovery although this does remain a challenge for the Trust. The Trust has agreed with commissioners that it will continue to deliver CAMHS for a further year whilst a review of the specification is undertaken. One area for continued focus is the waiting times for Autism Spectrum Disorder (ASD).
- No decision on commissioning intentions for Tier 4 CAMHS is expected from NHS England and the development with Priory is, therefore, on hold. He confirmed that this is not an area the Trust could seek to develop speculatively given the national view of bed-based services despite the need identified at national level.
- This has implications for Castleford, Normanton and District Hospital (CNDH). The Trust's aim has always been to maintain a health legacy in Eastern Wakefield. The Trust does have an option to dispose of the entire site, which would provide an opportunity to

invest in community health services in conjunction with commissioners and other partners. IB commented that the Trust needs a new 'Plan A' and asked when this would come back to Trust Board. SM advised February 2016.

- SM has undertaken site visits over the last few weeks. He observed that acuity has increased in Trust units; however, management of capacity and activity has improved, which means there has been very limited use of placements out-of-area supporting the Trust's aim to provide services for people as close to home as possible.
- The CQC inspection takes place in the week beginning 7 March 2016. Detailed preparation is in place, led by TB as Director of Nursing. The final report is likely within two to three months following a Quality Summit with the Trust. If any areas are seen as 'outstanding' or as requiring immediate attention, the CQC will inform Trust Board at the closing meeting at the end of the inspection week. JJ asked if it were possible that the outcome would affect whether the new Chief Executive would wish to join the Trust. IB responded that, alongside the independent well-led review, it will provide the new Chief Executive with a clear, independent view of Trust services and a blueprint for the way forward. As such, it must be seen as an advantage.

AF provided feedback to Trust Board on the national planning event on 4 December 2015. Key messages include four 'must do's' in relation to achieving financial balance, eliminating clinical variation, meeting constitutional standards and service re-design. Financially, this will mean an efficiency saving of 2% with an uplift of 3.06% representing 1% net impact. Although £1.8 billion of settlement will go to Trusts in deficit, there was a very strong message that the NHS needs to manage the deficit collectively.

TB/15/82 Transformation – update on progress and current position (agenda item 6)

AF introduced this paper.

LC asked if the productivity project commissioned from Meridian was something the Trust was unable to do itself. SM responded that it arose from a concern about the pace of transformation and the skills needed in clinical areas to support and engender change. Meridian is working alongside staff and the challenge has been welcomed. Community services offer a further opportunity for this work to support the pace of transformation. AF added that the Trust will be much clearer on the outcome and impact of transformation by the next Trust Board.

JF asked how the Trust is engaging and involving stakeholders, and, as there is an impact on social care, how it is ensuring a joined-up approach. SM responded that alignment with different agendas is very important and the Trust must ensure it contributes to the wider transformation in the health and social care economy. Discussions with different stakeholders so far have been constructive and positive. AF added that there are a number of forums in place, including local authority Overview and Scrutiny Committees, to work with commissioners and stakeholders to take change forward. SM suggested a presentation to Trust Board of the Trust's plans for engagement with stakeholders to provide assurance that arrangements are in place and are happening.

Rachel Court (RC) commented on her experience at a recent Middleground session, which demonstrated what a tough challenge it is to ensure staff feel engaged and involved. AGD responded that this is a key part of the staff engagement strategy with a focus on better alignment between consultation and implementation, which is beginning to be seen.

Chris Jones (CJ) asked whether the Trust was on track to achieve its milestones for transformation. AF responded that revised models of service should be implemented by the

beginning of April 2016 although issues remain with rehabilitation and recovery services. General community services are an area where work is needed to speed up the process. Forensic services are not included in the report as service development is tied in with national commissioning intentions. The Trust's approach, supported by Meridian, is now more focussed, which is reaping results in terms of pace.

SM added that transformation is more complicated and intricate than the report shows and the organisational development work involved should not be underestimated.

CD asked whether stakeholder views of Trust plans were supportive and that she would welcome a more detailed update. SM responded that this is very much tied in with stakeholder understanding of what the Trust does and the scale of the challenge the Trust is undertaking. AF added that there has been much discussion with commissioners on Trust plans for transformation and the impact of commissioning intentions as a result.

RC commented that she would like to see reports focus not just on timescales and money but also on outcome measures. AF responded that this is very much the focus of the work with Meridian to ensure patient experience and the patient journey is improved.

TB/15/83 Performance reports month 8 2015/16 (agenda item 7)

TB/15/83a Performance report (agenda item 7.1)
IB invited comments from Trust Board.

- Trust Board asked that performance on improving access to psychological therapies is scrutinised by the Clinical Governance and Clinical Safety Committee.
- CJ asked if there was any risk for the CQC inspection in relation to workforce metrics. AGD responded that mandatory training will be a key area and managers are aware that staff should be up-to-date with their training. An improvement in performance against the indicator is expected.
- LC commented that the surplus indicator shows a downward trend. AF responded that this reflected a small movement and is not material.
- SM asked Trust Board to note that sickness levels in Barnsley are 4.2%, which demonstrates that levels can be brought below the target. AGD added that the accessibility of workforce information at all levels of the organisation has been an important factor for managers and the improvement in Barnsley demonstrates the approach within an individual BDU where management focus has been to improve performance. AGD added that specialist services are also showing a huge improvement due to the additional support the Trust has given in these areas. There is also a greater joint ownership and responsibility for sickness absence between managers and staff.

TB/15/83b Finance report (agenda item 7.2)
AF highlighted the following.

- The Trust financial risk rating is 4 against a plan of 4 and it is anticipated that the Trust will retain this rating to the end of the financial year.
- The revised surplus planned is £100,000 and the year-to-date position is £0.02 million ahead of this revised plan.
- The cash position is £28.91 million, which is £1.65 million ahead of plan.
- The capital spend to November 2015 is £7.14 million, which is £0.14 million (2%) behind plan.

There are two key issues in relation to cost improvement programme performance and income. In terms of income, the Trust is forecasting a CQUIN income shortfall of £1.1 million, mainly in relation to a shortfall in mental health clustering. Recovery plans are in

place within BDUs to meet trajectories and the Trust will negotiate with commissioners to improve the process to allow for recognition of what has been achieved by the Trust. In relation to the cost improvement programme, the Trust will utilise provisions to counter the shortfall; however, the risk to the Trust currently in terms of non-recurrent cost improvements is £2.7 million.

LC asked what will happen if the Aberford Field receipt does not materialise. AF responded that the Trust will look at release of contingency provisions, redeployment of discretionary spend, mainly linked to investment in information management and technology, and a review of balance sheet provisions, which take a prudent view currently.

TB/15/83c Exception reports and action plans – Child and adolescent mental health services progress report (agenda item 7.3(i))
TB introduced the paper. Following a discussion at the Clinical Governance and Clinical Safety Committee, JF asked whether it was intended to continue reporting into Trust Board or to delegate to the Committee to continue to scrutinise. SM responded that the outcome of the 'summit' made the proposal feel very sensible; however, JJ was not as persuaded. SM provided assurance that Nette Carder (NC) would remain in post until Carol Harris (CH) starts and he has confidence in the senior team in place to support both NC and CH.

CJ commented that he would like to see some metrics in the report and some improvement in these metrics, particularly for service users. He would be happy for this to be reviewed in the Clinical Governance and Clinical Safety Committee but would like a further report to Trust Board at some point. JF suggested that she could include specific comment on metrics in her feedback from the Committee to Trust Board. Trust Board supported the proposal for monitoring to continue through the Committee.

AF confirmed that CAMHS remains on the organisational risk register and will be reviewed by the EMT following the 'summit' and then Trust Board in January 2016.

It was RESOLVED to NOTE the progress report.

TB/15/83d Exception reports and action plans – Serious incidents report Q2 2015/16 (agenda item 7.3(ii))
LC asked if there was a continued focus on Kirklees. TB responded that there had been a review in Q1, which was presented to the Clinical Governance and Clinical Safety Committee, and this has continued in Q2, which will also be reported to the Committee.

IB expressed a concern at the number of lessons learnt extracted from incident reporting and how these could all be addressed. TB responded that these are collated into themes, which translate into the learning lessons report (see agenda item 7.3(iii)).

It was RESOLVED to NOTE the report.

TB/15/83f Exception reports and action plans – Learning lessons from incidents (agenda item 7.3(iii))
TB explained that the purpose of the report is to provide assurance that the Trust is using learning to improve services and make them safer.

IB asked if the Trust was good at sharing learning across BDUs and services. TB responded that the report highlights how this has improved over the last eighteen months and how services learn from each other. CJ asked if there were instances where the same lesson has to be learnt. TB responded that any more than once is too many; however, there are some areas, particularly communication between agencies, that recur. A piece of work is in place to improve interoperability of systems between different organisations.

JF asked that the report includes information on ethnicity and TB agreed to take this forward.

It was RESOLVED to NOTE the report.

TB/15/83g Exception reports and action plans – NHS community mental health survey (agenda item 7.3(iv))
Dawn Stephenson (DS) highlighted the three areas of significant improvement and the two areas of decline, and confirmed action was in place to address these areas.

IB commented that he would have liked to have seen more statistical analysis of this Trust's performance and felt there was a real lack of hard information. JJ added that a sense of the Trust's ambition does not come across in the report and the outcome confirms the Trust is 'average'. SM responded that the survey outcome and report represents a snapshot of how the Trust benchmarks and there is a wealth of benchmarking information that the Trust can use to support its ambitions.

It was RESOLVED to NOTE the report.

TB/15/83h Exception reports and action plans – IT virus incident – update report (agenda item 7.3(v))
LC asked if the Trust was targeted and AF responded that there was nothing uncovered to suggest this was the case. CD sought assurance on how the Trust remains up-to-date on emerging threats. AF responded that this was a prime reason why an external report was commissioned, which found the Trust is as well prepared as it can be. The support service is contracted to a specialist provider specifically to provide this type of expertise.

LC asked whether the Trust had determined its risk appetite for the protection of different types of data. AF responded that information governance is prescribed for NHS organisations, and the Trust is assessed against the associated toolkit, which is reviewed by internal audit.

AF also reported that business continuity processes were tested when the Trust's clinical information system (RiO) was upgraded in November 2015, which showed a more robust process is now in place, which the Trust will continue to review and improve. AGD added that this also tested service continuity plans and a number of areas for improvement have been identified.

It was RESOLVED to NOTE the report.

TB/15/84 Terms of reference for Executive Programme Board with Locala (agenda item 8)

It was RESOLVED to APPROVE the draft terms of reference.

LC asked who would respond to PR/media enquiries. SM responded that communication leads would discuss and agree any joint response required. SM commented that the work with Locala also provides an opportunity to explore the sharing of back-office functions although this has not yet begun.

TB/15/85 Use of Trust seal (agenda item 9)

It was RESOLVED to NOTE the use of the Trust's seal since the last report in September 2015.

TB/15/86 Date and time of next meeting (agenda item 10)

The next meeting of Trust Board will be held on Friday 29 January 2016 in the conference room, Textile Centre of Excellence, Textile House, Red Doles Lane, Huddersfield, HD2 1YF.

Signed …… Date ……

Trust Board 29 January 2016
Agenda item 4 – assurance from Trust Board Committees

Information Management and Technology Forum

Date	5 January 2016
Presented by	Ian Black
Key items to raise at Trust Board	➢ RiO V7 upgrade implementation and action taken by the Trust. ➢ Overarching vision and key areas for a revised Information Management and Technology Strategy. ➢ Support for proposal for the award of the contract for community and child health information systems and to upgrade Microsoft Explorer across the Trust. ➢ As standing items, the Forum also reviewed progress against plan and against capital spend.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Quality Performance Report

Strategic Overview

December 2015

Table of Contents

Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for December 2015 information unless stated. The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions.

The Trust continues to improve its performance framework to deliver the Trust IM&T strategy of right information in the right format at the right time. Performance reports are now available as electronic documents that allow the reader to look at performance from different perspectives and at different levels within the organisation.

Performance is reported through a number of key performance indicators (KPIs) using the Trust's balanced score card to enable performance to be discussed and assessed with respect to

- Business Strategic Performance – Impact & Delivery
- Customer Focus
- Operational Effectiveness – Process Effectiveness
- Fit for the Future - Workforce

KPIs provide a high level view of actual performance against target and assurance to the Board about the delivery of the strategic objectives and adhere to the following principles:

- Makes a difference to measure each month
- Focus on change areas
- Focus on risk
- Key to organisational reputation
- Variation matters

Quality Headlines

1. Improvements to Datix web – dashboards
Datix Web dashboards are being developed and rolled out following a successful business case. The dashboards provides real time data on incidents that are configured to meet the needs the end user using graphics. To date all Consultants, specialist advisors and management Trio's (service manager, practice governance coach and clinical lead) and team managers have access to dashboards to support their work. The feedback has been really positive from reduction in the amount of time taken by specialist advisors to produce reports or note trends to practice governance coaches and managers commenting on how useful to be able to see trends.
Some specific dashboards have also been set up to support safe wards pilot and Sign up to safety.

2. Learning Lesson Reports
The Trust continues to learn from incidents and developing a learning culture. Historically the learning lessons section has been included in the incident reports however from April 2015 separate reports have been produced captures some of the changes to support learning that has taken place from incidents.
This report is based on the completed investigation reports that have been submitted to the Commissioners and other incidents from a Business Delivery Unit perspective.
The reports bring a flavour of the changes that have taken place in practise as a result of the action plans being implemented and the future development plans within the Business Delivery Units.
The reports should be read alongside the quarter/annual incident reports.
This report is in addition to BDU learning events.

3. Nursing Strategy
The launch of nursing strategy took place 16th November and was well attended with over 70 nurses from across trust attending. Speakers were a mix of local and national speakers and the "what nursing means to me" video was screened and very well received. The Nursing Quality Group now leads on implementation of the nursing strategy.

4. Safer staffing
Safer staffing lead commenced on Monday 11th Jan and will be progressing the peripatetic workforce pilot and continuing to refine the monthly exception reports. Safer staffing group continues involving senior staff from BDU's, Nursing and HR directorates meeting. Overall shift fill rates are positive but there are some wards that remain a challenge. This is being addressed through a new monthly recruitment and assessment day to expedite applications

5.Mental Capacity Act
Mental Capacity Act training is currently identified within the trust as 'core training'. Training over the years has been provided and delivered mainly in response to the needs of the services, i.e. formal training sessions, external trainers (legal, local authority, external experts), group sessions, 1-1 sessions, training for medical staff (part of education programme), university training for allied health professionals, social workers, nursing staff and higher trainee doctors).
Over the past 12 months we have continued to provide a wide range of training, support and advice in relation to the MCA and DoLs. Guidance notes and full text of the MCA remains available on the trust intranet
A new MCA/Dols training programme has been developed for the period of January to December 16.
A review of the MCA e learning packages is currently being undertaken and updated accordingly.
A paper is currently being prepared for EMT to consider MCA/DoLs being made mandatory for all staff who are working with service users.

6. Immediate Life Support Training:
Given the size and complexity of the Trust, It has been agreed by EMT that we can develop a trust wide Resuscitation team who will be able to flexibly meet the training needs of the organisation.
The trust wide team will be in place by 31st March 2016 when the contract for 'first on Scene' will cease. The cost benefits from terminating this contract will be used to develop the existing in house team who currently work within the Barnsley BDU.
EMT have agreed to this training being mandatory from April 2016.

7. Wakefield CQC Visit – Safeguarding thematic review :
The final report from the CQC visit has now been published and SWYPFT are discussed in very favourable terms. The inspectors were impressed by the level of support available from the safeguarding team to CAMHS and the coordination of the visit.
They were also impressed by the demonstration of the organisation to understand and meet the requirements of the CQC inspection, this was reflected in the diversity of role and responsibility of the staff who took part.
There are two specific areas which require action in relation to adult mental health services. An action plan has been developed and will be monitored through our strategic safeguarding group and Wakefield BDU service line.

8. Safeguarding- Kirklees Challenge team
The safeguarding Children team for mental health and learning disabilities attended a challenge event in Kirklees with regard to the effectiveness of our organisational response to safeguarding children. The event was attended by an Assistant Director of Nursing, the Named Nurse for Safeguarding Children within mental health and learning disabilities and the Practice Governance Coach who is specifically assigned to CAMHS across Calderdale and Kirklees. The team were able to describe the governance structures within the organisation and demonstrate organisational commitment to ensuring that children are supported and protected in order to improve outcomes for children and families.
The team were subject to two interviews, one by Safeguarding Children Board members and the other by a panel of children and young people who were specifically focussed on child sexual exploitation, organisational understanding and responsiveness.
Out of 12 different agencies, including children's social care, SWYPFT were given the highest score by the panel of children and young people.

Quality Headlines

9. Ward Manager Network
A meeting of the relaunched Ward Manager Network was held on 7th December 2015 and was welcomed by the inpatient ward managers. The main aim of this network is to be a supportive, learning, developmental network for the ward managers across the trust. It will build on the systems working Middle ground 4 programme. The dates are set for 2016 and Tim Breedon has committed to attend each session. We are holding the network every two months and alongside this we have set up a Ward Manager network on Yammer.

10. Clinical Supervision
In SWYPFT we recognise the important role that the appropriate supervision of clinical staff plays both in contributing to high quality clinical and professional practice leading to improved outcomes for the people using our services and also in maintaining the well-being of our workforce. Supervision supports the implementation of the workforce development strategy and sits with the clinical governance framework. As a Trust we are looking to improve the way we deliver and record clinical supervision. There are currently three work streams in place to meet this aim.
1. Review of our systems to facilitate inpatient staff to have increased access to supervision.
2. Developing a clinical supervision electronic reporting mechanism (linked to ESR) that will provide us a consistent way to capture, the type of supervision our staff access and how frequently.
3. A review of the clinical supervision policy which will capture the above.

11. Horizon - External review
Following the External Review an action plan has been developed and a steering group has been established. The inaugural meeting of this group took place on 7th January 2016, where the action plan was discussed at length. Updates to the plan are being made and will be presented to Clinical Governance & Clinical Safety Committee in February 2016.
Admissions remain restricted due to the demands on the service from an individual who is presenting significant challenges to the clinical team. The care plan remains under regular close review and has been subject to independent expert advice.

12. Clinical Record Keeping
The Trusts has identified clinical record keeping as an area on improvement for our organisation.
The updated Quality Improvement Strategy will include a focus on improving the quality of clinical information
The quality account will continue to include a goal to improve quality of clinical information.
Quality Improvement Meeting (16.9.15) – group work was undertaken by TRIO's to identify top 5 clinical information issues. Improving Information Group (sub group of Improving Clinical Information group) will now focus on the agreed "Top 5" in terms of monitoring, supporting with guidance/SOPs, learning from each other's experiences, looking for ways to improve quality and champion the importance of this work.
A Trust wide review of integrated performance reporting.
Project initiated which aims to introduce solutions within the Trust that start to join up our clinical information systems and allow increased information sharing capabilities across our clinical services (initial focus RiO and SystmOne).

13. Clinical Risk Training
Clinical risk assessment, formulation and management are vital skills for staff who work in mental health and learning disability services. Although the Trust has continued to provide clinical risk training which is open to all staff, concerns around clinical risk training emerged as a result of several recent findings including increase in suicides nationally and ongoing concerns about vulnerable children and adults. In response, SWYPT developed a Patient Safety Strategy in June 2015 and a dedicated Clinical Risk Training group was formed in July 2015.
In summary, the group concluded that, the Trust needs to develop best practice in clinical risk training that is mandatory and relevant for all clinical staff and delivered in a way that minimises time away from the workplace. More advanced and specialist clinical risk training must be based on training needs analysis at BDU level to meet local needs and priorities. This should be supplemented by practice-based learning (e.g. learning events, reflective practice). A proposal to implement these actions was accepted by EMT in December 2015 and work is ongoing to update the SWYPT clinical risk policy to reflect developments in training and develop knowledge and expertise in this area within the Trust.

14. RIO V7
The introduction of RiO V7 has presented some challenges which have been addressed through daily reviews and action from IM&T. However, the full impact of the issues around the server capacity at Servelec has yet to be evaluated.

15. 0-19 Children and Young People Health and Wellbeing Services.
The decommissioning of the Family Nurse Practitioner service remains a concern and we are working with BMBC to ensure that the appropriate arrangements are in place to ensure a safe transition to the new system.
Discussions continue around the 0-19 service and again we continue to work to the provision of a revised service offer that is clinically safe and the correct quality

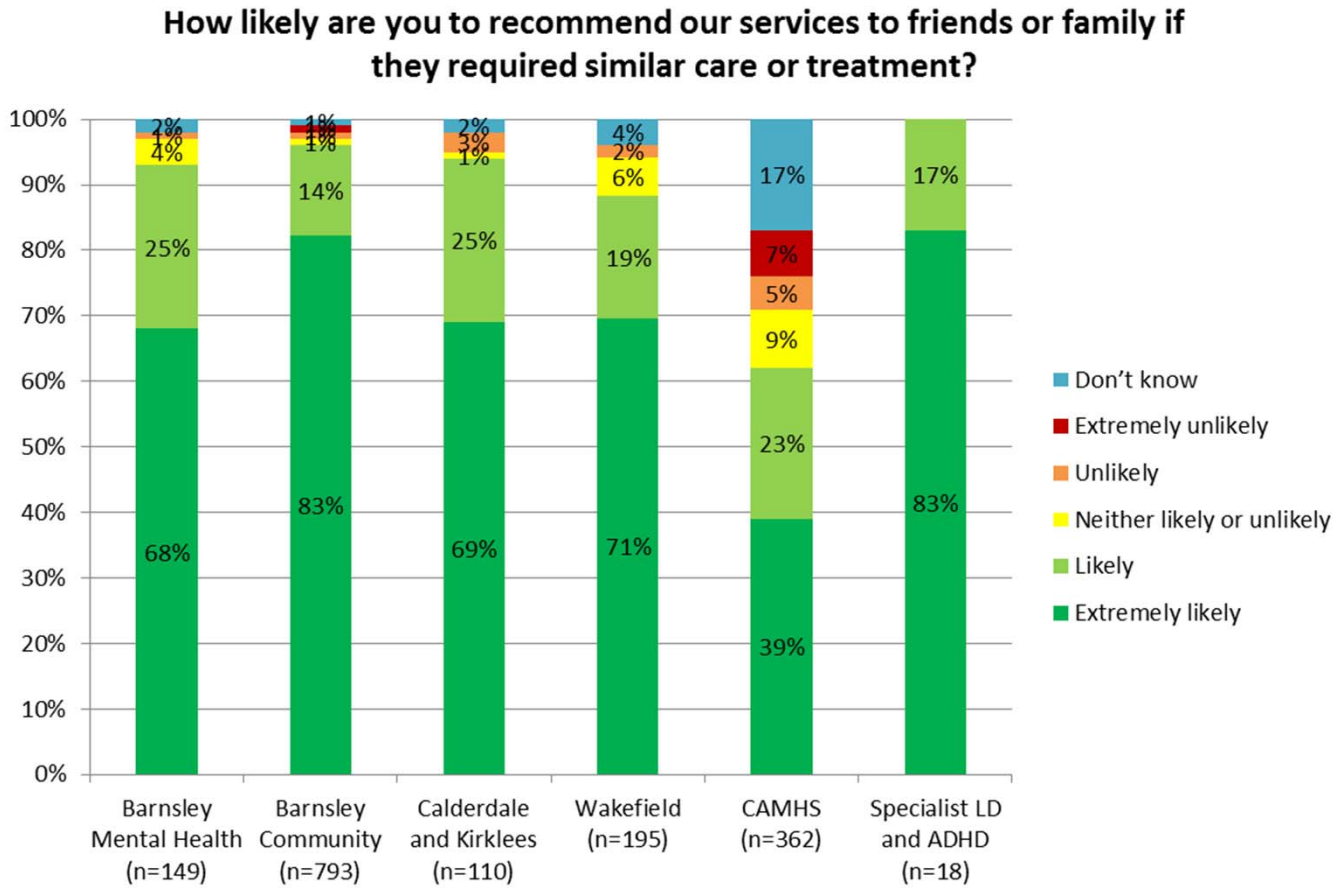
16. Revalidation
The Trust employs 1600 registered nurses all of whom require 3 yearly re-validation. The process commences 1/04/2016 and the Trust has committed to support this process by the appointment of 2 secondees to undertake training and coordination of the process offering individual support where necessary. Assistant Directors of Nursing will over-see the process and regular monthly progress report will be provided into Trust Board. No issues are anticipated at present.

Compliance

1. Intelligent Monitoring
Intelligent Monitoring is a tool which assesses risk within care services. It has been developed to support CQC's regulatory function and purpose of ensuring that health and social care services provide people with safe, effective, compassionate, and high-quality care. Intelligent Monitoring highlights those areas of care to be followed up through inspections and other regulatory activity.

On 12th January 2016 the Trust received a draft Intelligent Monitoring report (3rd report) . We are currently checking the report for factual accuracy and our response will be submitted by 26th January 2016. The report will be published by the CQC on 25th February 2016.

2. Patient Experience
The trust has adopted the FFT as its quality measure for patient experience as this is the one consistent question that is asked across all trust services. The Q3 results can be seen on the chart below:



Strategic Overview Dashboard

Business Strategic Performance Impact & Delivery

1	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Q1	Q2	Q3	National Average	Year End Forecast Position
2	Monitor Compliance	Monitor Governance Risk Rating (FT)	M	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green			4
3		Monitor Finance Risk Rating (FT)	M	4	4	4	4	4	4	4	4	4	4	4	4			4
4	CQC	CQC Quality Regulations (compliance breach)	CQC	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green			4
5	CQUIN	CQUIN Barnsley	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G			3
6		CQUIN Calderdale	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G			3
7		CQUIN Kirklees	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G			3
8		CQUIN Wakefield	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G			3
9		CQUIN Forensic	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Green*	Amber/G	Amber/G	*Amber/G*	Amber/G	*Green*			3
10	Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	C	6	0	0	0	2	1	0	0	0	0	0	3			4
11	C-Diff	C Diff avoidable cases	C	0	0	0	0	0	0	0	0	0	0	0	0			4

Customer Focus

12	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Q1	Q2	Q3	National Average	Year End Forecast Position
13	Complaints	% Complaints with Staff Attitude as an Issue	L	< 25%	12% 8/66	14% 6/44	13% 9/69	12% 9/73	12% 5/42	15% 6/41	12% 5/42	16% 9/58	15% 6/40	14% 23/179	13% 20/156			4
14	Service User Experience	Friends and Family Test	L	TBC	89.00%	92.00%	87.00%	93.00%	89.00%	91.00%	88.00%	85.79%	93.51%	89.00%	91.00%	88.83%		
15	MAV	Physical Violence - Against Patient by Patient	L	14-20	Above ER	Above ER	Above ER	Within ER	Above ER	Above ER	Above ER	Data Not Avail	Data Not Avail	Above ER	Above ER			4
16		Physical Violence - Against Staff by Patient	L	50-64	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Data Not Avail	Data Not Avail	Above ER	Above ER			4
17	FOI	% of Requests for Information Under the Act Processed in 20 Working Days	L	100%	100% 24/24	100% 17/17	100% 24/24	100% 28/28	100% 20/20	100% 25/25	100% 19/19	100% 13/13	100% 19/19	100% 65/65	100%73/73			4
18	Media	% of Positive Media Coverage Relating to the Trust and its Services	L	60%	92.00%	92.00%	92.00%	80.00%	75.00%	50.00%	40.00%	50.00%		92.00%	68.00%			4
19	Befriending services	% of Service users allocated a befriender or volunteer led group support (gardening/music/social) within 16 weeks	L	70%	50.00%	50.00%	50.00%	20.00%	20.00%	100%	100%	100%	100%	50.00%	20.00%	100%		4
20		% of Service Users Requesting a Befriender Assessed Within 20 Working Days	L	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		4
21		% of Potential Volunteer Befriender Applications Processed in 20 Working Days	L	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		4

Operational Effectiveness: Process Effectiveness

22	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Q1	Q2	Q3	National Average	Year End Forecast Position
23	Monitor Risk Assessment Framework	Max time of 18 weeks from point of referral to treatment - non-admitted	M	95%	99.11%	100%	99.86%	100%	99.32%	98.60%	99.86%	97.64%	100%	99.70%	99.28%			4
24		Max time of 18 weeks from point of referral to treatment - incomplete pathway	M	92%	98.06%	97%	99.82%	100%	97.31%	99.16%	98.92%	97.58%	100%	98.35%	98.76%		93.10%	4
25		Delayed Transfers Of Care	M	7.50%	2.69%	1.64%	2.06%	1.96%	1.70%	1.80%	3.49%	2.89%	2.42%	2.12%	1.83%	2.73%		4
26		% Admissions Gatekept by CRS Teams	M	95%	93.28%	96.30%	97.20%	100%	95.90%	96.12%	95.49%	95.90%	96.77%	95.51%	97.29%			4
27		% SU on CPA Followed up Within 7 Days of Discharge	M	95%	98.21%	100%	97.86%	97.70%	95.35%	100%	95.39%	95.60%	95.95%	98.66%	97.97%		96.90%	4
28		% SU on CPA Having Formal Review Within 12 Months	M	95%	96.37%	95.18%	97.92%	96%	86.57%	98.44%	86.88%	97.52%	98.56%	97.92%	98.44%		97.67%	4
29		Meeting commitment to serve new psychosis cases by early intervention teams QTD	M	95%	108.97%	102%	104.60%	147.59%	108.97%	113.25%	83.42%	99.48%	94.24%	104.60%	113.25%			4
30		Data completeness: comm services - Referral to treatment information	M	50%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100%	100.00%			4
31		Data completeness: comm services - Referral information	M	50%	94.00%	94%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%			4
32		Data completeness: comm services - Treatment activity information	M	50%	94.00%	94%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%			4
33		Data completeness: Identifiers (mental health)	M	97%	99.70%	100%	99.62%	100%	99.62%	99.54%	99.65%	99.55%	99.45%	99.62%	99.54%	99.45%		4
34		Data completeness: Outcomes for patients on CPA	M	50%	78.83%	79.07%	77.63%	78.67%	77.64%	76.97%	78.40%	77.94%	78.58%	77.63%	76.97%	78.58%		4
35		Compliance with access to health care for people with a learning disability	M	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	*Compliant*	Compliant	Compliant			Compliant
36		IAPT - Treatment within 6 Weeks of referral	M	75%	Avail Month 8	Avail Month 8	Avail Month 8	Avail Month 8	53.46%	41.93%	48.33%	48.71%	28.98%	Data Not Avail	Data Not Avail			
37		IAPT - Treatment within 18 weeks of referral	M	95%	Avail Month 8	Avail Month 8	Avail Month 8	Avail Month 8	77.40%	70.70%	71.81%	77.28%	56.33%	Data Not Avail	Data Not Avail			
38		Early Intervention in Psychosis - 2 weeks (NICE approved care package)	M	50%	40.00%	81.82%	58.33%	56.25%	55.56%	80.00%	66.67%	84.60%						
39	Data Quality	% Valid NHS Number	C (FP)	99%	99.87%	100%	99.88%	99.71%	99.58%	99.76%	99.58%	99.30%	Data Avail Month10	99.88%				4
40		% Valid Ethnic Coding	C (FP)	90%	99.05%	95%	94.86%	94.88%	94.90%	94.83%	94.73%	94.12%	Data Avail Month10	96.28%				4

Fit for the future Workforce

41	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Q1	Q2	Q3	National Average	Year End Forecast Position
42	Sickness	Sickness Absence Rate (YTD)	L	4.4%	4.80%	5.10%	5.00%	4.80%	4.80%	4.90%	4.90%	4.90%	5.00%	5.00%	5.00%			1
43	Appraisal	Appraisal Rate Band 6 and above	L	95%	Avail M3	Avail M3	56.80%	72.90%	80.30%	87.30%	89.50%	91.60%	92.90%	56.80%	92.90%			4
44		Appraisal Rate Band 5 and below	L	95%	Avail M6	Avail M6	Avail M6	Avail M6	Avail M6	66.30%	75.80%	80.30%	83.60%	Avail M6	83.60%			4
45	Vacancy	Vacancy Rate	L	10%														4
46	Mandatory Training	Aggression Management	L	80%	73.70%	73.65%	75.83%	77.04%	78.89%	78.85%	80.38%	80.78%	83.12%	75.83%	83.12%			1
47		Equality, Diversity & Inclusion	L	80%	82.30%	84.55%	84.87%	85.76%	87.17%	88.28%	88.81%	89.37%	90.31%	84.87%	90.31%			4
48		Fire Safety	L	80%	86.50%	86.24%	86.31%	86.55%	86.44%	85.33%	84.60%	84.83%	85.56%	86.31%	85.56%			4
53		Food Safety	L	80%	65.20%	66.89%	69.00%	70.67%	71.80%	73.06%	74.30%	74.10%	75.79%	69.00%	75.79%			1
50		Infection, Prevention & Control & Hand Hygiene	L	80%	80.60%	82.09%	82.82%	83.69%	85.25%	85.55%	85.58%	84.86%	85.84%	82.82%	85.84%			4
51		Information Governance	L	95%	91.90%	92.55%	92.67%	92.76%	92.73%	91.96%	91.56%	90.58%	89.06%	92.67%	89.06%			4
52		Safeguarding Adults	L	80%	82.80%	82.60%	84.14%	84.95%	86.16%	86.94%	87.74%	87.34%	88.34%	84.14%	88.34%			4
53		Safeguarding Children	L	80%	84.70%	85.22%	86.00%	86.39%	87.12%	87.93%	86.12%	85.54%	87.68%	86.00%	87.68%			4
54		Moving & Handling	L	80%	71.80%	73.66%	75.31%	77.40%	79.32%	80.37%	82.11%	83.03%	83.83%	75.31%	83.83%			1

KEY	
4	Forecast met, no plan required/plan in place likely to deliver
3	Forecast risk not met, plan in place but unlikely to deliver
2	Forecast high risk not met, plan in place but vey unlikely to deliver
1	Forecast Not met, no plan / plan will not deliver
CQC	Care Quality Commission
M	Monitor
C	Contract
C (FP)	Contract (Financial Penalty)
L	Local (Internal Target)
ER	Expected Range
N/A	Not Applicable

Impact and Delivery

• Performance for Quality indicators (CQUINs) is monitored by BDU's on a monthly basis. The risk assessment on achievement of all indicators for 2015/16 is predicting an overall potential shortfall in income of £1.25M, which equates to 74% achievement and the overall rating for the year end position remains at Amber/Green.

• Under performance issues related to CQUINS to date are linked to MH Clustering in all BDU's, Care Planning in Calderdale, Kirklees and Wakefield and High Performing Teams in Barnsley - detailed action plans have been drawn to improve performance however, some underperformance is forecast to continue to end of Q4.

Operational Effectiveness

• Issues in performance associated with waiting times for IAPT are anticipated to continue in Dec 15 (data to be available at month end). Issues mostly relate to psychological wellbeing practitioner vacancies within all IAPT teams in the Trust.

Workforce

• Sickness continues to remain above trajectory at end of December 15 and has increased compared to the last few months. Work continues to focus on reducing sickness related absence within the Trust.

• Appraisal rates continue to perform under threshold; however, performance has increased across all staff groups to end December 2015.

• Mandatory training shows an increase in performance in all areas except Information Governance to end December 2015.

Additional Notes

• Safer Staffing fill rate data is to be added to the dashboard from January 2016. Position for December 2015 is Nurses - 93.9%; HCAs - 114.3%.

• The proportion of people experiencing first episode psychosis or 'at risk mental state' that wait 2 weeks or less to start NICE recommended package of care will commence monthly national reporting from December 2015. Reporting will be split between the waiting time for those whose treatment commenced during the reporting period and those who were still waiting at the end of the reporting period. For December 2015 the Trust will be reporting – 85% of new cases commenced treatment within 2 weeks of referrals and 25% of those still waiting for treatment have been waiting no more than 2 weeks as at the end of the reporting period. The 2 lines will be added to the dashboard for monitoring from January 2016.

Overall Financial Performance 2015 / 2016

Performance Indicator		Month 9 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent		
Trust Targets					8	7	6
1	Monitor Risk Rating	●	●	⇔	●	●	●
2	REVISED £0.10m Surplus on Income &	●	●	↑	●	●	●
3	Cash Position	●	●	↑	●	●	●
4	Capital Expenditure	●	●	⇔	●	●	●
5	Delivery of CIP	●	●	↓	●	●	●
6	Better Payment Practice Code	●	●	↑	●	●	●

Key		
	●	In line, or greater than plan
	●	Variance from plan ranging from 5% to 15%
	●	Variance from plan greater than 15%

Summary Financial Performance

These Key Performance Indicators (KPI's) help the Trust to monitor progress against each element of our financial strategy.

1. The Trust Financial Risk Rating is 4 against a plan level of 4. (A score of 4 is the highest possible) The forecast is that the Trust will retain a rating of 4 at 31st March 2016.

2. The year to date position, as at December 2015 , is a surplus of £0.2m. As part of the Month 6 Monitor return the Trust confirmed a revised plan of £100k surplus.This year to date position is £0.92m ahead of this revised plan.

Supported by the utilisation of Trust provisions the Trust are confident that the financial plan for 2015 / 2016 will be achieved. If the current trend continues this would enable the Trust to achieve a small surplus rather than a deficit. The Trust will continue to validate this position, and the risks contained within, and will update to Board accordingly.

3. At December 2015 the cash position is £28.09m which is £1.53m ahead of plan.

4. Capital spend to December 2015 is £7.82m which is £0.6m (7%) behind the Trust capital plan.

5. At December 2015 the Cost Improvement Programme is £809k behind plan. Overall a Full Year Value of £1435k (15%) has been rated as red, after mitigations. A red rating indicates that the CIP opportunity does not currently have an implementation plan and therefore carries a high risk on non achievement.

6. As at December 2015 92% of NHS and 96% of non NHS invoices have achieved the 30 day payment target (95%). This continues to be a small improvement from previous months.

Contracting

Trust Summary by BDU - Current Contract Performance

Contract Variations	
BBDU NHSE National Childhood Flu Immunisation (3 yr contract) - completed	£60.9
BCCG & Associates CV 1 Various Signed	£359.1
C&K CAMHS: Awaiting signed 2015-16 deed of variation from Commissioners	
WBDU WCCG Portrait of a Life - Care Home Vanguard (signed 11-11)	£67.0
SBDU WCCG offer tbc to fund 12-18mths Psychologist support to reduce ASD backlog	£61.4

CQUIN Performance **Q3 Forecast based on**

Quarter	Quarter 2 £000s	Achieved	Variance	M8 Performance	Variance
Barnsley	£411.8	£251.8	-£160.0	£402.6	-£24.0
Wakefield	£190.0	£128.0	-£61.9	£92.4	-£15.3
Kirklees	£214.7	£126.7	-£88.0	£103.4	-£17.6
Calderdale	£96.3	£30.4	-£65.9	£46.4	-£7.9
Specialised	£75.4	£75.4	£0.0	£56.5	-£18.9
Forensics	£120.0	£120.0	£0.0	£22.5	£0.0
Trust Total	£1,108.2	£732.3	-£375.9	£723.9	-£83.7

CQUIN Performance Year-end Forecast

Quarter	Annual £000s	Forecast Achievement	Variance
Barnsley	£1,790.1	£1,465.3	-£324.8
Wakefield	£793.9	£485.9	-£308.0
Kirklees	£878.2	£519.4	-£358.9
Calderdale	£394.1	£206.7	-£187.4
Specialised	£301.7	£263.9	-£37.8
Forensics	£562.3	£528.6	-£33.7
Trust Total	£4,720.4	£3,469.7	-£1,250.7

CQUIN Performance Q3

West CCGs: MH Clustering - Q2, 3 out of 4 indicators failed for C &K, 2 out of 4 for W. Remedial work in place. Reason for non achievement is recording/data reporting
Care Planning - Partial achievement for W & K. No achievement for C. Action Plan to be completed in preparation of Q4 audit.
Improving Physical Healthcare: Partial Achievement. Performance low against target.
BBDU: MH Clustering - The BDU only met the target for % in crisis plans for Q2, it failed all other targets. A recovery plan has been produced and work is still ongoing with the Teams to achieve this CQUIN & to achieved crisis plan target in Q3
BBDU - High Performing Teams - the CCG has not accepted the report. SWYPFT is meeting to discuss issues with them to ensure Q3 acceptance and look at Q2 issues

Report continues with Contract Issues

QIPP Targets & Delivery for 2015/16

CCG	Target £000s	Planned £000s	Remainder £000s	RAG	
Wakefield*	£1,790.0	£1,843.3	£53.3		***
Kirklees**	£1,000.0	£659.6	-£340.4		
Calderdale	£0.0	£0.0	£0.0		
TOTAL £000s	£2,790.0	£2,502.8	-£287.2		

* W target is cumulative covering 2014/15 & 2015/16: ** K includes Specialist LD scheme
*** W RAG remains at R as risks identified ~ see summary below

Proposals under the QIPP scheme -

W:- £1.79m in total. OOA Bed Mgt - above plan: OPS Reconfiguration (Savile Park) - on target: MH contract reduction - delivered: OAPs for LD & CHC (CCG held budgets)- high risk: Castle Lodge (CCG budget - prevention client OOA) ~ CCG contesting this £47k : Repricing LD beds - ongoing: Risk within plan as includes £41k for use of Barnsley PICU bed & SWYPFT funded £338k from contract growth for ADHD sustainable case & backlog clearance ~tbc by CCG
C:- 15/16 Schemes to be identified by end of Q1. Potential Productivity Schemes identified, not finalised/agreed.
K:- £1m in total: 1) Reduction on OOA spend for Specialist Rehabilitation & Recovery placements £500k, 2) Reduction in OOA LD Specialist placements £500k (CCG budgets), both schemes required to generate in excess of £1m, for reinvestment in new service models. Below target

KPIs and Penalties

Commissioner	Penalty £000s	Comment
Barnsley CCG	£7.0	MSK as at Mth 8

Contract Performance Information - based on month 8

Key areas where performance is above contracted levels

· Acute MH Inpatient services for adults of working age across W,K,C BDUs
· MH PICU Inpatient services for adults of working age in Wakefield
· Older People's MH inpatients services in Wakefield
· Older People's Memory services in Calderdale
· Intermediate Care in Barnsley

Key areas where performance is below contracted levels

· MH PICU Inpatient services for adults of working age in C & K
· K IAPT Below target for recovery, 6 week & 18 week waits (ref to entering IAPT treatment)
· MH Adult Crisis Resolution services in Wakefield
· MH Adult Rehabilitation services in W & C
· Older People's Memory services in Wakefield
· Diabetes nursing and MSK in Barnsley

Contracting

Trust Summary by BDU - continued

Contract Issues - Specialist

CAMHS - Future in Minds: All Transformation Plans have been assured. ED allocation across the organisation £666k.
Total recurrent uplift from 2016/17 £2.3m
C&K: Positive move from Recovery to Action position. DoV still awaiting signature from Commissioners. Finance being reviewed. 2016/17 new contract being issued. 17/18 Assumption service will go out to procurement
Barnsley: Positive rapport with Commissioners. Deep dive work ongoing in relation to data.
Wakefield: CV being prepared to capture agreed funding and temporary work streams.
To note: MHS data set going live Jan 2016. May be accuracy issues initially within Barnsley. BCCG aware.
Learning Disability
W - constraints on the number of patients able to be admitted against contract plan due to intake of complex client
C - SWYPFT team delivering on timescales. Positive feedback and service being recognised as good practice

Key Contract Issues - Calderdale

IHBT: CCCG only commissioner that has not commissioned 24/7 IHBT service. Business case submitted, ongoing discussion with CCG. % overhead and contribution for business case being reworked No contentious elements relating to quality.
MHL: Ongoing discussion re provision. CCCG & KCCG to discuss separately. SWYPFT to review specification and core 24hr cover and ascertain what can be provided within current financial envelope.
Police Liaison: Ongoing review of finance. Same % overhead & contribution to be applied as that of IHBT
R&R: CCCG clear about intentions re redesign of pathway. Joint pathway with health & social care. Move from bed based approach and moving to community rehab model.
Psychology: CCCG looking at new model going forward and considering funding implications.
IAPT (AQP): DoV outstanding. Service out to procurement Dec/Jan 16
ED: CCCG would like 'basic' service initially. SWYPFT to work with Commissioners focussing on primary care and supporting patients through need. Meeting 20th Jan

Contract Issues - Barnsley

Wakefield MDC PH - The Council have offered a 6 months extension to the contract but require a 10% reduction in the contract value. SWYPFT is negotiating this as the Commissioner has said that they did not want any reductions in staff
Rotherham & Doncaster MBCs PH - the Commissioners have requested a reduction in the contract value of 2% per annum. SWYPFT is working on identifying the saving
Sheffield CC PH - the Commissioner has instructed SWYPFT to cap activity at the contract target. SWYPFT is working on how this can be achieved
Substance Misuse Services - through Barnsley DAAT PF have asked SWYPFT to put in a model of service which meets a new cap of £500k , a £578k reduction
Intermediate Care - SWYPFT is working with BCCG re the I/C Pilot

Contract Performance Issues

Health & Wellbeing - There are still issues with meeting activity targets as the targets contracted for were arrived at prior to the national downturn in activity

Forensics:- National procurement now identified for 2015/16/17 for Medium & Low Secure MH Services. Joint Commissioner / Provider review of Outreach services & pathways to verify funding
Joint Review of Service Unit Prices to inform future Commissioning and service delivery
Commissioners identified Re-procurement of Forensic CAMHs Services
Discussions held with Commissioner re medium secure occupancy being below 90% (M8 was 88.9%) at present NHSE not concerned given pressure on beds nationally. However BDU expect additional referrals in next few months to achieve threshold.

Key Contract Issues - Kirklees BDU

Psychology: 18 week pathway holding although there has been an increase in referrals. Waiting lists beginning to reduce.
IAPT: Remaining below target for recovery, 6 week & 18 week waits (ref to entering IAPT treatment).
Police Liaison: Ongoing review of finance.
MHL: Ongoing discussion re provision.

Currency Development - Payment by Results (PbR)

The Trust has been a key member of the Care Packages and Pathway Project (CPPP) - a consortium of organisations in the Yorkshire & Humber and North East SHA areas who have been working together to develop National Currencies and Local Tariffs for Mental Health.

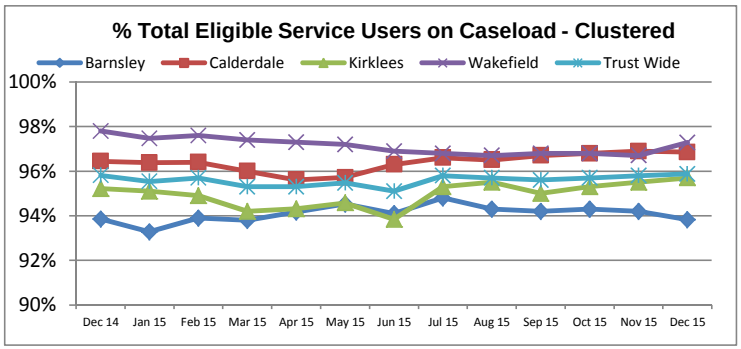
The currency for most mental health services for working age adults and older people has been defined as the 'clusters'. That means that service users have to be assessed and allocated to a cluster by their mental health provider, and that this assessment must be regularly reviewed in line with the timing and protocols. It is the intention that clusters will form the basis of the contracting arrangements between commissioners and providers, the commencement of this is not yet clear. This will mean that for working age adults and older people that fall within the scope of the mental health currencies the activity value will be agreed based on the clusters, and a price will be agreed for each cluster review period. The cluster review period is the time between reassessments and their is some protocol behind this. The mental health clustering tool (MHCT) guidance booklet has recently been revised to update the care transition protocols.

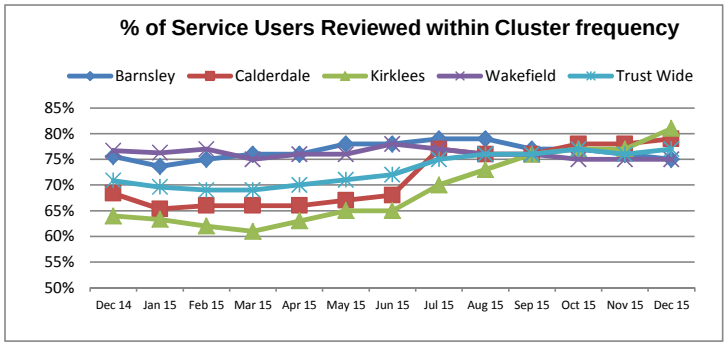
In the Trusts two main contracts for 2015/16 are a set of Quality (CQUIN) indicators related to MH Clustering, this will assist the Trust in preparedness.

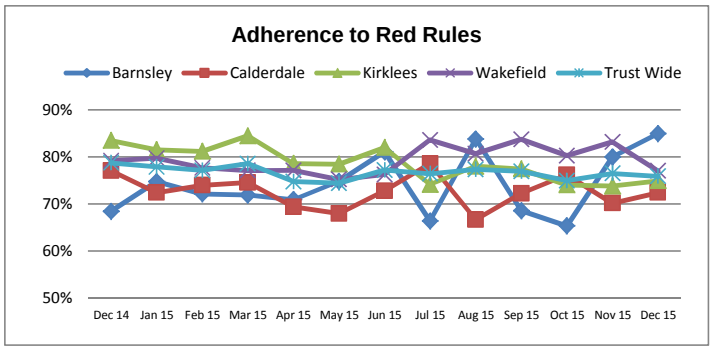
The CQUINs have 3 common elements:
Clustering of Initial Referral Assessments - 98% to be clustered within 8 weeks of 'eligible' initial referral assessments
Review of Service Users and Clusters - agreed % to be reviewed by March 2016.
Adherence to Red Rules (assurance that the cluster is accurate, complete and of high quality)
The West contract includes the development of a PbR Dashboard and this will be an interactive reporting tool. Developments are on track and requirements have been met to end of quarter 3.

There has been some underperformance against the contracts in all BDU's and a detailed action plan is in place which is being monitored locally.

MH Currency Indicators - December 2015







IAPT & Forensic Secure Services and Clustering

The scope of PbR was extended into other areas of Mental Health such as Forensic, IAPT and Children and Adolescent Mental Health Services during 2015/16.
All IAPT clients entering treatment from 1st April 2015 must be clustered. The trust are participating in the Forensic PbR Pilot submission and submitting data on a regular basis into the pilot. The datasets have been flowing from April 15 and internal monitoring of the completeness of this data has been taking place during 15/16. From quarter 2 the monitoring of clustering for these services was included in the relevant BDU dashboards.

The implementation of clustering for Learning Disabilities service users, in relation to the CP&PP LD pilot, has been slower than anticipated, the service are now planning to commence data collection in January 2016 which will then enable data to flow into the pilot.

Currency Development - Payment by Results (PbR)

Monitors Payment Proposals for Adult Mental Health Care 2016/17

Monitor are proposing changes to Local Payment Rules covering Mental health care contracts for 2016/17 because block contracts do not incentivise delivery of the objectives in the Five Year Forward View and do not facilitate timely evidence based care.

The aim of the new payment system is to increase equity of access to evidence based services with a focus on prevention and to reward quality and outcomes.

Monitor are proposing that there will be NO un-accountable block contracts or payment based on cluster days for 2016/17 and have suggested two payment approaches to adopt:-
• A Payment approach based on a pathway / year of care or episode of treatment as appropriate to each MH cluster with a proportion linked to outcomes
(This is suitable where CCGs are not providing integrated care – i.e. across mental, physical and community healthcare)

• A Payment approach based on capitation – informed by care cluster data and other evidence required to understand population needs – with a proportion linked to outcomes
(This would require the outcomes based element across one of more providers and a lead provider arrangement to monitor performance)

Under both approaches an element for payment should be linked to achievement of agreed quality and outcome measures including patient experience, achievement of MH access and waiting time standards (ex IAPTS and EIS) and measures that support the delivery of NICE concordant care.

A gain and loss share arrangement would be required to limit providers and commissioners financial risk due to any unanticipated changes in demand.

Data reporting requirements based on MH Cluster will remain the same.

Secure Services, CAMHS are not part of this payment system and IAPTs services are being looked at separately.

Feedback from providers and commissioners about the proposals has to be returned to Monitor by 19th November and will inform the Formal 2016/17 national tariff guidance and sector support materials.

The Trust is currently reviewing the Draft Reference Cost Guidance for 2015/16. Issues to note relate to IAPT services - proposal that these will be reported in a similar way to the main mental health cluster collection, separate costs will be collected for the initial assessment of a patient before acceptance into services and the costs of a treatment episode by cluster.
The Unit cost per completed episode is the proposed currency unit for IAPT services.

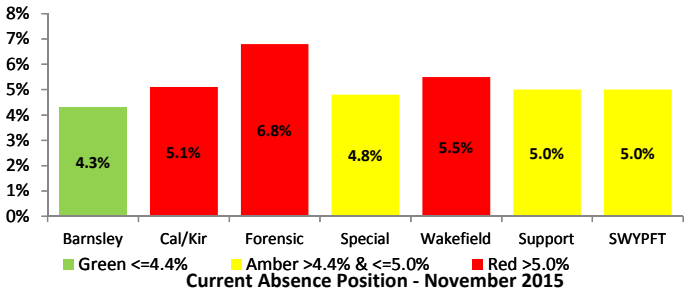
Community Currency Development

The continues to monitor the national position regarding the development of Community Currency Development. The Trust has expressed an interest in being involved in the national project for this and further updates will be available as the project progresses.

NHS England held an event towards the end of 2015 to begin working on this development. The aims of the event were to undertake joint work to agree the dataset, develop the currencies and outcome indicators for community services and to develop payment approaches for community services. To provide an overview of the work that is currently taking place; to ensure the current work is co-ordinated and aligned and consider future steps to deliver the work; to understand how to involve community services in the work; to capture local innovation and best practice.

Human Resources Performance Dashboard - December 2015

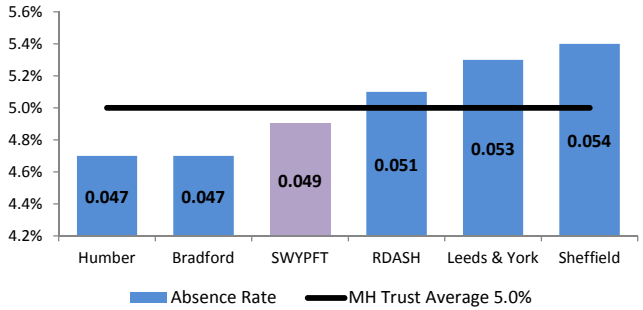
Sickness Absence



Current Absence Position - November 2015

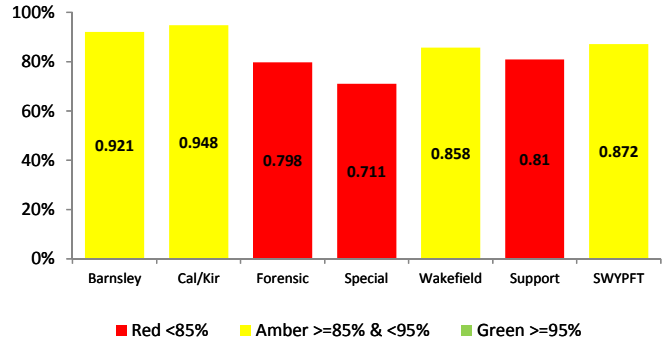
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	5.0%	5.6%	5.6%	3.6%	6.0%	6.1%	5.3%
Trend	↓	↓	↑	↑	↔	↑	↓

The Trust YTD absence levels in November 2015 (chart above) were above the 4.4% target at 5%.



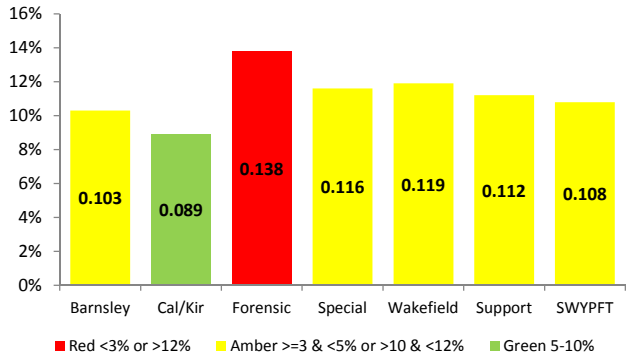
The above chart shows the YTD absence levels in MH/LD Trusts in our region to the end of September 2015. During this time the Trust's absence rate was 4.9% which is below the regional average of 5%.

Appraisals - All Staff

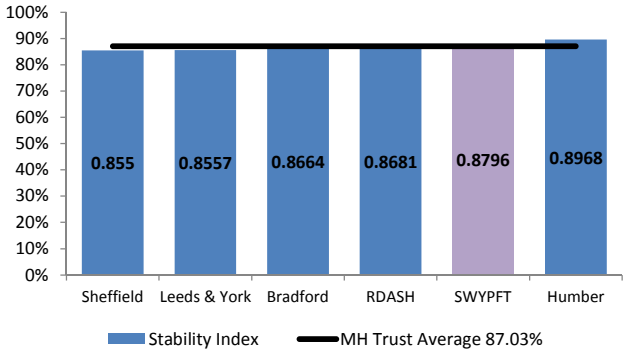


The above chart shows the YTD appraisal rates for all Trust staff to the end of December 2015.
The Trust's target for appraisals is 95% or above.
All areas have shown improvement each month since the inclusion of Bands 1 to 5 in the figures in September 2015.

Turnover and Stability Rate Benchmark



This chart shows the YTD turnover levels up to the end of December 2015.



This chart shows stability levels in MH Trusts in the region for the 12 months ending in October 2015. The stability rate shows the percentage of staff employed with over a year's service. The Trust's rate is better than the average compared with other MH/LD Trusts in our region.

Fire Lecture Attendance

The chart shows the YTD fire lecture figures to the end of December 2015.
The Trust continues to achieve its 80% target for fire lecture training, with all areas having maintained their figures above target for several months.

Workforce - Performance Wall

Trust Performance Wall

Month		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Sickness (YTD)	<=4.4%	4.80%	4.80%	4.80%	4.90%	4.90%	5.00%
Sickness (Monthly)	<=4.4%	4.60%	4.80%	5.00%	4.90%	5.40%	5.30%
Appraisals (Band 6 and above)	>=95%	73.30%	80.30%	87.30%	89.50%	91.60%	92.80%
Appraisals (Band 5 and below)	>=95%	28.00%	42.10%	66.30%	75.80%	80.10%	83.50%
Aggression Management	>=80%	77.00%	78.90%	78.90%	80.40%	80.80%	83.10%
Equality and Diversity	>=80%	85.80%	87.20%	88.30%	88.80%	89.40%	90.30%
Fire Safety	>=80%	86.60%	86.40%	85.30%	84.60%	84.80%	85.60%
Food Safety	>=80%	70.70%	71.80%	73.10%	74.30%	74.10%	75.80%
Infection Control and Hand Hygiene	>=80%	83.70%	85.30%	85.50%	85.60%	84.90%	85.80%
Information Governance	>=95%	92.80%	92.70%	92.00%	91.60%	90.60%	89.10%
Moving and Handling	>=80%	77.40%	79.30%	80.40%	82.10%	83.00%	83.80%
Safeguarding Adults	>=80%	84.90%	86.20%	86.90%	87.70%	87.30%	88.30%
Safeguarding Children	>=80%	86.40%	87.10%	87.90%	86.10%	85.50%	87.70%
Bank Cost		£473k	£445k	£488k	£478k	£428k	£414k
Agency Cost		£694k	£566k	£637k	£772k	£770k	£606k
Overtime Cost		£8k	£26k	£38k	£30k	£37k	£22k
Additional Hours Cost		£89k	£83k	£67k	£74k	£87k	£89k
Sickness Cost (Monthly)		£458k	£473k	£484k	£479k	£551k	£530k
Vacancies (Non-Medical) (WTE)		351.53	353.84	351.54	324.2	306.46	316.89
Business Miles		313k	340k	270k	333k	347k	323k

Barnsley District

Month		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Sickness (YTD)	<=4.4%	4.10%	4.20%	4.10%	4.20%	4.20%	4.30%
Sickness (Monthly)	<=4.4%	3.90%	4.20%	4.10%	4.30%	4.60%	5.00%
Appraisals (Band 6 and above)	>=95%	78.00%	83.60%	90.50%	92.10%	94.40%	95.60%
Appraisals (Band 5 and below)	>=95%	32.10%	51.90%	73.40%	83.30%	87.50%	89.80%
Aggression Management	>=80%	82.00%	84.30%	83.60%	83.50%	82.90%	84.10%
Equality and Diversity	>=80%	87.60%	89.20%	90.40%	90.70%	91.30%	92.60%
Fire Safety	>=80%	85.10%	86.60%	85.90%	84.70%	85.80%	86.20%
Food Safety	>=80%	81.10%	80.50%	80.70%	80.10%	75.70%	74.90%
Infection Control and Hand Hygiene	>=80%	84.40%	85.60%	86.60%	86.40%	87.00%	88.10%
Information Governance	>=95%	91.50%	91.80%	91.70%	92.10%	90.90%	90.50%
Moving and Handling	>=80%	80.00%	81.70%	82.60%	84.50%	85.10%	86.10%
Safeguarding Adults	>=80%	87.30%	87.90%	88.90%	90.00%	89.20%	89.80%
Safeguarding Children	>=80%	86.70%	88.30%	89.20%	87.90%	87.40%	89.00%
Bank Cost		£67k	£70k	£84k	£85k	£75k	£65k
Agency Cost		£151k	£77k	£157k	£119k	£200k	£130k
Overtime Cost		£3k	£17k	£19k	£10k	£17k	£8k
Additional Hours Cost		£40k	£47k	£31k	£35k	£40k	£36k
Sickness Cost (Monthly)		£132k	£144k	£138k	£141k	£156k	£171k
Vacancies (Non-Medical) (WTE)		111.96	116	100.85	92.75	85.33	87.34
Business Miles		139k	137k	111k	144k	148k	126k

Calderdale and Kirklees District

Month		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Sickness (YTD)	<=4.4%	4.60%	4.60%	4.70%	4.80%	5.00%	5.10%
Sickness (Monthly)	<=4.4%	4.60%	4.40%	5.20%	5.10%	6.60%	5.60%
Appraisals (Band 6 and above)	>=95%	79.40%	90.60%	97.50%	98.80%	99.70%	99.10%
Appraisals (Band 5 and below)	>=95%	33.90%	49.50%	76.50%	85.00%	88.80%	91.70%
Aggression Management	>=80%	81.10%	82.60%	83.00%	83.20%	82.80%	86.10%
Equality and Diversity	>=80%	86.60%	87.70%	89.80%	90.60%	91.60%	92.00%
Fire Safety	>=80%	87.70%	87.20%	85.40%	83.00%	83.20%	85.40%
Food Safety	>=80%	65.90%	66.80%	67.70%	69.50%	70.20%	72.00%
Infection Control and Hand Hygiene	>=80%	85.70%	87.20%	88.60%	88.60%	90.00%	90.40%
Information Governance	>=95%	93.70%	93.60%	92.80%	90.40%	89.80%	87.50%
Moving and Handling	>=80%	75.40%	77.50%	78.80%	81.30%	82.70%	83.40%
Safeguarding Adults	>=80%	81.40%	83.00%	85.20%	86.60%	86.80%	88.20%
Safeguarding Children	>=80%	86.00%	85.50%	87.20%	86.20%	86.50%	89.40%
Bank Cost		£131k	£123k	£134k	£117k	£124k	£114k
Agency Cost		£167k	£110k	£141k	£199k	£173k	£117k
Overtime Cost		£2k	£1k	£1k	£1k	£2k	£0k
Additional Hours Cost		£7k	£4k	£2k	£2k	£3k	£3k
Sickness Cost (Monthly)		£95k	£88k	£104k	£101k	£142k	£117k
Vacancies (Non-Medical) (WTE)		77.32	82.59	82.93	71.14	75.66	72.44
Business Miles		64k	77k	57k	65k	73k	61k

Forensic Services

Month		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Sickness (YTD)	<=4.4%	7.90%	7.60%	7.30%	7.20%	7.00%	6.80%
Sickness (Monthly)	<=4.4%	7.30%	6.60%	6.10%	6.80%	5.80%	5.60%
Appraisals (Band 6 and above)	>=95%	58.70%	65.20%	68.60%	70.00%	74.70%	84.70%
Appraisals (Band 5 and below)	>=95%	14.00%	29.30%	61.00%	66.20%	71.50%	77.60%
Aggression Management	>=80%	78.80%	78.40%	77.40%	78.20%	80.70%	81.70%
Equality and Diversity	>=80%	89.70%	90.20%	89.20%	90.40%	92.40%	92.80%
Fire Safety	>=80%	88.20%	87.20%	85.50%	87.30%	88.60%	89.00%
Food Safety	>=80%	59.50%	63.20%	65.40%	70.60%	73.50%	79.70%
Infection Control and Hand Hygiene	>=80%	86.00%	87.80%	85.80%	85.30%	84.40%	85.40%
Information Governance	>=95%	94.10%	92.70%	90.70%	91.70%	91.90%	90.80%
Moving and Handling	>=80%	81.50%	83.90%	84.00%	85.80%	87.60%	87.90%
Safeguarding Adults	>=80%	87.40%	88.40%	85.50%	88.50%	89.90%	91.50%
Safeguarding Children	>=80%	85.10%	85.70%	84.50%	85.30%	85.90%	87.70%
Bank Cost		£95k	£99k	£114k	£114k	£97k	£86k
Agency Cost		£93k	£77k	£96k	£122k	£68k	£68k
Overtime Cost		£1k	£0k	£0k	£0k	£2k	£0k
Additional Hours Cost		£0k	£0k	£0k	£0k	£0k	£0k
Sickness Cost (Monthly)		£65k	£58k	£57k	£58k	£56k	£49k
Vacancies (Non-Medical) (WTE)		20.56	28.42	14.34	24.94	24.54	37.11
Business Miles		3k	6k	3k	9k	9k	12k

Workforce - Performance Wall cont…

Specialist Services

Month		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Sickness (YTD)	<=4.4%	5.40%	5.20%	5.10%	5.10%	5.00%	4.80%
Sickness (Monthly)	<=4.4%	4.80%	4.50%	5.00%	4.70%	4.60%	3.60%
Appraisals (Band 6 and above)	>=95%	39.80%	45.40%	60.50%	68.70%	73.80%	75.10%
Appraisals (Band 5 and below)	>=95%	13.10%	21.50%	44.00%	47.50%	53.60%	64.80%
Aggression Management	>=80%	70.30%	73.80%	73.40%	76.40%	77.10%	79.80%
Equality and Diversity	>=80%	88.20%	89.60%	89.60%	89.90%	90.00%	90.50%
Fire Safety	>=80%	83.70%	85.90%	82.20%	83.20%	82.10%	84.60%
Food Safety	>=80%	72.20%	72.20%	69.10%	69.00%	71.20%	73.70%
Infection Control and Hand Hygiene	>=80%	81.60%	83.30%	83.80%	84.00%	84.30%	85.90%
Information Governance	>=95%	90.10%	90.80%	89.10%	90.10%	90.20%	89.50%
Moving and Handling	>=80%	76.70%	79.70%	82.20%	82.50%	83.10%	83.10%
Safeguarding Adults	>=80%	81.50%	83.20%	84.70%	83.20%	82.00%	84.40%
Safeguarding Children	>=80%	82.70%	82.90%	85.40%	84.90%	81.30%	85.60%
Bank Cost		£44k	£33k	£38k	£31k	£28k	£32k
Agency Cost		£195k	£208k	£127k	£228k	£216k	£146k
Overtime Cost		£2k	£2k	£2k	£1k	£1k	£1k
Additional Hours Cost		£11k	£5k	£7k	£5k	£7k	£11k
Sickness Cost (Monthly)		£49k	£50k	£54k	£53k	£55k	£42k
Vacancies (Non-Medical) (WTE)		52.66	44.93	50.41	45.31	44.49	40.71
Business Miles		32k	30k	29k	30k	39k	40k

Support Services

Month		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Sickness (YTD)	<=4.4%	4.30%	4.60%	4.70%	4.70%	4.90%	5.00%
Sickness (Monthly)	<=4.4%	4.50%	5.40%	5.30%	4.90%	5.50%	6.10%
Appraisals (Band 6 and above)	>=95%	86.20%	91.80%	94.80%	95.90%	96.50%	96.90%
Appraisals (Band 5 and below)	>=95%	20.70%	26.60%	54.80%	71.10%	72.70%	74.80%
Aggression Management	>=80%	60.10%	65.10%	68.60%	72.40%	74.30%	78.60%
Equality and Diversity	>=80%	74.60%	76.20%	78.10%	78.70%	78.90%	80.40%
Fire Safety	>=80%	87.70%	85.30%	86.00%	84.60%	84.30%	83.50%
Food Safety	>=80%	95.50%	95.50%	93.60%	90.10%	89.20%	89.90%
Infection Control and Hand Hygiene	>=80%	79.90%	80.90%	81.20%	82.30%	76.80%	78.30%
Information Governance	>=95%	94.90%	94.60%	92.80%	91.70%	89.60%	86.60%
Moving and Handling	>=80%	76.70%	77.70%	78.80%	81.10%	81.50%	81.90%
Safeguarding Adults	>=80%	83.60%	84.70%	84.80%	84.90%	84.50%	85.40%
Safeguarding Children	>=80%	88.70%	89.80%	90.30%	83.70%	82.80%	84.80%
Bank Cost		£40k	£36k	£35k	£60k	£14k	£39k
Agency Cost		£16k	£27k	£103k	£71k	£40k	£74k
Overtime Cost				£0k	£4k	£0k	£0k
Additional Hours Cost		£21k	£18k	£19k	£22k	£19k	£20k
Sickness Cost (Monthly)		£63k	£75k	£71k	£62k	£70k	£84k
Vacancies (Non-Medical) (WTE)		36.6	36.53	42.54	51.48	36.73	37.2
Business Miles		36k	47k	38k	42k	35k	48k

Wakefield District

Month		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Sickness (YTD)	<=4.4%	5.10%	5.20%	5.30%	5.30%	5.40%	5.50%
Sickness (Monthly)	<=4.4%	4.80%	5.30%	5.70%	5.60%	6.10%	6.00%
Appraisals (Band 6 and above)	>=95%	78.30%	83.20%	87.40%	88.10%	90.20%	91.80%
Appraisals (Band 5 and below)	>=95%	41.40%	50.00%	64.30%	68.40%	76.70%	81.30%
Aggression Management	>=80%	81.00%	81.30%	79.30%	82.90%	82.80%	84.20%
Equality and Diversity	>=80%	89.80%	91.70%	91.70%	92.20%	92.20%	92.60%
Fire Safety	>=80%	88.70%	86.20%	84.60%	86.10%	84.70%	85.20%
Food Safety	>=80%	60.30%	61.70%	67.60%	68.60%	69.70%	69.50%
Infection Control and Hand Hygiene	>=80%	83.30%	86.50%	84.10%	83.80%	81.80%	82.00%
Information Governance	>=95%	93.00%	92.90%	93.30%	92.60%	91.50%	89.00%
Moving and Handling	>=80%	71.10%	73.50%	73.60%	74.00%	75.70%	77.60%
Safeguarding Adults	>=80%	86.70%	88.80%	89.70%	89.70%	88.90%	89.00%
Safeguarding Children	>=80%	86.50%	86.60%	86.40%	85.60%	85.30%	86.30%
Bank Cost		£97k	£85k	£83k	£71k	£90k	£78k
Agency Cost		£71k	£67k	£12k	£34k	£73k	£71k
Overtime Cost			£5k	£16k	£14k	£14k	£12k
Additional Hours Cost		£9k	£8k	£9k	£9k	£13k	£12k
Sickness Cost (Monthly)		£54k	£57k	£60k	£63k	£72k	£66k
Vacancies (Non-Medical) (WTE)		50.63	43.37	55.47	36.58	34.71	40.49
Business Miles		40k	42k	31k	43k	44k	37k

Publication Summary

Department of Health (DoH)

The Government's mandate to NHS England for 2016-17

The mandate helps set direction for the NHS and helps ensure the NHS is accountable to parliament and the public. The mandate must be published each year, to ensure that NHS England's objectives remain up to date. It was produced following public consultation.
Click here for link to Mandate

National Institute for Health and Care Excellence (NICE)

Care of dying adults in the last days of life

These guidelines aim to put the dying person at the heart of decisions about their care, so that they can be supported in their final days in accordance with their wishes. Until recently, the Liverpool Care Pathway was used to provide good end of life care. It was withdrawn however, following widespread criticism and a subsequent government review that found failings in several areas. As a result, NICE was asked to develop evidence-based guidelines on care of the dying adult. The new guideline aims to tackle these and other issues by providing recommendations for the care of a person who is nearing death no matter where they are.
Click here for link to guidance

NHS England

Delivering the Forward View: NHS planning guidance 2016/17 - 2020/21

The leaders of the national health and care bodies in England have set out steps to help local organisations plan over the next six years to deliver a sustainable, transformed health service and to improve quality of care, wellbeing and NHS finances. The planning guidance outlines a new approach to help ensure that health and care services are planned by place rather than around individual institutions.
Click here for link to guidance

Monitor

National tariff update and draft prices for 2016/17

This guidance contains current national tariff draft prices and a workbook and aims to assist trusts with planning for 2016/17.
Click here for link to guidance

Publication Summary cont….

Monitor

Considerations for determining local health and care economies

The NHS planning guidance, Delivering the Forward View: NHS planning guidance 2016/17 to 2020/21 asks every health and care system to produce its own sustainability and transformation plan (STP). One of the first steps in this process is for local health and care systems to agree the geographic scope of their STP. Monitor has produced resources to support CCGs, providers, local authorities and other key stakeholders to help determine their planning footprint.

Click here for link to guidance

Department of Health

2016/17 Better Care Fund: policy framework

The Better Care Fund (BCF) will provide financial support for councils and NHS organisations to jointly plan and deliver local services. This document sets out the agreed way in which the Better Care Fund will be implemented in financial year 2016 to 2017.

Click here for link

This section of the report identifies publications that may be of interest to the Trust and it's members.

Health survey for England, 2014: trend tables
NHS sickness absence rates - August 2015
NHS foundation trust bulletin: 16 December 2015
Learning disability services monthly statistics - England commissioner census (assuring transformation) - November 2015, experimental statistics
Hospital episode statistics-diagnostic imaging dataset data linkage report - provisional summary statistics, April 2015-August 2015 (experimental statistics)
NHS foundation trust bulletin: 6 January 2016
Combined performance summary, November 2015

Glossary

ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FT	Foundation Trust
HONOS	Health of the Nation Outcome Scales
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IWMS	Integrated Weight Management Service
KPIs	Key Performance Indicators
LD	Learning Disability
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NICE	National Institute for Clinical Excellence
NK	North Kirklees
OOA	Out of Area
OPS	Older People's Services
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
Sis	Serious Incidents
SK	South Kirklees
SMU	Substance Misuse Unit
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YTD	Year to Date

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 9 (2015 / 2016)

Contents

Overall Financial Performance 2015 / 2016

Performance Indicator		Month 9 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent		
Trust Targets					8	7	6
1	Monitor Risk Rating	●	●	⇔	●	●	●
2	REVISED £0.10m Surplus on Income & Expenditure	●	●	↑	●	●	●
3	Cash Position	●	●	↑	●	●	●
4	Capital Expenditure	●	●	⇔	●	●	●
5	Delivery of CIP	●	●	↓	●	●	●
6	Better Payment Practice Code	●	●	↑	●	●	●

Key		
	●	In line, or greater than plan
	●	Variance from plan ranging from 5% to 15%
	●	Variance from plan greater than 15%

Summary Financial Performance

These Key Performance Indicators (KPI's) help the Trust to monitor progress against each element of our financial strategy.

1. The Trust Financial Risk Rating is 4 against a plan level of 4. (A score of 4 is the highest possible) The forecast is that the Trust will retain a rating of 4 at 31st March 2016.

2. The year to date position, as at December 2015 , is a surplus of £0.2m. As part of the Month 6 Monitor return the Trust confirmed a revised plan of £100k surplus.This year to date position is £0.92m ahead of this revised plan.

Supported by the utilisation of Trust provisions the Trust are confident that the financial plan for 2015 / 2016 will be achieved. If the current trend continues this would enable the Trust to achieve a small surplus rather than a deficit. The Trust will continue to validate this position, and the risks contained within, and will update to Board accordingly.

3. At December 2015 the cash position is £28.09m which is £1.53m ahead of plan.

4. Capital spend to December 2015 is £7.82m which is £0.6m (7%) behind the Trust capital plan.

5. At December 2015 the Cost Improvement Programme is £809k behind plan. Overall a Full Year Value of £1435k (15%) has been rated as red, after mitigations. A red rating indicates that the CIP opportunity does not currently have an implementation plan and therefore carries a high risk on non achievement.

6. As at December 2015 92% of NHS and 96% of non NHS invoices have achieved the 30 day payment target (95%). This continues to be a small improvement from previous months.

Monitor Risk Rating

As per the Risk assessment Framework, updated August 2015, the financial performance of the Trust is monitored through a number of financial sustainability risk ratings.

This revision increased the number of metrics from 2 to 4. This retains the original 2 which focus on the Continuity of Services and add 2 further in relation to Financial Efficiency. A further metric in relation to capital expenditure performance against plan was proposed but has not been adopted.

				Actual Performance		Annual Plan	
	Financial Criteria	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Continuity of Services	Balance Sheet Sustainability	25%	Capital Service Capacity	3.2	4	2.0	3
	Liquidity	25%	Liquidity (Days)	16.2	4	10.5	4
	Weighted Average - Continuity of Services Risk Rating				4		4
Financial Efficiency	Underlying Performance	25%	I & E Margin	0.5%	3		
	Variance from Plan	25%	Variance in I & E Margin as a % of income	1.6%	4		
	Weighted Average - Financial Sustainability Risk Rating				4		

Definitions

Capital Servicing Capacity - the degree to which the Trust's generated income covers its financing obligations; rating from 1 to 4 relates to the multiple of cover.

Liquidity - how many days expenditure can be covered by readily available resources; rating from 1 to 4 relates to the number of days cover.

I & E Margin - the degree to which the organisation is operating at a surplus / deficit

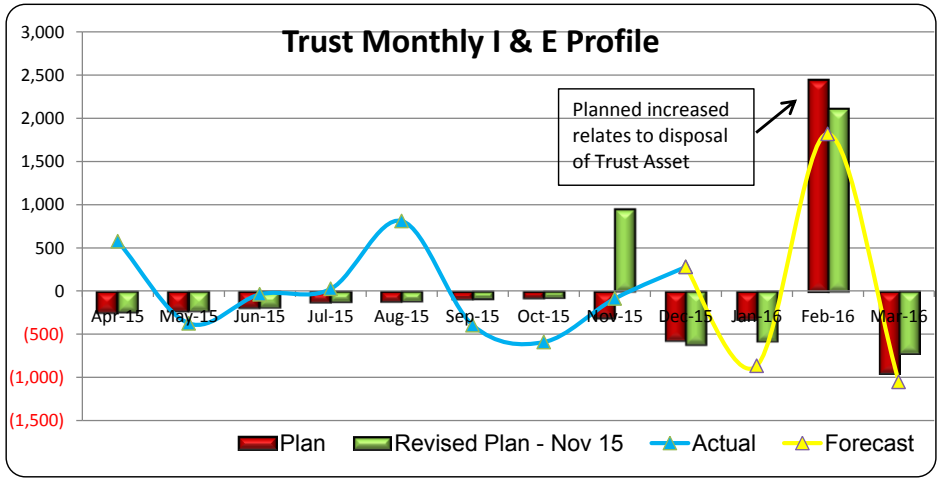
I & E Variance - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

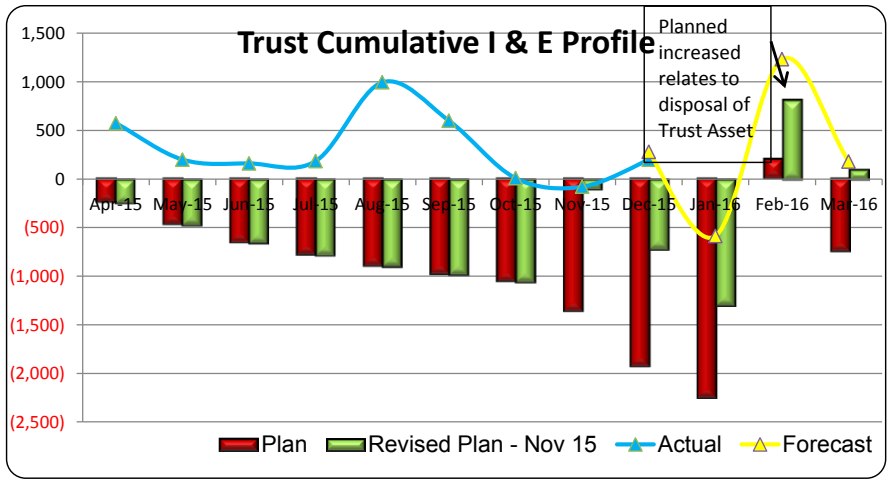
Risk Rating 4 - No evident Concerns

Risk Rating 3 - Emerging or minor concern potentially requiring scrutiny.

Income & Expenditure Position 2015 / 2016

Budget Staff in Post	Actual Staff in Post	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				(17,498)	(17,116)	382	Clinical Revenue	(158,510)	(157,466)	1,044	(210,715)	(209,638)	1,077
				(17,498)	**(17,116)**	**382**	**Total Clinical Revenue**	**(158,510)**	**(157,466)**	**1,044**	**(210,715)**	**(209,638)**	**1,077**
				(1,728)	(1,770)	(43)	Other Operating Revenue	(12,621)	(12,889)	(268)	(16,334)	(16,856)	(521)
				(19,226)	**(18,887)**	**339**	**Total Revenue**	**(171,131)**	**(170,355)**	**776**	**(227,049)**	**(226,494)**	**555**
4,382	4,214	(168)	3.8%	14,290	14,156	(134)	BDU Expenditure - Pay	128,885	128,130	(755)	171,290	171,347	57
				4,145	3,532	(613)	BDU Expenditure - Non Pay	34,469	33,167	(1,302)	45,544	46,296	752
				698	230	(468)	Provisions	2,133	2,676	543	4,335	3,148	(1,188)
4,382	**4,214**	**(168)**	**3.8%**	**19,133**	**17,918**	**(1,215)**	**Total Operating Expenses**	**165,487**	**163,973**	**(1,514)**	**221,169**	**220,791**	**(378)**
4,382	**4,214**	**(168)**	**3.8%**	**(93)**	**(969)**	**(876)**	**EBITDA**	**(5,644)**	**(6,382)**	**(738)**	**(5,880)**	**(5,703)**	**177**
				456	450	(7)	Depreciation	4,106	4,039	(67)	5,475	5,408	(67)
				257	245	(12)	PDC Paid	2,310	2,205	(105)	3,080	2,975	(105)
				(6)	(5)	2	Interest Received	(56)	(61)	(5)	(75)	(80)	(5)
				0	0	0	Revaluation of Assets	0	0	0	(2,700)	(2,700)	0
4,382	**4,214**	**(168)**	**3.8%**	**614**	**(279)**	**(893)**	**Deficit / (Surplus)**	**716**	**(199)**	**(915)**	**(100)**	**(100)**	**(0)**





Income & Expenditure Position 2015 / 2016

Month 9

The year to date position, as at Month 9, reflects a surplus position of £0.2m. This is currently £0.92m ahead of the revised Trust plan. This revised plan was communicated to Monitor as part of the Quarter 2 trust submission.

As per previous months, Trustwide, we have experienced underspends against plan within both pay and non pay expenditure which has resulted in an in month underspend of £0.89m.

Large elements of this include additional income which has now been paid, reduced costs following additional analysis with SLA providers and improved recharges made following improved information provided.

Forecast

At month 6 the Trust informed Monitor of a revised forecast year end position of £100k surplus. This was an improvement of £842k from the original plan. The forecast outturn position for 2015 / 2016 is a surplus position of £0.1m. This is in line with the revised plan.

Based upon the current forecasts, funds within provisions (£1.19m) are being used in order to support this position. This will continue to be assessed alongside BDU forecasts. This is broadly in line with the utilisation of provisions highlighted at month 8.

BDU's have forecast increased levels of expenditure during the remainder of the year. These run rates and assumptions continue to be challenged. Currently pay and non pay are all individually forecast to overspend against plan. These positions include the impact of non delivery against CIP plans.

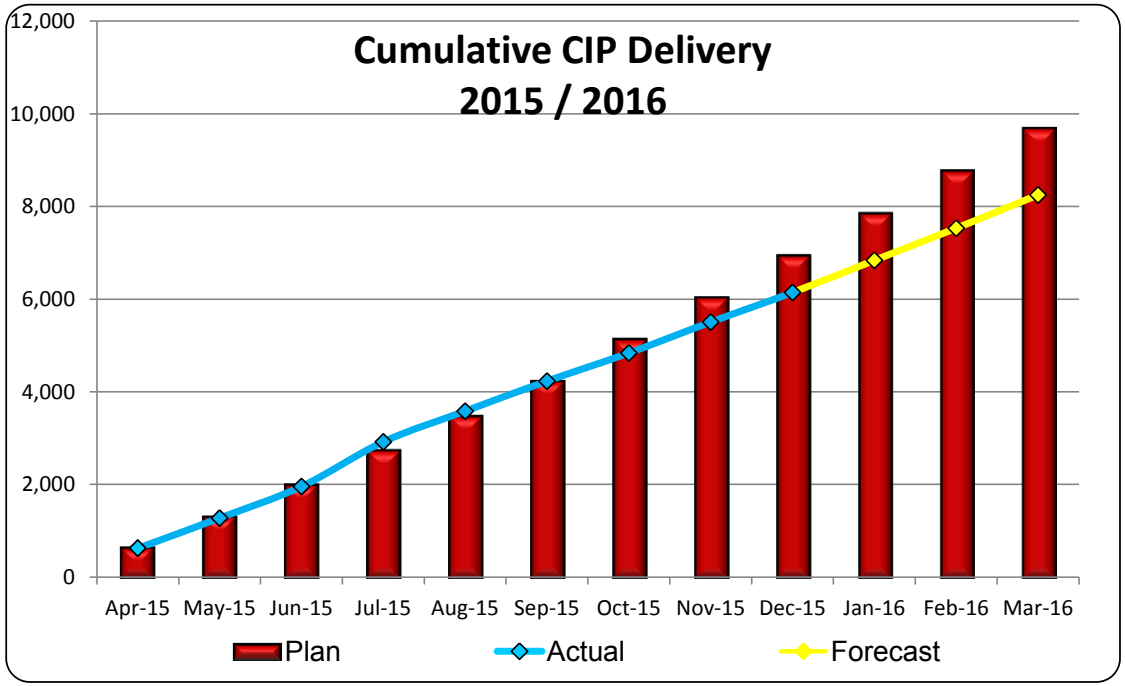
Delivery of this position incorporates the following assumptions; the most significant of which are:

*	£1.43m	Assumption that CIP's, classified as red, will not be achieved. Work is ongoing to find substitutions.
*	£0.07m	Assumption that CIP's, classified as amber, will be delivered in full during 2015 / 2016.
*	£2.7m	The planned disposal of a Trust asset during 2015 / 2016 will be agreed.
*	tbc	Impairments / revaluations / demolition - these risks continue to be assessed and quantified. As such they are not reflected in the current forecast.

Provisions will continue to be monitored and managed in order to ensure that this position is achieved.

Cost Improvement Programme 2015 / 2016

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Forecast
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Target - Recurrent	606	613	642	686	690	705	845	850	849	856	856	864	6,485	9,061
Target - Non Recurrent	52	52	52	52	52	52	52	52	52	52	52	52	466	622
Target - Monitor Submission	657	664	694	738	742	756	897	902	901	908	908	916	6,951	9,683
Target - Cumulative	657	1,322	2,016	2,754	3,496	4,252	5,149	6,051	6,951	7,859	8,767	9,683	6,951	9,683
Delivery as planned	400	824	1,244	1,769	2,215	2,661	3,119	3,646	4,131	4,660	5,189	5,729	4,131	5,729
Mitigations - Recurrent	11	22	32	43	54	65	76	87	102	117	132	148	102	148
Mitigations - Non Recurrent	210	428	678	1,107	1,313	1,504	1,642	1,772	1,910	2,060	2,209	2,372	1,910	2,372
Total Delivery	**621**	**1,274**	**1,955**	**2,920**	**3,582**	**4,230**	**4,837**	**5,504**	**6,143**	**6,837**	**7,530**	**8,248**	**6,143**	**8,248**
Shortfall / Unidentified	36	48	60	(166)	(86)	22	312	547	809	1,022	1,237	1,435	809	1,435



The profile of the Trust Cost Improvement Programme for 2015 / 2016 is outlined above. This follows a detailed bottom up process conducted as part of the Trust Annual Plan; one which was subjected to an external review.

Year to Date

For the Year to Date £6.14m CIP has been achieved out of the £6.95m target. (88%) It is £809k behind plan.

The CIP acheivement includes £1910k non recurrent substitutions (31% of total delivered).

Forecast

The current forecast is that £8.25m out of £9.68m will be achieved in 15/16. This leaves a forecast shortfall of £1.43m (15%) and this is reflected in the Trust overall forecast position.

As part of the Trust Annual Planning Process BDU's have conducted a full, and frank, assessment of recurrent CIP shortfall for 2016 / 2017. Substitutions for this shortfall need to be identified.

Balance Sheet 2015 / 2016

	2014 / 2015 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	106,649	110,880	110,138	1
Current Assets				
Inventories & Work in Progress	204	204	204	
NHS Trade Receivables (Debtors)	3,015	2,015	1,350	2
Other Receivables (Debtors)	4,963	5,213	8,398	2
Cash and Cash Equivalents	32,617	26,560	28,093	3
Total Current Assets	**40,799**	**33,992**	**38,045**	
Current Liabilities				
Trade Payables (Creditors)	(5,851)	(5,851)	(4,590)	4
Other Payables (Creditors)	(3,621)	(4,391)	(3,925)	4
Capital Payables (Creditors)	(770)	(1,620)	(629)	
Accruals	(10,335)	(8,835)	(12,718)	5
Deferred Income	(751)	(751)	(854)	
Total Current Liabilities	**(21,328)**	**(21,448)**	**(22,717)**	
Net Current Assets/Liabilities	**19,471**	**12,543**	**15,328**	
Total Assets less Current Liabilities	**126,120**	**123,424**	**125,466**	
Provisions for Liabilities	(8,104)	(7,422)	(7,250)	
Total Net Assets/(Liabilities)	**118,016**	**116,002**	**118,215**	
Taxpayers' Equity				
Public Dividend Capital	43,492	43,492	43,492	
Revaluation Reserve	16,780	16,780	17,217	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	52,524	50,510	52,287	6
Total Taxpayers' Equity	**118,016**	**116,002**	**118,215**	

The Balance Sheet analysis compares the current month end position to that within the Monitor Annual Plan, submitted May 2015. The previous year end position is included for information.

1. Fixed Assets are currently slightly behind plan; as noted within the capital programme.

2. Debtors, specifically Non-NHS debtors, continue to be higher than planned. The main value remains with 1 Local Authority and relates to payment of 1 block invoice.

3. The reconciliation of Actual Cash Flow to Plan compares the current month end position to the Annual Plan position for the same period. This is on page 11.

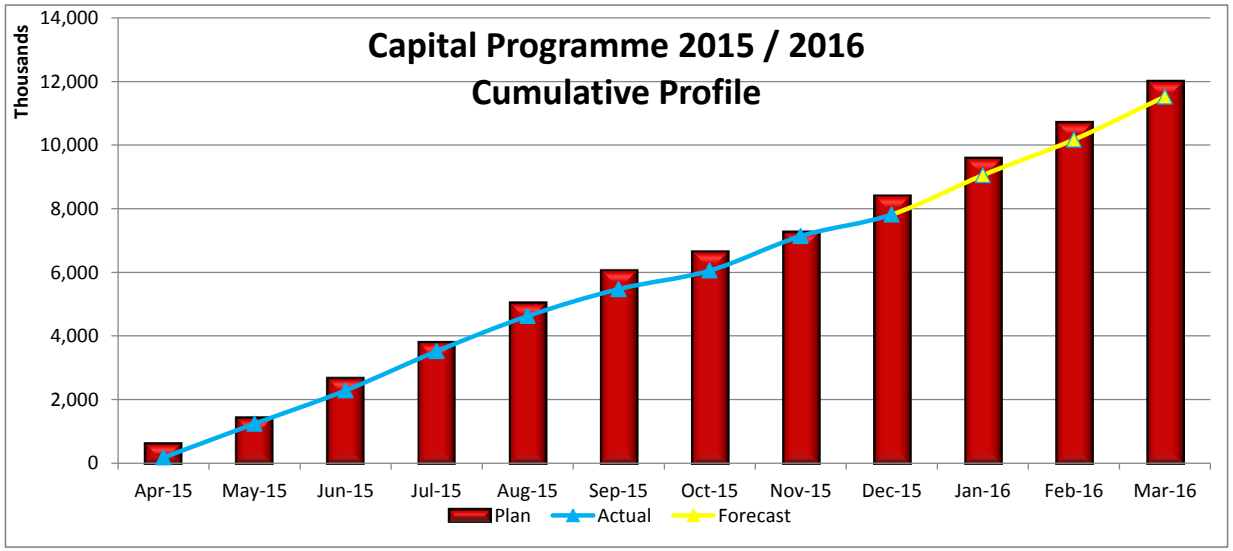
4. Creditors remain lower than planned as the Trust continues to proactively pay invoices. Work continues to ensure that the Trust does not hold any old creditor values / unresolved issues.

5. Accruals remain higher than planned as the Trust is still awaiting invoices. There is c. £1m regarding an SLA with a local Trust which the Trust continue pursue a resolution to.

6. This reserve represents year to date surplus plus reserves brought forward.

Capital Programme 2015 / 2016

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	2,200	1,498	1,412	(86)	2,362	162	4
IM&T	2,348	1,370	434	(936)	1,807	(541)	3
Total Minor Capital & IM &T	**4,548**	**2,868**	**1,846**	**(1,022)**	**4,169**	**(379)**	
Major Capital Schemes							
Barnsley Hub	950	950	1,177	227	1,172	222	5
Halifax Hub	4,052	3,901	3,960	59	4,100	48	6
Hub Development	1,450	250	587	337	1,658	208	7
Fieldhead Development	1,000	450	340	(110)	427	(573)	8
Total Major Schemes	**7,452**	**5,551**	**6,063**	**512**	**7,356**	**(96)**	
VAT Refunds	0	0	(93)	(93)	0	0	
TOTALS	**12,000**	**8,419**	**7,816**	**(603)**	**11,525**	**(475)**	



Capital Expenditure 2015 / 2016

1. The Trust Capital Programme for 2015 / 2016 is £12.0m and schemes are guided by the overall Trust Estates Strategy.

2. The year to date position is £0.6m under plan (7%). The current full year forecast is £11.53m.

Monitor has written to all Foundation Trusts during October and November 2015 to confirm capital expenditure plans and any potential deferment which can be undertaken. This position reflects the current Trust position (£0.5m reduction in IM&T spend).

3. IM & T procurement is being finalised and improved costs from the original market testing prices. Overall this is c.£0.5m less than originally planned.

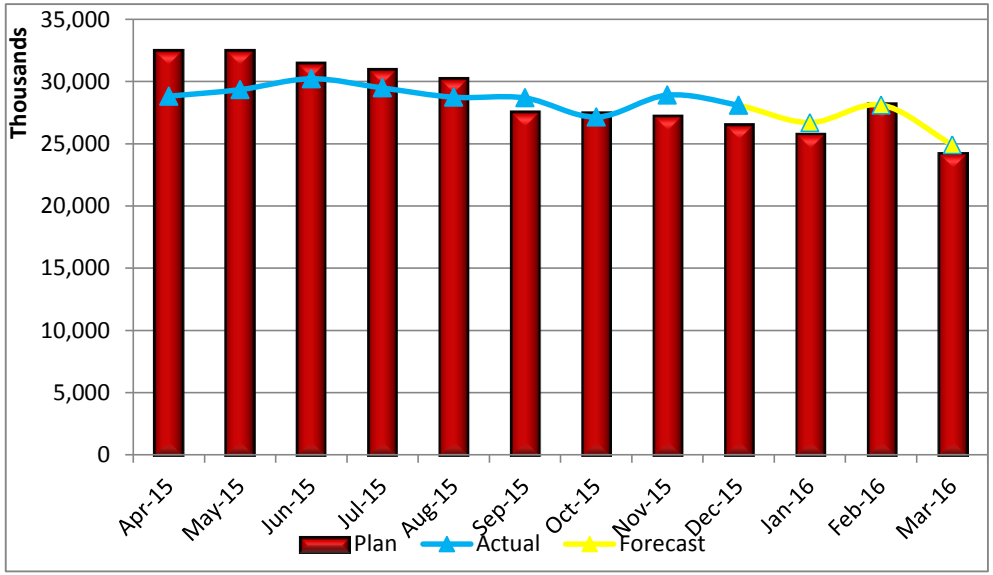
4. The works to the Bretton Centre entrance are now underway.

5 & 6. Both hubs are now operational.

7. Work continues on the approved Pontefract and Wakefield hubs.

8. Following Trust Board approval of the Non Secure Fieldhead scheme the design group for that project has recommenced.

Cash Flow & Cash Flow Forecast 2015 / 2016



	Plan £k	Actual £k	Variance £k
Opening Balance	32,617	32,617	
Closing Balance	26,560	28,093	1,533

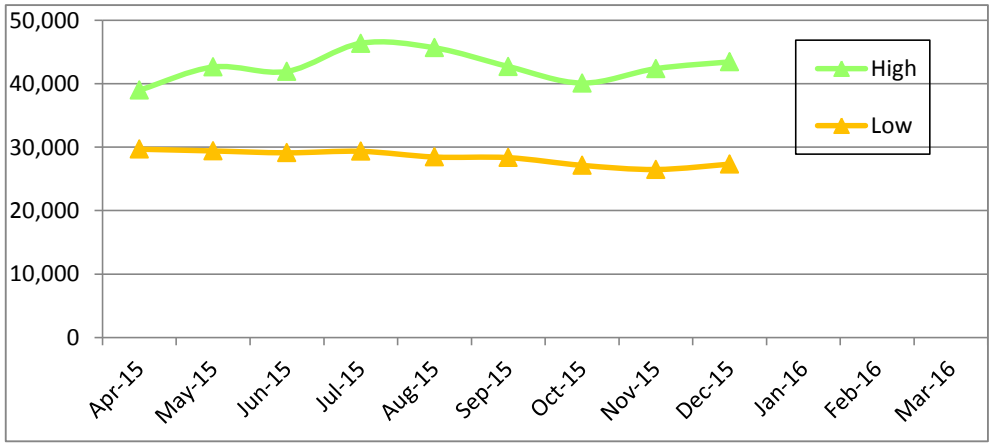
The Cash position provides a key element of the Continuity of Service and Financial Efficiency Risk Rating. As such this is monitored and reviewed on a daily basis.

Weekly review of actions ensures that the cash position for the Trust is maximised.

Overall the cash position is £28.09m which is £1.53m higher than planned.The forecast continues to assume the cash receipt of the Trust Asset in February 2016. This element remains a risk.

A detailed reconciliation of working capital compared to plan is presented at page 11.

Due to changes in the interest rates offered, the Trust is utilising the National Loans Fund scheme to invest £10m cash (until March 2016). This remains low risk investment but will attract improved rates of interest. (0.46%)



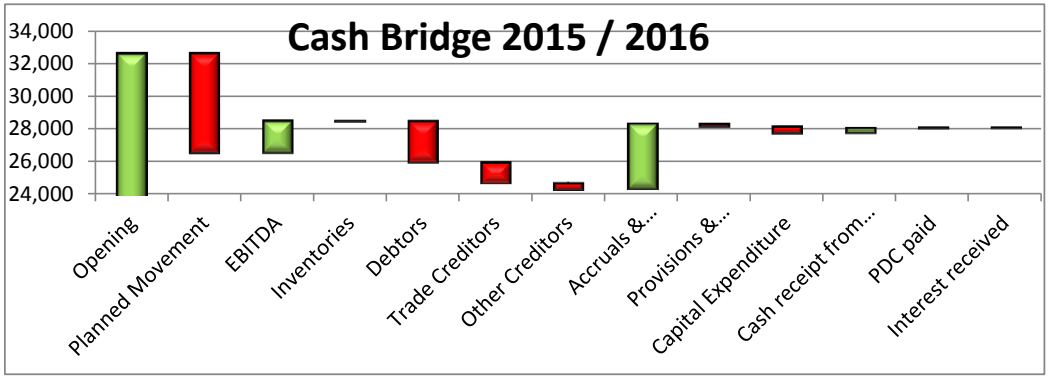
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is: £43.45m
The lowest balance is: £27.34m

This reflects cash balances built up from historical surpluses that are available to finance capital expenditure in the future.

Reconciliation of Cashflow to Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**32,617**	**32,617**		
Surplus (Exc. non-cash items & revaluation)	4,428	6,376	1,948	1
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	750	(1,770)	(2,520)	4
Trade Payables (Creditors)	0	(1,260)	(1,260)	5
Other Payables (Creditors)	0	(385)	(385)	
Accruals & Deferred income	(1,500)	2,486	3,986	2
Provisions & Liabilities	(682)	(854)	(171)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(7,569)	(7,957)	(388)	3
Cash receipts from asset sales	0	294	294	
PDC Dividends paid	(1,540)	(1,516)	24	
PDC Received	0		0	
Interest (paid)/ received	56	61	5	
Closing Balances	**26,560**	**28,093**	**1,533**	



The Plan value reflects the May 2015 submission to Monitor.

Factors which increase the cash positon against plan:

1. EBITDA, arising from the current operational I & E position, is better than planned. This is shown within the overall Trust financial position.

2. Accruals remain higher than planned. This gives the Trust a cash benefit as we have yet to receive and pay expected invoices. This includes c. £1m for SLA's which have not yet been invoiced.

Factors which decrease the cash position against plan:

3. Although the capital programme overall is behind plan the level of capital creditors is also lower than planned which have a negative impact on cash.

4 . Debtor levels overall are higher than planned. In particular non NHS continues to be the area of focus and in particular a number of key organisations.

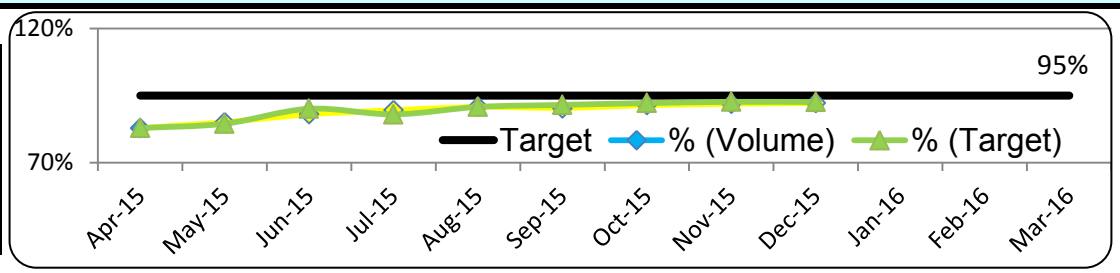
5. Creditors remain lower than planned as the Trust continues to proactively pay invoices as soon as possible. This is being reviewed in line with the Trust overall cash position.

The cash bridge to the left depicts, by heading, the positive and negative impacts on the cash position as compared to plan.

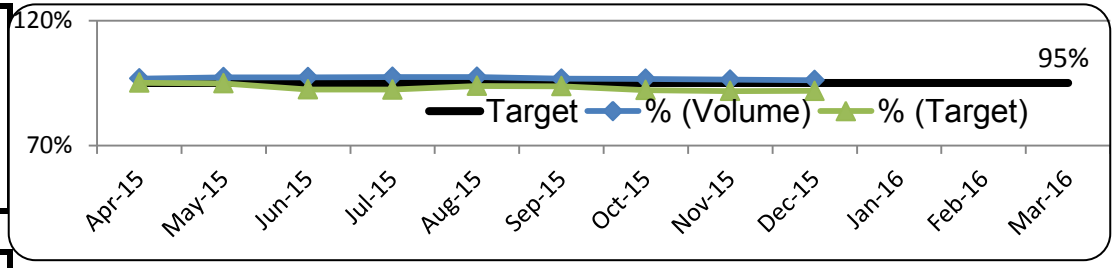
Better Payment Practice Code

The Trust is committed to following the Better Payment Practice Code , payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.
In November 2008 the Trust adopted a Government request for Public Sector bodies to pay local Suppliers within 10 days. This is not mandatory for the NHS.
The team continue to review reasons for non delviery of the 95% target and identify solutions to problems and bottlenecks in the process.

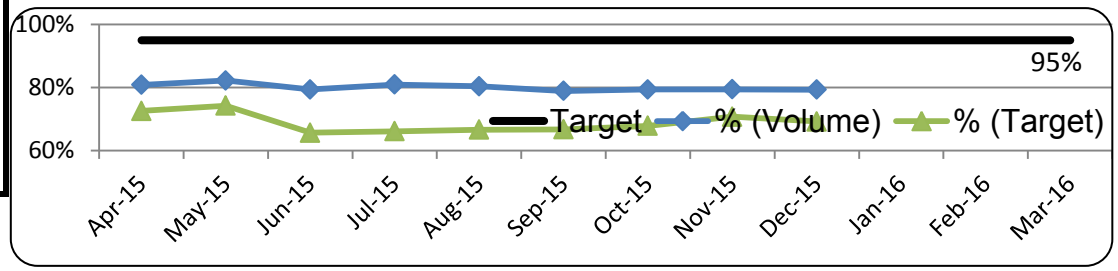
NHS	Number %	Value %
Year to November 2015	92%	93%
Year to December 2015	92%	93%



Non NHS	Number %	Value %
Year to November 2015	96%	92%
Year to December 2015	96%	92%



Local Suppliers (10 days)	Number %	Value %
Year to November 2015	79%	71%
Year to December 2015	79%	69%



Transparency Disclosure

As part of the Government's commitment to greater transparency, there is a requirement to publish online, central government expenditure over £25,000.

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence.

At the current time Monitor has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.

The transparency information for the current month is shown in the table below.

Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
17/12/2015	Availability Charge SLA	Calderdale	Calderdale and Huddersfield NHS Fou	8148038	208,399
16/11/2015	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2192012	119,667
15/12/2015	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2193368	113,589
02/12/2015	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership NHS FT	2192889	55,851
04/11/2015	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership NHS FT	2191026	52,106
13/11/2015	Drugs	Trustwide	Lloyds Pharmacy Ltd	2191850	44,738
13/10/2015	Drugs	Trustwide	Lloyds Pharmacy Ltd	2190091	40,365
13/11/2015	Drugs	Trustwide	Lloyds Pharmacy Ltd	2191850	39,350
13/10/2015	Drugs	Trustwide	Lloyds Pharmacy Ltd	2190091	38,431
17/12/2015	Staff Recharge	Support	Wakefield MDC	2193670	36,928
08/12/2015	Staff benefits expenses	Trustwide	Childcare Vouchers Ltd	2193118	25,371

Glossary

* Recurrent - action or decision that has a continuing financial effect

* Non-Recurrent - action or decision that has a one off or time limited effect

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year.

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

* Forecast Surplus - This is the surplus we expect to make for the financial year

* Target Surplus - This is the surplus the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. Recently this has been set as part of the IBP/LTFM process. Previously we aimed to achieve breakeven.

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not pat of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - We only agree actions which have a recurring effect, so these savings are part of our Recurrent Underlying Surplus.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. This Trust has historically only approved recurrent CIP's. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.

* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.

* IFRS - International Financial Reporting Standards, there are the guidance and rules by which financial accounts have to be prepared.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 January 2016
Agenda item 7.3

Title:	**Customer services report quarter 3 2015/16**
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. To note also summary Friends and Family Test results.
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 reviews the Customer Services policy on an annual basis and is reviewing the revised policy in January 2016. Most recent policy updates reflect Care Quality Commission (CQC) essential standards, Trust action following an internal audit and best practice in complaints management as outlined in 'My Expectations' (a vision outlined following collaborative work by the Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England). Weekly customer services reporting to BDUs is enabling increased scrutiny of issues and themes, complaints investigation, response timeframes and action planning, to ensure service improvement in response to feedback.
Executive summary:	**Customer Services Report quarter 3 2015/16** This report provides information on feedback received, the themes indicated, lessons learned and action taken in response to feedback. The report format has been revised to support summary information to BDUs to supplement weekly reporting on specific cases. In 3, there were 72 formal complaints, 73 compliments, 332 issues were responded to and 51 requests to access information under the Freedom of Information Act. This report is distributed to commissioners and is subject to discussion at Quality Boards and through contracting processes. It is reviewed by Healthwatch across the Trust's geography. The information is also reviewed alongside other service user experience intelligence at the internal Customer Experience Group. The Group's most recent work has been with the Picker Institute Europe (who analyse the results of national surveys on behalf of the CQC). Findings of the 2015 community mental health survey were presented, with workshop activity to take forward necessary actions.
Recommendation:	**Trust Board is asked to REVIEW and NOTE the feedback received through customer services in Q3 2015/16.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Customer Services Report Quarter 3 2015/ 16

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 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 Board will review updated policy in January 2016.

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. Any potential risks to Trust reputation identified through Customer Services processes would be highlighted to the relevant BDU and escalated to the Trust wide risk register / assurance framework as appropriate.

The report includes:

- The number of issues raised and the themes arising
- External scrutiny and partnering
- Equality data
- A breakdown of issues at BDU level including:
    - Customer Service standards
    - Actions taken / changes as a consequence of service user and carer feedback
    - Compliments received
    - Friends and Family Test results
- The number and type of requests processed under the Freedom of Information Act

Contact

The customer services team processed 150 general enquiries in Qtr. 3, in addition to '4 Cs' management. Consistent with past reporting, signposting to Trust services was the most frequently requested advice. Other enquiries included requests for information about Trust Services, providing contact details for staff and information on how to access healthcare records. The team also responded to over 420 telephone enquiries from staff, offering support and advice in resolving concerns at local level (a decrease in staff contact on the previous quarter).

Feedback received

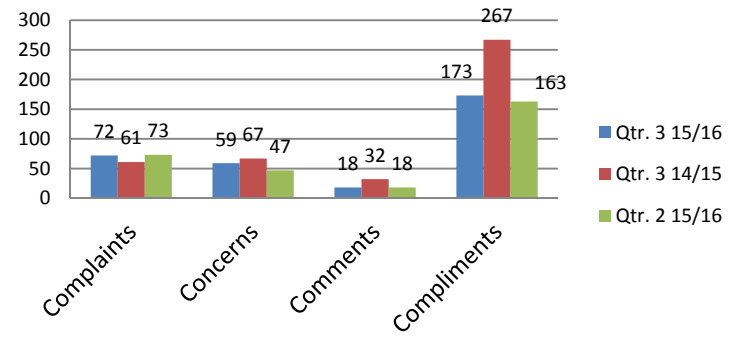
In Qtr. 3. The Customer Services team responded to 332 issues (301 in Qtr. 2); 72 formal complaints were received (73 in Qtr. 2) and 173 compliments (163 in Qtr. 2).

Across all complaints, communications was identified as the most frequently raised negative issue (26). This was followed by patient care (22), values and behaviours (staff) (22), appointments (12), access to treatment or drugs (11) and Trust admin/ policies/ procedures (10). Most complaints contained a number of themes

In Qtr.3 there were 13 formal complaints regarding CAMHS services – with access to services and waiting times in Calderdale and Kirklees continuing to be the issues of most concern. These are being addressed through on-going work with local CCGs.

Friends and Family Test – In Qtr. 3 79% would recommend mental health services, 97% would recommend community health services

Trust wide



NHS Choices

The Trust has introduced measures to attempt to drive traffic to NHS Choices, in recognition that this site is an external source of information about the Trust. Survey materials promote NHS Choices as an additional means to offer feedback about the Trust and its services. The website is monitored to ensure timely response to posted feedback.

During Qtr. 3, 3 individuals added comments on NHS Choices about their experience of Trust services. All posts are acknowledged. The Trust is attempting to make direct contact with 1 individual to follow up on the issues posted (attitude of member of staff , service not identified)

2 positive comments were posted, one regarding Forensic services and one regarding the support provided to Veterans and their families in Barnsley.

PHSO (Ombudsman)

In Qtr. 3, 3 complainants asked the Parliamentary and Health Service Ombudsman to review their complaint following contact with the Trust. Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. Information requested by the Ombudsman in relation to the above was provided within the prescribed timeframe.

During the quarter, the Trust received feedback from the Ombudsman regarding 4 cases . 3 were closed with no further action required. 1 case (Wakefield Inpatients WAA) was subject to review and partially upheld. Recommendations to the Trust included the preparation of an action plan, and an appropriate apology to the complainant.

The Trust currently has 7 cases pending with the Ombudsman.

It can take a number of months before the Ombudsman is in a position to advise the Trust on its decisions (due to the volume of referrals received by PHSO).

Mental Health Act (MHA)

3 complainants raised concerns with the Trust in Qtr. 3 regarding detention under the Mental Health Act. Two individuals chose not to specify their ethnicity - one described themselves as white – British.

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.

The CQC

2 issues were referred to the Trust by the CQC in Qtr. 3: (1 Wakefield Older People In-patient Services and 1 Learning Disability Services, Inpatient Assessment and Treatment). The CQC requested information in regards to staff attitude on a ward, inconsistent information shared with a family, level of nursing care and medication issues. The Trust has provided a full response to the complaint regarding Wakefield OPS and there has been no further follow up to date. The Trust has provided a holding statement to the CQC regarding the PLD issues, and has committed to update on progress with the investigation and subsequent findings.

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.

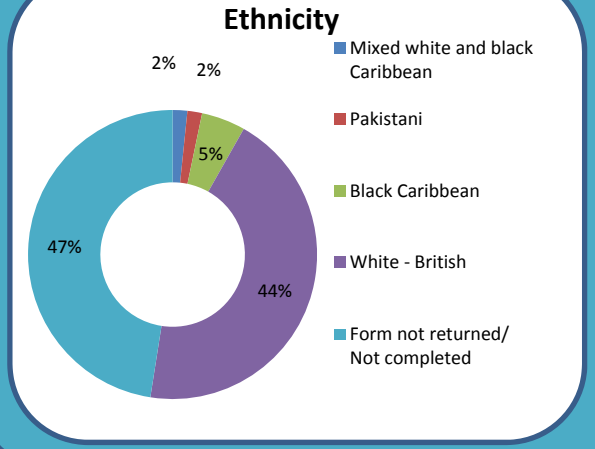
Joint working protocols are in place with each working partnership. The purpose of these is to simplify the complaints process when this involves more than one agency and improve accessibility for users of health and social care services.

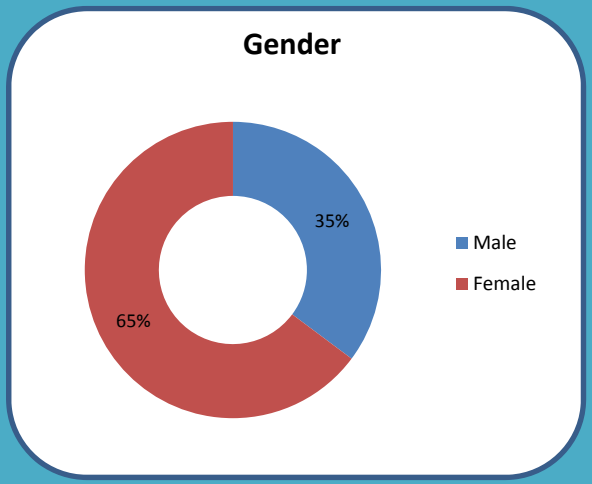
The Customer Services function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information. Healthwatch are provided with copies of quarterly reports and request additional information from the Trust on occasion.

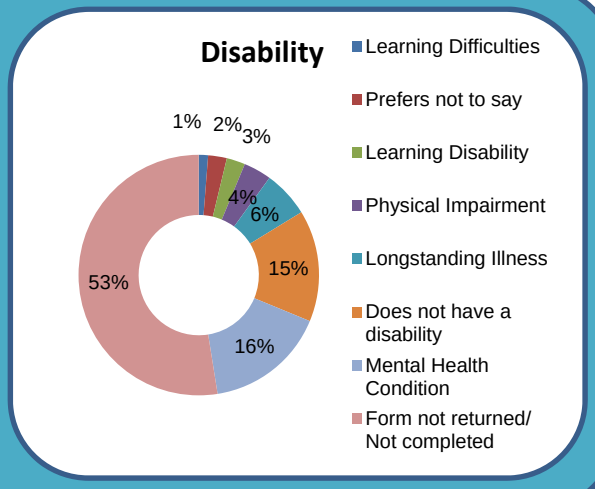
Healthwatch are encouraging local people to share their experience of health services via their websites and will theme and share feedback as data is collected and collated.

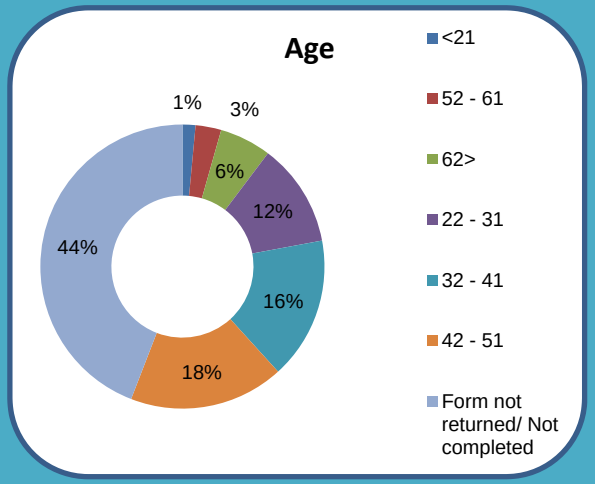
Issues spanning more than one organisation Qtr. 3	Complaint	Concern	Comment
Barnsley Metropolitan Borough Council	0	0	1
Calderdale and Huddersfield NHS FT	1	0	0
CQC	2	0	0
Member of Parliament	2	1	0
NHS Bassetlaw CCG	0	1	0
NHS Wakefield CCG	1	0	0

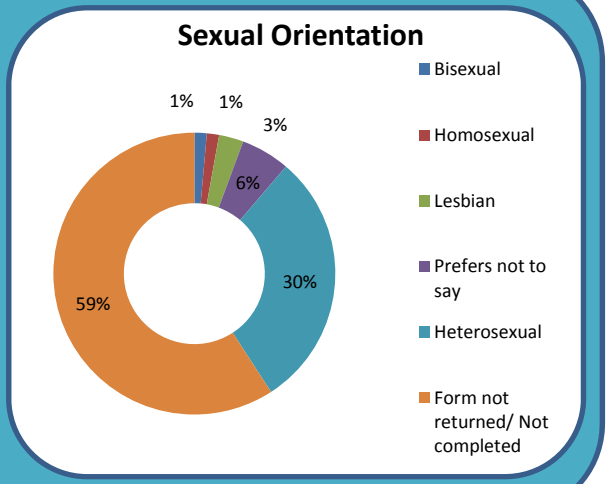
Equality and Inclusion – Formal Complaints - Protected Characteristics Data











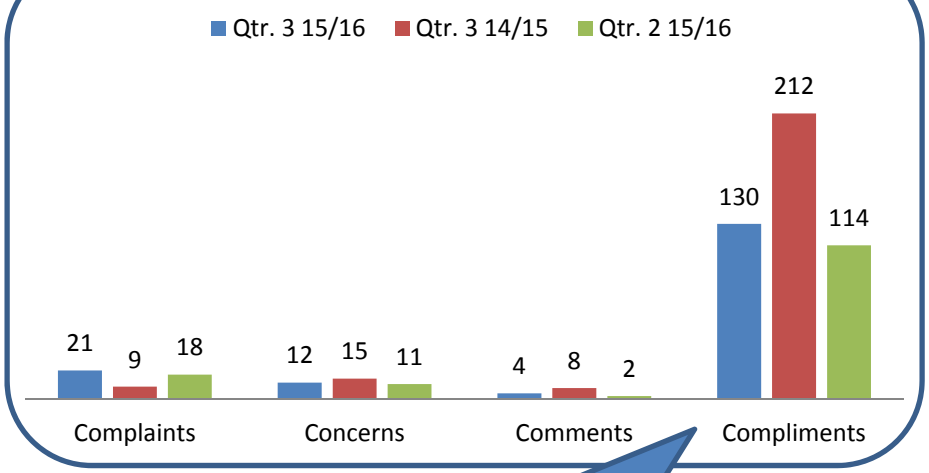
Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. To support improvement in the number of forms returned / completed, additional information 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 continues to explore best practice in data capture, both internally with teams and externally with partner organisations and networks, and incorporates any learning into routine processes.

The charts show, where information was provided, the breakdown in respect of ethnicity, gender, disability, age and sexual orientation. This is collated Trust-wide.

Barnsley Business Delivery Unit

Number of issues



I would like to say a massive thank you to the staff member for all her care, help and support. The staff member has gone that extra mile. Super credit to the health visiting team.
0-19 Children's Universal Services - Central

Complaints closed <25 days 25%

Complaints closed 26 – 40 days 35%

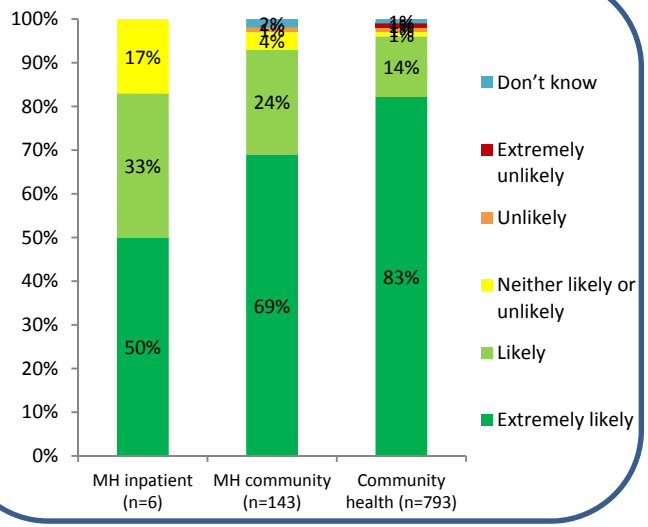
Complaints closed >40 days 40%

In Qtr. 3 85% of complaints (17) took over 5 days for a lead investigator to be allocated, and 1 complaint re-opened.

Actions Taken

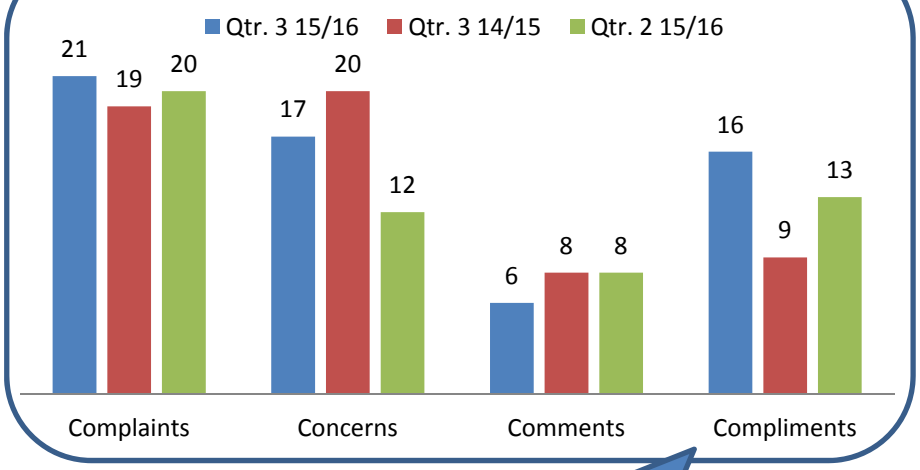
- Service to ensure all records are accurate and up to date – *0-19 Children's Universal Services – Central*
- Improved communication with service users/carers regarding assessment processes. –-*Mental Health Access Team*
- Team to ensure all correspondence from family/ carers is acknowledged, and a response offered. – *CMHT Central*
- Service to ensure a full explanation for clinical decisions is provided to family/ carers (if consent is provided by service user). – *CMHT Central*
- Service to increased training and guidance for nursing staff in relation to pre-emptive prescribing. Staff to ensure that service users/relatives are fully informed of any changes in care and treatment. – *District Nurses (Locality 1)*
- Staff to check service user understanding, ensure the service user is listened to, and feels involved in their care/ decisions about care. – *CMHT North*

Friends and Family Test



Calderdale & Kirklees Business Delivery Unit

Number of issues



Actions Taken

- Staff to ensure that conditions of detention are fully explained to the nearest relative. – Priestly Unit
- Service to ensure staffing issues do not impact on consistency of service provided, and ensure that the reason for decisions is clearly explained to service user. – CMHT, Lower Valley
- A new procedure put in place to ensure that the inpatient consultant will now order medication prior to discharge. – CMHT, Lower Valley
- Service will continue to monitor staff behaviour and support any identified training in relation to communication skills. – CMHT , Calder Valley

We are so grateful for all your help and support. After many years I finally feel we are getting somewhere with the correct diagnosis and suitable medication.
Memory Service

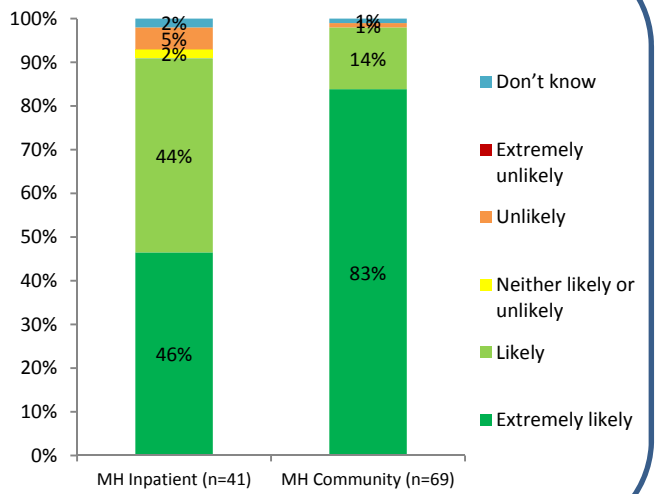
Complaints closed <25 days 30%

Complaints closed 26 – 40 days 35%

Complaints closed >40 days 35%

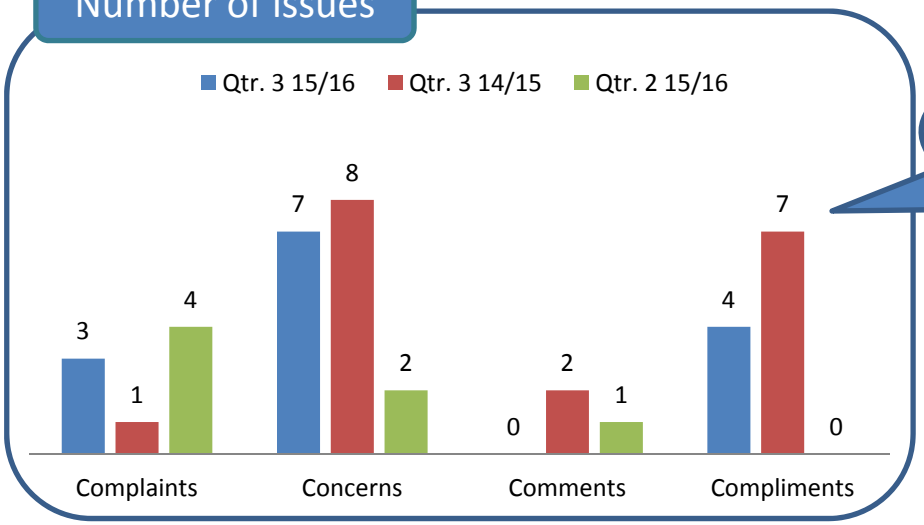
In Qtr. 3, 65% of complaints (13) took over 5 days to allocate a lead investigator ,and 2 complaints were re-opened.

Friends and Family Test



Forensics Business Delivery Unit

Number of issues



Post on NHS Choices:
The quality of the care I receive is good, it's 100%. The staff fully involve me in the planning of my care which is good. I think that the facilities here are very good and are kept nice and clean. Overall I would say I'm very happy to be here.

Complaints closed <25 days 0%

Complaints closed 26 – 40 days 0%

Complaints closed >40 days 100%

In Qtr. 3, 100% of complaints (1) took over 5 days for a lead investigator to be allocated.

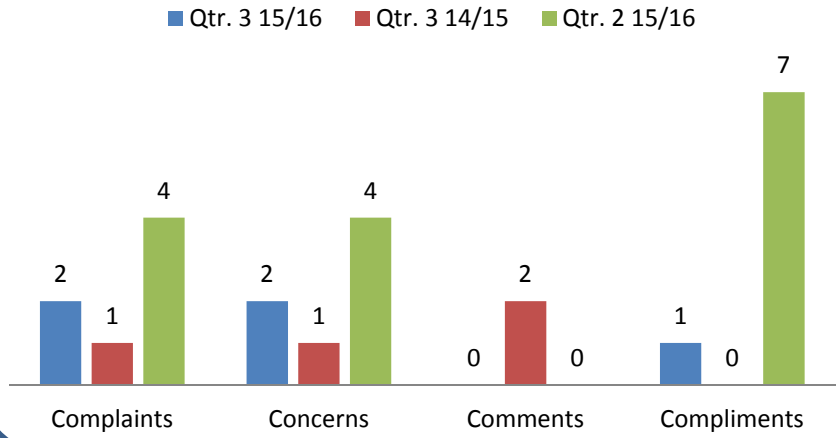
CQUINS Initiative:
FFT information was not collected in the period as a service user experience survey was conducted as part of the CQUIN initiative. The survey ran in October & November, involved service users from Newton Lodge, Bretton and Newhaven and covered healthier lifestyles / dining experience, activities and care planning. 92 responses were received. Feedback on care planning showed:

- 84% of respondents stated they understood the purpose of their care plan
- 55% of respondents stated they have a copy of their care plan
- 82% of respondents stated they were involved in the planning of their care plan
- 81% of respondents stated their care plan addresses their problems
- 81% of respondents stated they meet with their primary nurse
- 73% of respondents stated their carer(s) has been involved in their care (if wanted) (82% Newton Lodge, 59% Bretton Centre, 71% Newhaven).

Shaun raised concerns that an invitation to his CPA meeting was late being sent to his new clinical team. This meant that there was no time for the team to make arrangements to attend.
The complaint highlighted an issue with lack of administration support, due to a vacant post. This resulted in a delay in processing paperwork , including for CPA meetings.
The service provided an explanation and apology and administrative support to the service is subject to review.

Specialist Services Business Delivery Unit (Learning Disabilities)

Number of issues



Actions Taken

In circumstances where prescribing is outside the Trust guidance or advice, the service will ensure the rationale for this is shared with the service user, carers and other family members where appropriate. – Fox View

Thank you for the way you have worked with my son.

Learning Disability Team

Complaints closed <25 days 60%

Complaints closed 26 – 40 days 0%

Complaints closed >40 days 40%

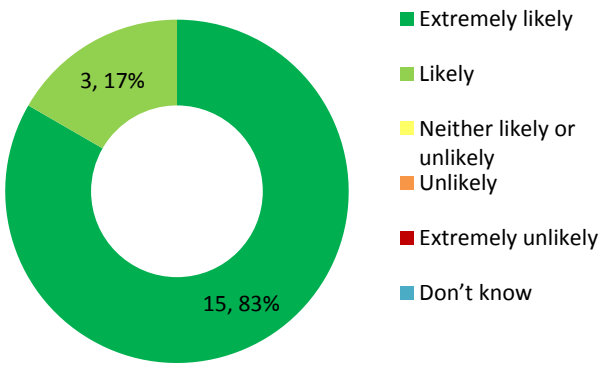
In Qtr. 3, 20% of complaints (1) took over 5 days for a lead investigator to be allocated.

Richard and Lynsey raised concerns regarding the overall management of care and treatment that their daughter, Suzie, had received from the Learning Disability, Inpatient service. Richard explained that he had felt that staff had not listened to or included the family in decisions made, that record keeping had not reflected decisions or discussions.

Following investigation of the concerns , the following areas of improvement have been identified:

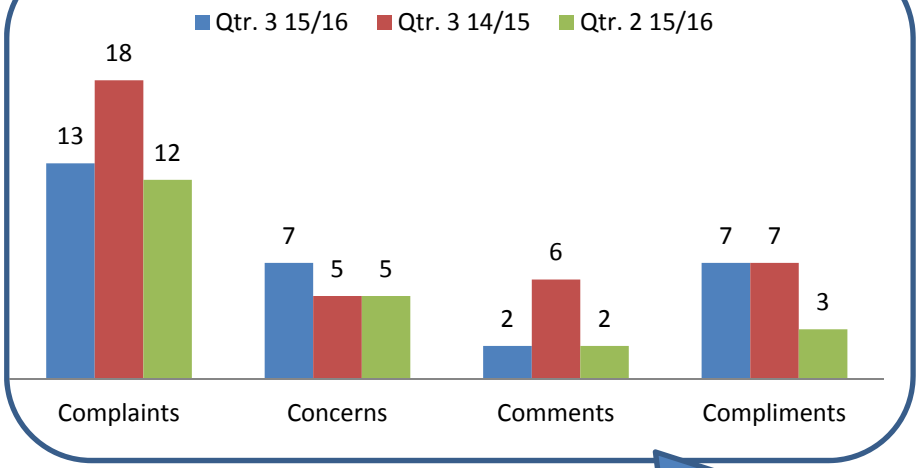
- The process for initial assessment is subject to review
- Staff are to undergo refresher training around person centred principles
- Staff to ensure that service users are involved with planning and developing their own treatment and care plan wherever possible
- Work is underway to increase the activities provided within the in-patient area of the centre, so these can be more varied and person centred.
- Staff to ensure that detailed and consistent record keeping is maintained in relation to incidents and individual behaviour at the centre. Where regular incidents/ behaviours are observed, these should be reviewed by staff with expertise in behaviour management, so that patterns and triggers for such behaviours can be identified, and addressed in care planning.

How likely are you to recommend our service to friends and family if they required similar care or treatment? (n=18)



Child and Adolescent Mental Health Services

Number of issues



Actions Taken

- The importance of clearly communicating agreed actions has been reiterated to all staff. – Barnsley
- Improved information sharing to ensure family members understand the roles of different organisations involved in a child's care, where there is a multi-agency approach. Full explanation to be provided where there are changes to care/ treatment. – Kirklees
- Training for staff around screening referrals to ensure that they are based on the geography of the GP – Kirklees
- Service to review content of CAMHS assessments, and how information is shared with families. – Calderdale

MP contact

2 MPs raised concerns on behalf of constituents:
Jason McCartney - waiting time for assessment for autism
Holly Lynch - waiting time for therapy.

A massive thank you for the work you have done with my son. You have made me feel positive and I am happy that things will now be put into place.
Mulberry House CAMHS Team

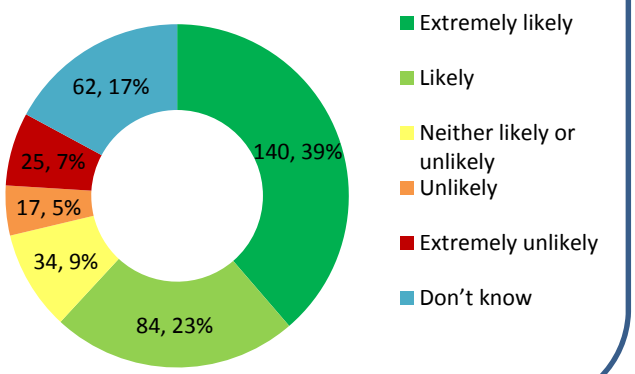
Complaints closed <25 days 27%

Complaints closed 26 – 40 days 27%

Complaints closed >40 days 46%

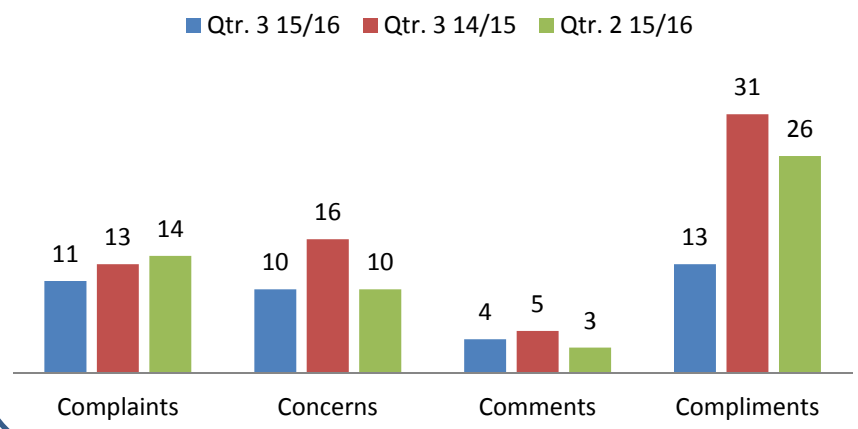
In Qtr. 3, 54% of complaints (6) took over 5 days for a lead investigator to be allocated, and two complaints were re-opened.

How likely are you to recommend our service to friends and family if they required similar care or treatment? (n=362)



Wakefield Business Delivery Unit

Number of issues



Actions Taken

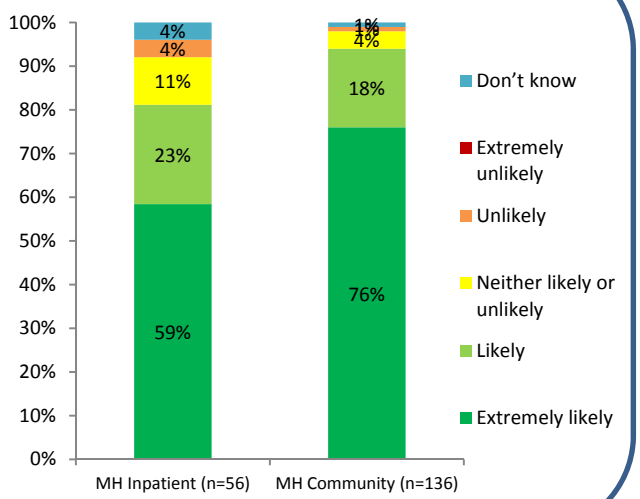
- Service to revise current information leaflet to include circumstances when information may be shared with other professionals/partner organisations. – Crisis Team
- Service to ensure carers and family members feel involved in decision making whilst also attempting to promote independence for service users. Staff to ensure reasons for clinical decisions are fully explained to carers and family members. – CMHT 3
- Staff will be updated on the funding panel process and what information is required from teams to support panel review – Trinity 2.

MP contact

Concern raised by Andrea Jenkyns, MP, on behalf of constituent, regarding access to services, and funding for treatment.

It was so nice to come and see mum calm, relaxed and smiling after a very agitated and aggressive period. As a family we are working with the whole team on Chantry unit to help mum.
Chantry Unit

Friends and Family Test



Complaints closed <25 days 27%

Complaints closed 26 – 40 days 27%

Complaints closed >40 days 46%

In Qtr. 3, 54% of complaints (6) took over 5 days for a lead investigator to be allocated, and two complaints were re-opened.

Freedom of Information requests

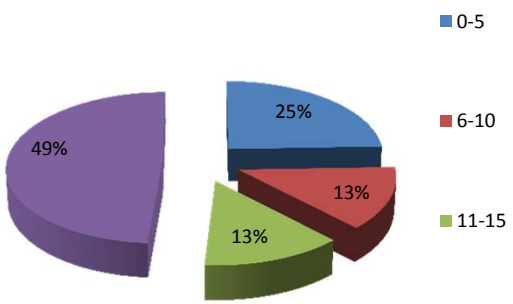
51 requests to access information under the Freedom of Information Act were processed in Qtr. 3, an increase on the previous quarter when 73 requests were processed. Many requests were detailed and complex in nature and required significant time to collate an appropriate response working with services 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.

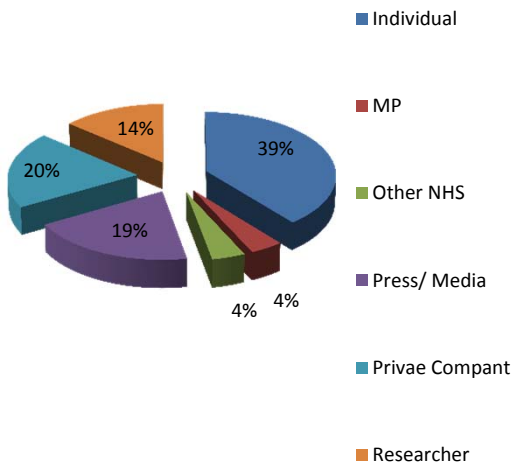
During Qtr. 3, no exemptions were applied.

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

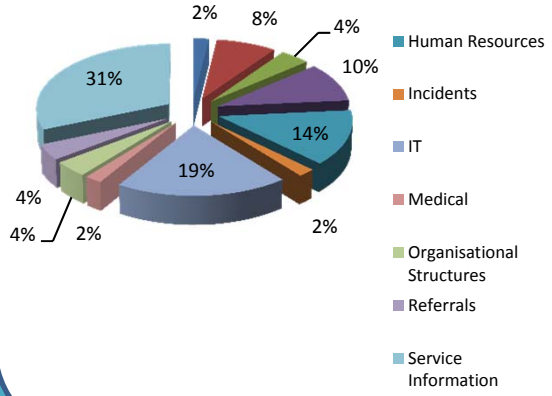
Number of days to respond



Origin of request



Types of request



With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 January 2016
Agenda item 7.4(i)

Title:	**Potential implications for the Trust arising from the Southern Health NHS Foundation Trust concerns**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	This paper provides an overview of the issues and implications arising from the recent external audit report into serious incident management at Southern Health NHS Foundation Trust.
Mission/values:	Honest, Open and Transparent
Any background papers/ previously considered by:	Previous verbal brief to Trust Board December 2015
Executive summary:	A draft report by independent auditors Mazars, commissioned by NHS England, was recently leaked to the BBC. It comments on services run by Southern Health NHS Foundation Trust. The report, published in December 2015 found failings in the way the trust investigated serious incidents, that too few deaths were investigated and some should have been investigated further, and the Trust could not demonstrate a comprehensive, systematic approach to learning from deaths. This Trust's approach to serious incident management is summarised in the following paper with data provided on number of deaths of Trust service users, number of deaths reported on the DATIX incident reporting system and the number of serious incident investigations between 2011 and 2015. The report also describes how this Trust's approach to incident reporting and investigation differs from the situation described in the Southern Health report. **Conclusion** Serious and far reaching concerns were identified in the report on incident management in Southern Health NHS Foundation Trust, which demonstrates the importance for Trusts to have robust processes in place. This has led the Department of Health to commission a national review of incident reporting in mental health and learning disability services. Monitor has taken regulatory action and agreed a number of steps with Southern Health to ensure these issues are addressed as quickly as possible. Southern Health has agreed to implement the recommendations of Mazars' report, and to get expert assurance on how well it plans and carries out those improvements. Monitor has appointed an Improvement Director for the trust, who will use their expertise to support and challenge the trust as it fixes its problems. This Trust has a comprehensive policy on the reporting and investigation of incidents that operates in accordance with national guidance and standards. It will fully comply with the national review. In the interim and thereafter, the Trust will continue to monitor its compliance with national guidance and ensure that the quality of investigations and serious incident reports remains high.
Recommendation:	**Trust Board is asked to NOTE the assurance provided in this report and make any recommendations if appropriate.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 January 2016
Implications of recent audit into incident reporting at Southern Health NHS Foundation Trust

Purpose of the paper

This paper provides an overview of the issues and implications arising from the recent external audit report into serious incident management at Southern Health NHS Foundation Trust. The Trust approach to serious incident management is summarised with data provided on number of deaths of Trust service users, number of deaths reported on DATIX incident reporting system and the number of serious incident investigations between 2011 and 2015.

Background

A draft report by independent auditors Mazars, commissioned by NHS England, was recently leaked to the BBC. The report comments on services run by Southern Health NHS Foundation Trust, which covers Hampshire, Dorset, Oxfordshire, Wiltshire and Buckinghamshire. The leaked report, published in December 2015, found failings in the way the Trust investigated serious incidents. The review was commissioned by former NHS England Chief Executive, Sir David Nicholson, after the preventable death of one of the Trust's patients, Connor Sparrowhawk, in 2013.

From April 2011 to March 2015, there were 10,306 deaths of people under the care of Southern Health (or its predecessor for services it subsequently acquired). This includes 1,454 unexpected deaths. The report found that:

- too few deaths were investigated and some should have been investigated further (272 treated as critical incidents, 195 investigated, treated as a serious incident and STEIS reported);
- the deaths most likely to be investigated were adults with mental health (30% were investigated, down to 1% for those with learning disabilities and 0.3% for over 65s);
- the Trust could not demonstrate a comprehensive systematic approach to learning from deaths despite having comprehensive data, which it failed to use effectively;
- investigations were of poor quality and often extremely late, with two-thirds not involving families with the report citing failure of leadership; and
- the coroner was critical of reports.

Outcome

On 12 January 2016, Monitor announced that Southern Health NHS Foundation Trust would receive expert support to improve the way it investigates and reports deaths, particularly among people with a learning disability and/or those who are experiencing mental illness. A key area of concern for Monitor was that, when investigating, Southern Health also failed to engage properly with families. .

Monitor has taken regulatory action and agreed a number of steps with Southern Health to ensure these issues are addressed as quickly as possible. Southern Health has agreed to implement the recommendations of Mazars' report, and to get expert assurance on how well it plans and carries out those improvements. Monitor has appointed an Improvement

Director for the trust, who will use their expertise to support and challenge the trust as it fixes its problems.

Monitor will also work closely with the Care Quality Commission to assess how deaths among people with a learning disability and/or mental illness are investigated and what further action is needed across the NHS and by the trust.

Implications

There has been and still is understandable media interest and the Trust, along with other Trusts, has received a Freedom of Information request on the subject from the BBC.

From June 2016, Jeremy Hunt, Secretary of State for Health, has committed to publishing Ofsted style ratings of the quality of care offered to people with learning disabilities by clinical commissioning group. This will also require NHS Trusts to publish the number of avoidable deaths. In addition, NHS England has commissioned the University of Bristol to undertaken an independent study of mortality rates of people with learning disabilities in NHS care.

Trust position

The main concerns highlighted in the report were in relation to the threshold for investigating deaths, the quality of the serious incident investigation reports, the lack of evidence that any lessons were learned following incidents and failure by the Trust to engage with the families of those who had died.

Table 1 provides the total number of deaths of Trust service users recorded on the Trust's clinical information system between 2011 and 2015. As would be expected, the vast majority are in older person's services and Barnsley Community services.

Table 1 Deaths of service users between 2011 and 2015

	Financial Year				
SERVICE	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**Total**
Child & Adolescent Mental Health Services				1	1
Forensics		1			1
Learning Disabilities	18	23	17	21	79
Low Secure Services	1				1
Non Mental Health Services	1	7	13	13	34
Older People Services	826	802	894	847	3369
Working Age Adults	66	78	82	97	323
Barnsley Community			1668	1887	3555
Grand Total	912	911	2674	2866	7363

The Trust has a comprehensive policy on the reporting and investigation of incidents; *Incident reporting and Management Procedures (including serious incidents).* The Trust's policy supports reporting in line with national reporting guidance from NHS England (Serious Incident Framework and National Reporting and Learning System). Staff are encouraged to report any potential unexpected deaths as incidents. Such deaths are investigated to establish the cause of death. This is followed up with the Coroner's office where necessary.

Most deaths are found to be due to natural causes, or where no issues relating to care delivery are identified. In such cases, the incident is not investigated further. Where the cause of death is not thought to be from natural causes, or where there may have been care delivery issues, further investigation is undertaken.

The Trust has a dedicated team of full-time investigators and part-time medical investigators, all trained in root cause analysis. Where incidents meet the national reporting requirements, incidents are reported to STEIS (Strategic Executive Information System) as Serious Incidents in full accordance with STEIS criteria. Relevant patient safety incidents are reported to the National Reporting and Learning System. All serious incident reports are reviewed internally by senior clinicians, the Medical Director and Director of Nursing before submission to commissioners.

Table 2 provides the number of deaths that were reported as incidents on DATIX between 1 April 2011 and 31 March 2015.

The Trust records 'service users' as anyone in contact with Trust services. This includes people who receive regular care and support and people who are seen intermittently, for example, by care home liaison services or by physiotherapists.

Table 2 Deaths reported on DATIX 2011-2015

Cause of death	**Mental Health and Learning Disability Services**	**General Community Services**
Natural cause or known physical cause	296	50
Unknown cause of death but no indication of suspicious circumstances	15	0
Accidental cause (e.g. RTA)	8	0
Drug or alcohol related death (reported and investigated through multi-agency processes)	26	0
Murder of patient (reported and investigated through multi-agency processes)	3	0
Uncertain cause of death but resulting in serious incident investigation	173	2
Total number of incidents resulting in death	521	52

Of the deaths reported on Datix between 2011 and 2015, 173 from mental health and learning disability services were investigated as serious incidents and two from general community services. Two incidents from learning disability services were reported as serious incidents and 17 from older person's services (Table 2).

The Trust's approach to incident reporting and investigation differs from the description of incident management described in the Southern Health external audit report.

We comply – The Trust fully complies with the requirements of the National Reporting and Learning Service and is fully compliant with chapter 8 of 'Working Together 2010 Learning Lessons from Serious Case Reviews'. This means that the Trust thoroughly embraces the review process and learns from reviews.
We report – The Trust uses Datix to report all incidents and immediately inform a number of people in the Trust depending on grade and type of incident. For example, all incidents of certain types go to specialist advisors (such as safeguarding, information governance, and health and safety) whose role it is to support and challenge teams. Management teams, made up of a general manager, clinical lead and practice governance coach, are always

copied into incidents for their area. Incidents are also reported hierarchically (amber to deputy directors/directors and red to all directors). The use of Datix enables the Trust to identify serious incidents, near misses and hot spots.

We investigate – Datix has a manager's investigation section on the system and all incidents reported are investigated. Green and yellow incidents are investigated by team managers, with amber incidents having a service level investigation (either by the service itself or by requesting another service to investigate). On occasion, these are investigated by the Trust's dedicated investigation team.

We escalate – If the incident meets the NHS England 2015 criteria for a serious incident, it will be reported on the Strategic Team Executive Information System (STEIS). The Trust's dedicated team of investigators set up an investigation meeting, including managers and clinical staff. At this meeting, the timeline is communicated and terms of reference agreed.

We take it seriously – The investigators undertake the investigation and meet with family, where terms of reference are reviewed and sometimes added to. The investigation report is peer reviewed and reviewed by the Assistant Director of Patient Safety and the Associate Medical Director before it is sent to senior managers. A post-investigation meeting takes place where the report and findings are fed back and recommendations agreed. A learning event takes place with the clinical staff and the team involved where the findings are shared and the recommendations are converted to action plans to ensure local ownership. At this point, the report is sent to the Medical Director and Director of Nursing for final approval. Once the report is approved, it is sent to commissioners, who provide feedback within 20 working days.

We communicate and engage – Families are always offered a supported reading of the report, and it is always shared with the Coroner if the incident resulted in death. The Trust reports and provides assurance to external agencies, such as the Counter Fraud and Security Management Service, the police, the Health and Safety Executive, Monitor and local commissioners.

We learn **–** The Trust uses action plans to make sure that findings are acted upon in order to improve services by and prevent recurrence. The Trust also uses data analysis from incidents, complaints and claims to highlight any trends and themes and uncover any further need for intervention. The Trust makes sure that learning is shared appropriately across services, including through lessons learned events, and applies themes learned to safeguarding practice.

We evaluate well – All serious incident reports are thoroughly reviewed then approved at Director-level before submission. Feedback in 2015 from commissioners on the quality of the Trust's serious incident reports showed that 90% of reports were viewed as 'excellent'.

Conclusion

Serious and far reaching concerns were identified in the external audit of incident management in Southern Health NHS Foundation Trust. This has led the Department of Health to commission a national review of incident reporting in mental health and learning disability services in addition to the action taken by Monitor. At the Trust, there is a comprehensive policy on the reporting and investigation of incidents that operates in accordance with national guidance and standards. The Trust will fully comply with the national review findings. In the interim and on an ongoing basis, the Trust will continue to monitor its compliance with national guidance and ensure that the quality of its investigations and serious incident reports remains high.

Trust Board 29 January 2016
Agenda item 7.4(ii)

Title:	**Care Quality Commission inspection preparation plan – update**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	The plan demonstrates the work streams and action plans that are in place to ensure quality improvement and assurance (in preparation for CQC inspection).
Mission/values:	Honest, open and transparent, person first and in the centre, improve and be outstanding, relevant today and ready for tomorrow and families and carers matter.
Any background papers/ previously considered by:	Previous briefings to Trust Board
Executive summary:	**Introduction** The CQC planned inspection of the Trust will take place week commencing 7 March 2016. Although the CQC has conducted on-site inspections in previous occasions, the pending inspection will be the first time the organisation will be examined under a new inspection framework. The new process enables the CQC to gain a broader understanding of the quality of care provided and also evaluates new areas such as governance and leadership. To date, the Trust has received two requests for, and has provided, pre-determined information on the quality of our services. The Trust is proud of the services its delivers and the continual focus on improving the quality of care. Whilst it is important to recognise the need to plan for the CQC inspection, the Trust is clear that the actions it takes are necessary to ensure the quality of care is in line with its values and goals. By continuing the mission to drive quality through continual improvement, the Trust will achieve the necessary regulatory compliance. The Trust is taking these actions as it believes they drive good quality care and are the right things to do, not solely to pass the 'inspection' by the CQC. **Action plan** There are a number of mechanisms currently in place to assure the quality of care. These include high level strategies (with implementation plans), systems and processes to monitor quality improvement and assurance, and structures that facilitate ward-to-board connectivity and meaningful activity to improve, the safety, effectiveness and experience of care The focus of the action plan is to ensure that the application of these mechanisms is consistent and effective across the Trust and to provide support where needed. This approach will require a whole systems approach from all staff and departments (from Board to frontline staff) and will be an additional invaluable opportunity to drive out any variations in clinical practice and (undesired) service standards. A detailed plan was developed and presented to Clinical Governance and

	Clinical Safety Committee on 8 September 2015. A progress update was provided for Trust board in December 2015. The action plan is a live document that is being constantly updated to reflect the actions undertaken and the further action to be carried out prior to the inspection. <u>Update of actions since the December report</u> • There has been a continuous high level risk scanning, gap analysis and action planning by all Trust services. • This has been supported by a continued focus on learning lessons activity. • Workshop events continue focussing on preparing staff for what to expect when the CQC visit. These continue to be well attended. • Continued bespoke support to clinical teams is in place to provide advice, expertise and practical support in their preparations. • The CQC has started to approach and meet with external groups and partners. • Arrangements have been made to visit Rotherham, Doncaster and South Humber NHS Foundation Trust and Bradford District Care NHS Foundation Trust to learn from their recent experience of CQC visits. • The Director of Nursing and Deputy Director of Nursing have established a weekly meeting with Deputy District Directors/District Directors. • A routine review of BDU governance groups has commenced, which will support preparation. • The Trust's opening presentation is under development. • The Trust has provided an updated copy of the organisational risk register. The Chief Executive and Director of Nursing held a pre-inspection meeting with the CQC Lead Inspector on 18 January 2016. The inspection will be chaired by former consultant psychiatrist, Dr Paul Lelliott, who is the CQC's Deputy Chief Inspector of Hospitals (mental health). The inspection lead will be Jenny Wilkes, Head of Hospital Inspection (mental health). In advance of the inspection, the CQC will ask a range of stakeholders for feedback about the Trust and its services. During the week itself, the inspection team will visit: - all mental health wards; - a third of mental health community teams; and - a good cross-section of general community services. The inspectors will be looking for clinical care to carry on as normally as possible. The inspectors do, however, appreciate the extra burden on services that will be caused by them being here. As a result, they expect that the Trust will have additional staff on duty to accommodate their visit. Following the inspection, the Trust expects to receive the CQC's draft reports in May 2016. The Trust will be able to comment on them for factual accuracy before they are published in June 2016. A Quality Summit event will then be held over the summer. In the next few weeks, the Trust expects to:

	- receive information on which teams will be included in the inspection visit. - prepare bespoke packages of support for the team managers of these teams; - receive an itinerary detailing the people/groups of staff the CQC wishes to speak to during the visit; and - receive the third data information request.
Recommendation:	**Trust Board is asked to NOTE the update report.**

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 January 2016
Agenda item 7.4(iii)

Title:	**Governance arrangements – arm's length organisations**
Paper prepared by:	Director of Corporate Development
Purpose:	To ensure the Trust is appraised of the governance arrangements in place for Altogether Better and Creative Minds.
Mission/values:	The development of models to deliver alternative capacity supports the Trust's mission to enable people to reach their potential and live well in their community and, in doing so, embodies the Trust's values.
Any background papers/ previously considered by:	Altogether Better transfer agreement and Audit Committee briefing paper
Executive summary:	Altogether Better (AB) joined the Trust in 2012 following the dissolution of its previous host organisation, NHS Yorkshire and the Humber. This move was brought about as a result of the shared values and synergy between the Trust and AB and the potential for working together on areas of shared interest, learning and mutual benefit. This paper provides an update on progress of AB since joining the Trust and clarifies the operational governance arrangements in place. Additionally, this paper provides assurance that there are no legal, financial or compliance issues for the Trust and that, although pursuing its own strategic vision and opportunities, AB works within the Trust's protocols and procedures. Since its launch in November 2011, Creative Minds has delivered more than 150 creative projects in partnership with over 50 community organisations. This has benefited over 4,000 people. Creative Minds uses creative approaches and activities in healthcare to increase self-esteem, provide a sense of purpose, develop social skills, help community integration and improve quality of life. The Trust develops community partnerships to not only co-fund but also co-deliver projects for local people. This paper provides an update on the governance arrangements in place to support the on-going development of Creative Minds.
Recommendation:	**Trust is asked to NOTE the report, which reflects the Trusts development of alternative capacity models as reflected within the its five-year plan.**
Private session:	Not applicable

Trust Board 29 January 2016
Governance arrangements for arm's length organisations

Introduction

The purpose of this paper is to provide an overview of the governance arrangement for arm's length organisations hosted by the Trust's Corporate Development Directorate. It provides clarification for Trust Board of the operational and governance mechanisms in place to ensure the reputation and interests of all parties are protected, and contributing to the Trust's five-year plan.

Altogether Better

Altogether Better (AB), a national network programme (then hosted by NHS Yorkshire & Humber), and the Trust entered into a Business Transfer Agreement in 2012 following an extensive due diligence process. The rationale for the transfer was that it would provide benefits for both AB and the Trust. For AB, the move provided the environment and conditions necessary to achieve its objectives and continue to flourish and innovate following the dissolution of NHS Yorkshire and the Humber. For the Trust, the hosting arrangement offered an opportunity to support a growing organisation with aligned values and purpose and offered potential opportunities for learning, collaboration and accessing extended markets as a result of AB's national reach. Additionally, it was anticipated that AB would bring a new dimension to the Trust's culture and approach to working with citizens. Much of AB's work has been developed within the South West Yorkshire health economy and, as such, is beneficial to the population the Trust serves.

AB transferred to the Trust with a portfolio of grants, commissioned contracts and income generation business, a staff team aligned to contract delivery and with a cash reserve to cover any potential liabilities, such as redundancy.

Operational Position Statement

Since the transfer completed in 2012, AB has continued to grow and flourish. It successfully completed the grant/contract delivery that transferred to the Trust, including a £2.7 million Big Lottery Funded programme across seven localities around the country (of which two areas of work were sub-contracted to the Trust at a contractual value of £400,000), and has in the last three years reached new commissioners and funders as a result of the development and high profile of its 'Community Centred Practice' model which has now reached over 60 GP practices in sixteen CCG areas.

Governance Arrangements

Two groups hold strategic and operational oversight of AB's work.

<u>Thought Leadership Group (TLG)</u>

This group provides a space for horizon scanning and strategic thinking and includes both the Trust's Chief Executive and Director of Corporate Development as members as well as senior and influential experts from the private, voluntary and statutory sectors who are interested in supporting AB's development and strengthen AB's innovation.

Operational Governance Group

As the name suggests, this group is the route through which AB is held accountable to the Trust and membership and includes the Trust's Chief Executive and Director of Corporate Development as well as a representative from the Thought Leadership Group, who chairs the group. Charlotte Dyson, Non-Executive Director, will also be joining the Operational Governance Group and will be another champion for AB within the Trust.

Terms of Reference have been approved for both the above groups and in addition a 'separation agreement' has been signed off which outlines the steps that would be taken in in the event of changes to, or termination of, the current hosting arrangement. This is in place in order to protect the mutual interests of both organisations and any potential redundancy costs would be covered by AB reserves.

Staffing

Following the end of staff contracts linked to the Big Lottery Funded programme in July 2015, the staff team has now reduced and AB has developed an associate framework in order to minimise staffing costs but maximise the calibre and quality of expertise it is able to draw on to deliver specialist areas of work, including organisation development, whole systems change and training development and delivery. Through this cost-effective mechanism, AB is working with several trusted partners that have a deep understanding of the work.

AB has greatly valued the support and technical expertise offered by the Trust's HR directorate, especially during the past twelve months when a consultation was undertaken with staff members at risk of redundancy. Similarly, the Trust's Procurement Team has offered expertise and support with developing the associate framework.

Finance

AB has continued to build its reserves as a result of consultancy work and income generation and the current end-of-year forecast position is a reserves level of c. £528,000 plus a further £63,000 remaining in the 'redundancy pot' that transferred into the Trust in 2012. There is an agreement in place for this reserve to be carried over financial years in order to safeguard AB's independent financial position.

A three to five-year income and expenditure forward plan is currently being developed for the Operational Governance Group based on known and projected costs. Given the significant reserves, however, there are currently no identified financial risks for the Trust and AB's financial position remains secure for a minimum of three years.

AB pays the Trust for financial support to AB and there is an excellent working relationship with the finance team.

Summary

Altogether Better and the Trust have developed a robust and mutually beneficial relationship since the business transfer was completed in 2012. AB benefits from the infrastructure, expertise, reputation and shared values of the Trust. In return, return the Trust has benefited from business opportunities, (for example, receiving £400,000 Big Lottery Funding) and association with AB at a national level. Additionally, the Trust has acknowledged the different way of working that AB brings, with an adaptive/innovative approach that colleagues within the Trust can draw on.

As a result of the current arrangements AB has been able to continue to develop its entrepreneurial approach and has been successful in securing income through grants, contracts and consultancy work, ensuring the ability to fully self-fund. This entrepreneurial approach, combined with AB's national reputation for innovation and impactful work and AB's ability to meet its own liabilities, has resulted in a continued commitment from the Trust's Executive Management Team to support AB's position within the Trust and to acknowledge this successful partnership within the Trust's five-year plan.

Creative Minds

Since its launch in November 2011, Creative Minds has delivered more than 150 creative projects in partnership with over 50 community organisations. This has benefited over 4,000 people. Creative Minds is all about the use of creative approaches and activities in healthcare, increasing self-esteem, providing a sense of purpose, developing social skills, helping community integration and improving quality of life. Creative Minds develops community partnerships to not only co-fund but also co-deliver projects for local people.

Creative Minds has an established governance group, membership of which includes creative partners, the Chief Executive, Deputy Chief Executive, Director of Corporate Development and a Non-Executive Director of the Trust. The governance arrangements ensure alignment of the Creative Minds Strategy with the five-year plan of the organisation, early identification of potential risks and production of action plans as applicable.

Creative Minds has been established as a designated fund within the Trust's charitable trust, which provides for a more flexible approach to financial management and, as a charity, allows access to a wider range of potential income streams, such as grants and Arts Council funding. The governance of the charitable funds is through the Trust's Charitable Funds Committee, with Trust Board being the Charitable Trustee.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board – 29 January 2016
Agenda item 8.1

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 January 2015. 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 against best practice. At the request of Trust Board, the Strategy also includes a statement regarding Trust Board's approach to risk. Other changes include: ➢ an update of the current control systems to reflect current practice (section 6); ➢ clarity on the 'duties' in relation to the policy (section 7); ➢ measuring compliance with the Strategy, which has been updated (appendix 1) and an updated implementation plan at appendix 6; ➢ Directors' responsibilities at appendix 5, which have been updated to reflect current portfolios.
Recommendation:	**Trust Board is asked to APPROVE the revised Risk Management Strategy.**
Private session:	Not applicable

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 V6 issued January 2015
Revised date:	**Revised January 2016**
Next review:	**January 2017**
Approved by:	Trust Board 20 December 2011 Trust Board 30 October 2012 Trust Board 17 December 2013 Trust Board 27January 2015 Trust Board 29 January 2016
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

RISK MANAGEMENT STRATEGY

1. Introduction

The Trust is committed to ensuring the safety of the people who use its services, its staff and the public through an integrated approach to managing risk regardless of whether the risk is strategic, clinical, financial or commercial or relates to compliance. The Trust recognises the importance of effective integrated risk management arrangements to underpin the safe and effective delivery of its services, its reputation and its organisational viability and sustainability. As a foundation trust, the Trust must have the 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.

2. 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. Definition of risk and risk exposure

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 provides 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;
- make sound decisions based on information and intelligence; and
- minimise the likelihood or impact of potential risks.

Trust Board takes a prudent and pragmatic attitude to risk, adopting a flexible approach and the determination of its response as the need arises. Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and determines its approach and its appetite for risk to suit the circumstances at the time.

Risks can be broadly defined as follows.

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 risks 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, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.

4. 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 as close to the user of Trust services as possible;
- 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. 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. 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 is in place 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.

The agenda and focus of Trust Board meetings is continuously reviewed to ensure attention is given to both strategy and implementation. Each quarter, there is a business and risk meeting, which is forward looking and risk-based, a performance and monitoring 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**:

- Audit Committee;
- Clinical Governance and Clinical Safety Committee;
- Mental Health Act Committee; and
- Remuneration and Terms of Service Committee.

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 through Non-Executive and Executive Directors. The Director of Corporate Development attends all committees (with the exception of the Remuneration and Terms of Service Committee) in her capacity as Company Secretary 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 the guiding principles set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty Standards.

The **Remuneration and Terms of Service Committee** has delegated authority 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 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.

Trust Board has also established three time-limited Board-level groups, which focus on the development and implementation of the Trust's estates and information and management technology strategies, and embeds diversity and inclusion in everything it does to provide assurance to Trust Board. Each is 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. The Members' Council primary duty is 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 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** (EMT). The EMT is made up of Executive and Operational Directors and is responsible for ensuring implementation of the strategy agreed by Trust Board. To ensure alignment with Trust Board meetings, EMT meetings are organised into forward-looking, externally-focused meetings (with a focus on transformation, risk and future vision with overarching scrutiny of the implementation of the transformation programme) 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 EMT 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 EMT also reviews the strategic position of the Trust and any potential threats to income or achievement of its plans.

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 deputy directors and clinical, general management and practice governance leads from Business Delivery Units. The Extended EMT provides a focus 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 continues 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 within geographical or specialist service areas, within a framework of devolved responsibility to ensure effective delivery of the Trust Plan and providing an effective performance framework for delivery.

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 EMT 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.

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

The role of the **Quality Academy** is to:

1. combine the work of the voting executive directors, including corporate development, communications and engagement, and health intelligence and innovation;
2. ensure key linkages and synergies between all portfolios to provide optimal support to delivery of services in BDUs;
3. ensure ongoing quality improvement and associated compliance with regulatory requirements; and
4. ensure 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. Executive Directors establish TAGs to support them to discharge their accountability.

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 and Medical Director.

The Trust has a dedicated **Contracting Team** to manage the relationship with commissioners ensuring there are sound systems in place to respond 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 EMT meetings where appropriate action is agreed.

Effective management of the Trust's relationships with commissioners is reviewed by the EMT 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 responsible for the identification, assessment and management of risk within their own area of responsibility. **Trust Board**, as a whole, provides leadership of the organisation within a framework of prudent and effective controls that enable risk to be assessed and managed. Trust Board is required to approve an annual self-certification confirming that risk management systems are effective and fit for purpose.

The **Chief Executive** has overall responsibility for risk management across the Trust and delegates general risk management responsibilities to all Executive and Operational Directors. Individual directors have lead responsibility for specific areas of risk management, which are detailed in appendix 5.

Managers are responsible for the management of day-to-day risks of all types within their remit and budget allocation. They are charged with ensuring that risk assessments are undertaken within their own service area on a proactive basis, ensuring risks identified are appropriately managed and controlled, and that risks which cannot be controlled or

prevented are recorded on the appropriate risk register at the appropriate level. Individual managers should:

- ensure adherence to Trust policies and procedures to support effective risk management;
- raise staff awareness of the key objectives in the risk management strategy;
- foster a supportive environment to facilitate the reporting of risks and incidents;
- manage clinical and non-clinical risks in their area, including risks to the Trust's reputation;
- manage communications, including adherence to Trust policy;
- ensure staff are aware (including sub-contractors) of risks in the working environment;
- ensure staff training needs are identified and addressed;
- ensure adherence to standing orders, 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 (such as, 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 requirement to report risks and how this is done within the Trust;
- 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 integral to good management practice and is 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 used by Trust Board 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 risks to the achievement of the Trust's objectives, ensure mitigating action is in place and prioritise 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.

As part of its **Licence** (issued by Monitor), the Trust is required to have a Constitution in place, 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.

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 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 risk 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 **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, the Medical Director and the Director of Human Resources, each cost improvement is subject to a **Quality Impact 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 the requisite skills are in place to identify and manage risks.

A risk management process based on the Australian/New Zealand Standard (appendix 2) 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 planned for the year ahead, offer opportunities to develop services but expose the organisation to a degree of risk. The Trust continues 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 themes across the organisation and risk areas, such as information governance, or 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 be 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 at Appendix 1.

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 8.

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 that 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	Presented to the 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	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	Annual work programme	Director of Finance	Presentation of reports to the Audit Committee. Head of Internal Audit Opinion

Risk process	Purpose	Frequency	Lead	Outcome
	internal controls are robust, appropriate and fit for purpose. The programme forms the basis of the Head of Internal Audit Opinion and the Accounting Officer's Annual Governance Statement.			forms a key part of the Trust's annual reporting statements. Supported by independent review of Trust annual report, accounts and Quality Accounts.
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 reflect its appetite for risk and 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 to ensure the Trust 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.

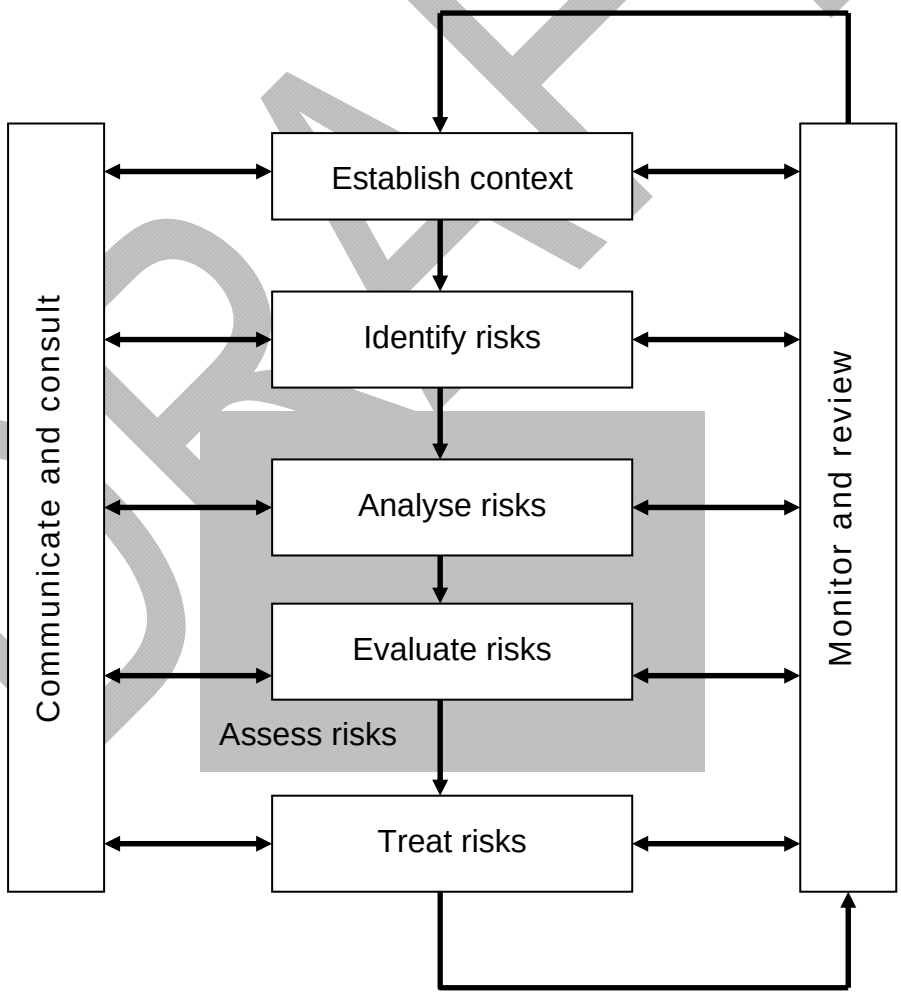
Appendix 2

Risk management process

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 supports the use of professional judgement and decision-making. The Trust seeks 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 recognises 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.

The risk management process is a continuous process to ensure the Trust works within its legal and regulatory framework, identifying and assessing possible risks facing the organisation, and identifying mitigating action to reduce and minimise risk to people who use its services, its staff, the public and the organisation. It covers the following five steps.



Risk Management Overview

Step 1: 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 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, the Datix system, which provides information about adverse events and complaints, and general risks identified by staff through environmental scanning of their work areas. Analysis of media coverage provides information about risks to the Trust's public reputation.

Step 2: 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 3: 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. For 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.
- Reversibility or otherwise of the risk.
- Quality or reliability of evidence surrounding the risk.
- Impact on the organisation, stakeholders of partners.
- Impact on the Trust'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 4: 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.

1. **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.

2. **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.

3. **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.

4. **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.

5. **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.

6. **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 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 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 EMT 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 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 risk register, 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 EMT. 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 registers 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 risk register and the risk grading matrix applied in the Trust are included in appendices 3 and 4 and in the document 'Risk Management Procedure'.

Step 5: Monitoring and review
Risk management systems are scrutinised by the Audit Committee, supported by internal audit and external audit, and the overall management of risk is monitored by 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 Trust 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 identified and documented and the underlying reasons for them understood and addressed.

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

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

Risk Management Database and Incident Reporting System
The Trust uses 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.

A project to develop and implement the Datix risk module across the Trust to enable it to manage the identification of risk and risk registers at all levels of the organisation has been completed. Ongoing work 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 3

	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 4

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 5

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 Business Plan.
Deputy Chief Executive	Executive Director with overall responsibility for coordination of the transformation programme to re-design services. Responsibility for performance management and information management and technology, including implementation of RiO, and information governance. Also holds director lead for business and commercial 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.
Director of Finance	Executive Director with accountability for strategic financial planning and management, demonstrating probity, including counter fraud, and value for money.
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, 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.
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	Deputy Chief Executive
Whistleblowing (Non-Exec)	Deputy Chair/Senior Independent Director

Appendix 6

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 to develop 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 Deputy Chief Executive with 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 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 2016	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 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 2016 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. Chair's quarterly reviews with Non-Executive Directors. Chief Executive's quarterly reviews with Directors.	During 2016 April 2016 Quarterly Quarterly	Chair/CE led SID with Members' Council Chair Chief Executive	None None None None

Action required	Action plan	Review date	Lead	Training implications
	Assessment of skills and experience of Trust Board to ensure remains fit for purpose as a Foundation Trust Board.	As part of role of Nominations Committee	Chair	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 2016 January/February 2016 On joining Ongoing	Chair Chair Chair Chair	Access to NHS Providers GovernWell training modules and other training (both internal and external) as appropriate
Assurance provided by Committees specifically reported to Trust Board	Chairs of committees provide specific assurance to each Board meeting 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 2016	Chair of Audit Committee, Chief Executive and Director of Corporate Development	
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.	During 2016	Chief Executive, Deputy Chief Executive and Director of Corporate Development	
	Review Standing Orders, Standing Financial Instructions and Scheme of Delegation.	April 2016	Chief Executive, Director of Corporate Development and Director of Finance Audit Committee and Trust Board	

Action required	Action plan	Review date	Lead	Training implications
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 to be developed for Trust Board, Extended EMT and risk co-ordinators.	January 2016 March 2016 During 2016	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	February 2016	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 requirements in relation to non-clinical records.	Complete work to update the document store.	By March 2016	Director of Corporate Development	Training relevant to roll out of individual policies as and when they are revised.

Appendix 7

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 8

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 EMT, 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 Trust Board and 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 EMT, is responsible for monitoring compliance by the Extended EMT.

An e-learning package will be developed by during 2016, 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 9

Checklist for review and approval

Date: 22 December 2015

	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 document?	YES	
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	N/A	

	Risk Management Strategy	Yes/No/ Unsure	Comments
	Resources/staff side committee (or equivalent) approved the document?		
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**		
	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	

Appendix 10

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
7	January 2016	Integrated Governance Manager	Final	Annual review approved by Trust Board

Appendix 10

Equality Impact Assessment Tool

Date of Assessment: 22 December 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, staff and members of the public 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:** 29 January 2016 **Title:** Director of Corporate Development

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board – 29 January 2016
Agenda item 8.2

Title:	**Customer Services Policy: management of complaints, concerns, comments and compliments**
Paper prepared by:	Director of Corporate Development
Purpose:	For Trust Board to note that the policy that provides the framework for responding to enquiries and learning lessons from feedback through complaints, concerns, comments and compliments has been reviewed and updated taking account of the information shown in the executive summary below.
Mission/values:	The Customer Services Policy links to all the Trust's values in supporting an improved service user experience through being open honest and transparent, respectful, putting the person first and in the centre, to improve and be outstanding, be relevant today and ready for tomorrow and demonstrating that families and carers matter.
Any background papers/ previously considered by:	None
Executive summary:	The Trust has an established Customer Services function, which works across all BDUs in supporting a response to all enquiries. This includes a response to issues raised under the NHS Complaints procedures. The policy provides the framework for responding to these enquiries and takes account of relevant legislation and best practice, most recently: ➢ CQC essential standards in relation to receiving and acting on complaints; ➢ House of Commons Health Committee report – Complaints and Raising Concerns; ➢ The Care Quality Commission report – Complaints Matter; ➢ The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch joint report – My Expectations (for raising concerns and complaints). Procedures in relation to the management of complaints have been reinforced in light of the above. Enhanced reporting has recently been introduced (weekly position statement to BDU service lines) to support effective resolution of issues and learning from feedback. Alerts have also been added to ensure any professional issues are highlighted to medical and nursing specialists to support an effective response in BDUs.
Recommendation:	**Trust Board is asked to APPROVE the Customer Service policy updated as outlined above**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Document name:	Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
Document type:	Policy and Procedure
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:	January 2016
Next review:	January 2017
Approved by:	Trust Board – 29 January 2016
Developed by:	Deputy Director of Corporate Development
Director leads:	Director of Corporate Development
Contact for advice:	Customer Services customer.services@swyt.nhs.uk 01924 327574

Policy Statement

The Trust's Customer Services function exists to facilitate a response to all enquiries, and to deal appropriately with feedback. The service operates as a single gateway for raising issues and enquiries, including requests under the Freedom of Information Act. This policy primarily covers feedback about Trust services and the management of complaints, concerns, comments and compliments.

To enable the Trust to provide a responsive, quality public service it is essential to actively seek the views of those people who use our services and to respond appropriately when things go wrong. Complaints handling is a good proxy for an open, transparent and learning culture – which must be evident in a well-led organisation.

The Customer Services policy incorporates the obligations in the NHS Constitution and the Health and Social Care Act. This current version responds to a number of key reports which follow on from the inquiry into Mid Staffordshire NHS FT, the Clwyd-Hart review into NHS complaints systems and the Government's response to both, 'Hard Truths'. These are:

- House of Commons Health Committee report – Complaints and Raising Concerns
- The Care Quality Commission report – Complaints Matter
- The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England's joint report – My Expectations (for raising concerns and complaints).

Experience demonstrates that the insight gained from listening to people who use services, and their relatives and carers, promptly and openly, will add considerable value to the quality of care provided. Ensuring that people have opportunity, and find it easy, to feedback their views and experiences of care is essential to delivering the Trust values and is part of how we ensure people have a say in public services.

Dealing with feedback in a transparent and responsive way demonstrates a commitment to improving people's experience of services and to ensuring they get the best possible support. This is built on the duty of candour, mutual respect, effective engagement, excellent customer service and a necessary and proportionate response to issues.

Complaints matter because every concern or complaint is an opportunity to improve and well-handled complaints will improve the quality of care for other people. Failure to deal with complaints appropriately presents a risk to the organisation – an adverse effect on the Trust's public reputation either directly through people's own experience, or as a result of missed opportunities to improve services as a consequence of feedback.

The Care Quality Commission's (CQC) expectations mirror the Trust's high standards in terms of listening to and acting on people's concerns. The CQCs makes complaints central to its inspection regime and will include a lead inspector for complaints (and staff concerns) in large inspection teams. The CQC use the 'My

Expectations' outcomes framework in inspections. This is a five-step framework developed by people who use NHS and social care services and describes what a good complaints handling service experience should look like (more information below).

The CQC use feedback on complaints handling to inform Intelligent Monitoring reports.

Introduction

People who use Trust services have a right to have their views heard and acted upon.

The Trust has given a commitment through its mission and values to put the person first and centre and to be honest, open and transparent in all its dealings.

NHS complaints legislation (DOH, 2009) requires a single approach for the handling of complaints across health and social care. The Trust has adopted a person centred approach to ensure that issues are dealt with in a way that people are empowered and able to make choices about how their concerns are dealt with. This approach has been further strengthened through the Trust's response to the Francis report and to subsequent reviews arising from Francis recommendations. The recent report 'My Expectations' sets out a framework to support a positive experience for people raising concerns and complaints. The framework sets out best practice in five steps which is reflected in this policy:

- Considering a complaint – ensuring people are given information about how to complain, that they will be supported to do so and care will not be compromised.
- Making a complaint – ensuring all staff can help, and that making a complaint is easy and convenient.
- Staying informed – keeping people up to date and making the response personal.
- Receiving outcomes – resolving complaints and achieving the appropriate outcome.
- Reflecting on the experience – ensuing complaints are handled fairly and consistently and people understand how their feedback has helped to improve services.

Every member of staff is responsible for supporting people who wish to provide feedback or raise concerns. Staff will be alerted to customer services processes at induction and through promotional activity with services and teams, supported by publicity material and web based information. All staff should be able to advise service users, carers, relatives and visitors to the Trust on how to access the customer services process, including how to make a complaint. Staff assigned to investigate complaints should be appropriately trained and supported to take action as appropriate in accordance with Trust policy and procedures and in highlighting necessary learning.

The Trust's Customer Services function will provide a comprehensive service incorporating complaints, concerns, comments and compliments (the 4C's). The

team will support service users, and others raising issues, regardless of whether feedback is handled as a complaint, concern, comment or compliment. Business Delivery Units (BDUs) will ensure that the insight gained is acted upon to improve, plan, develop and evaluate service delivery.

The Customer Services function exists to ensure this ethos is adhered to, and to contribute to improved service delivery through supporting prompt resolution of issues and providing insight into service user experience. The function provides a single gateway for enquiries about the Trust and its services, and to signpost to other sources of support, information and advice.

Customer Services will ensure that:

- Staff have access to relevant information to support service users, their relatives and carers in giving feedback. This will be achieved via access to this policy, leaflets/posters displayed in Trust facilities and via information accessible on the Trust's internet and intranet sites.
- Insight gained as a result of complaints, concerns, comments and compliments, and other forms of feedback, is provided to BDUs in a timely manner to support its use to improve the care provided to service users and carers.
- Investigation of complaints and concerns is performed in a thorough and timely manner, facilitating resolution in an open and conciliatory way.
- People who make complaints are treated fairly.
- Information gained through feedback forms an essential element of the Trust's approach to Governance.

The Trust takes all service user feedback seriously. Every effort must be made by staff to act on feedback at the time wherever possible and to try to resolve concerns promptly and locally. Service users must feel confident that any member of staff can help with their concerns. Care must be taken to ensure that no clinical details are disclosed without the written permission of the service user.

The Trust will assure service users that they will continue to be treated according to their clinical needs, and care will not be compromised as a consequence of their feedback. Equally, relatives / carers will not be treated differently should they raise concerns. This assurance is included in Customer Services promotional literature, including leaflets, and outlined in acknowledgement letters for all complaints. Customer Services support will be offered to complainants who may be concerned that discrimination may occur and any reports of discrimination will be reported to the Customer Services Manager for investigation and corrective action. All concerns regarding actual or potential discrimination will be recorded by Customer Services on Datix web and included in the weekly reporting to BDUs and the quarterly report to Trust Board.

The Trust will ensure the response to complaints and concerns is fair and equitable to both the complainant and the staff involved.

What is feedback?

For the purposes of this policy, feedback is defined across four categories:

Compliments
Positive feedback received regarding care received by service users, their relatives and carers.

Comments
Comments may be made either verbally or in writing to any member of staff within the Trust.

Concerns
An issue raised in writing, or verbally, to any member of Trust staff, identifying issues about a service or proposing ways to improve services for the people who use them, their relatives or carers.

Complaints
The NHS complaints regulations define a complaint as an expression of dissatisfaction with care, services or facilities provided by the Trust, where any of the following apply:

- Action by the Trust or someone working for the Trust has detrimentally affected the experience of the service user or carer
- The complainant believes that a mistake or error occurred and that this has detrimentally affected them
- The complainant brings to the attention of the Trust an issue about a Trust service which could detrimentally affect them or someone else which they expect the Trust to put right.

Other forms of feedback

A range of approaches are in place across the Trust to obtain feedback from people who use our services, which, taken together, provide a framework for gathering insight into service user experience.

The framework includes real time feedback, surveys, focus groups, workshops and events, and participation in National Patient Surveys as prescribed by the Department of Health.

Who can give feedback?

Any individual can give feedback to any Trust employee or to Customer Services. Feedback is most commonly received from service users, those affected by service provision, those acting as a representative of a service user, carers, relatives, MPs, councillors, advocates and Healthwatch.

Process for receiving feedback

The Trust promotes ways to offer feedback through:

- Leaflets and posters distributed to all areas of the Trust indicating the various ways to contact the Trust.
- Members of staff and volunteers - staff are encouraged and expected to discuss any comment, concern or complaint raised and facilitate immediate action and fast resolution of any problems. In the event that the staff member cannot resolve issues immediately, or answer questions, the member of staff

and the person giving feedback should jointly decide to either involve a more senior member of staff or refer the matter to Customer Services.

- Web based information – including a link to raise an issue or contact Customer Services. Service user feedback sent electronically is received by Customer Services and will be actioned proportionate to the nature of the feedback
- The Customer Services function – contact can be made with Customer Services by telephone, fax, e-mail, text, referral by a member of staff, or in person by appointment.
- The Trust's corporate social media accounts (Facebook and Twitter) and external websites (for example Patient Opinion) are monitored to ensure feedback is captured and responded to.
- In writing to the relevant ward or department - compliments, comments and concerns received at service level will be responded to by the manager or service lead, using the most appropriate method. Feedback / action will be shared with Customer Services.
- In writing to the Chief Executive – correspondence will be forwarded to Customer Services and processed in accordance with this policy.

Process for Handling Feedback

Compliments

- Compliments can be provided to any member of staff by any member of the public, other members of staff or partner organisations. If a compliment is provided in writing to the relevant ward/department, the manager will respond either by telephone or in writing.
- Thank you letters/cards received by the Chief Executive will be responded to in writing if the author provides contact details. A copy will be forwarded to the appropriate department, ward, manager or staff member with a covering note from the Chief Executive.
- Each BDU is responsible for ensuring all compliments are logged and that logs are submitted to Customer Services on a monthly basis.

Comments

- Comments can be made in person, in writing, electronically or by telephone.
- All comments submitted by post are received by Customer Services, who will refer to the appropriate department, ward or service manager, or progress using the complaints process if relevant.
- Each BDU is responsible for ensuring comments received are reviewed and actioned appropriately, including responding to the person offering the comment.
- BDUs must ensure that service areas log all comments received and that logs are submitted to Customer Services on a monthly basis.

Concerns and Complaints
Verbal

- Services should ensure that service users and carers know how to give feedback or raise concerns and that feedback in all its forms is welcome.

- Response to concerns and complaints should be *on the spot* wherever possible and a concern report form completed.
- If it is not possible to resolve the concern or complaint straight away, assistance should be sought from line management. If the concern or complaint is raised verbally, and can be resolved within one working day, the response does not need to be in writing. The issue should be documented using the concern reporting form.
- Customer Services will offer assistance as required. The Customer Services Manager will triage issues raised and assign to a customer services officer, who will liaise with the person, explain the process, act as a point of contact, and agree how the issue will be dealt with, and within what timeframe.

In Writing

All written concerns and complaints will be triage assessed by the Customer Services Manager and assigned to a customer services officer, who will work with the person raising the issue to determine a handling plan. Any plan will respond to individual needs and preferences.

The complainant will be offered the choice of the complaint being dealt with through a formal route, culminating in a written response, or whether they wish to be supported to resolve the issue directly with the clinical team. Irrespective of the chosen route, written concerns will be investigated, responded to either verbally or in writing and all activity will be recorded on Datix web. If a response is in writing the response should be signed by the Chief Executive.

Written complaints will always require a formal investigation and written response. The NHS Complaint Procedure encompasses complaints made by:

- A person who is in receipt of, or who has received, services from the Trust.
- A person who is affected, or likely to be affected, by an action, omission or decision of the Trust.
- A person who is acting on behalf of a person who has died, is a child, is unable to make the complaint themselves because of physical incapacity, or lack of mental capacity (Mental Capacity Act), or has been requested to act as a service user's representative
- Complaints should be made within twelve months of the incident or becoming aware of the incident that has caused concern. However, this timescale can be extended if the Customer Services Manager is satisfied that there is good reason for any delay and that it is still possible to investigate the complaint effectively.
- When a complaint is made by a representative, the Trust's Customer Services Manager must be satisfied that there are reasonable grounds for a complaint to be made by a third party on behalf of another person. Consent should be obtained from the individual affected.
- All complainants will be informed about the right to access independent complaints advocacy.
- All complainants have the option to apply to the Parliamentary and Health Service Ombudsman, to ask for independent review of their complaint, should they remain dissatisfied following the Trust's management of their complaint.

In keeping with the NHS regulations, the following are **not** covered by the Trust's Customer Services policy:

- Requests for access to records or an amendment to the clinical record (refer to Access to Records procedure).
- Requests for a change to care plan or medication (refer to clinical team).
- Reports of lost or stolen item (refer to clinical team).
- Challenges to policy decisions by the Trust Board (refer to Trust Board chair).
- Complaints made by a member of staff about their employment or about another member of staff. (refer to HR policies).
- Complaints made about volunteer activity (refer to Partnerships Team).
- Complaints about involvement activity (refer to Partnerships Team).
- Complaints made by a GP about a service (refer to appropriate District Director).
- Commissioning decisions (refer to appropriate Clinical Commissioning Group).
- Complaints about services delivered by an independent provider, on behalf of the Trust (the Trust is required to ensure independent providers have their own complaints procedure).
- Complaints about superannuation (refer to payroll/HR department).
- Staff who wish to voice concerns or grievances. These should be raised through appropriate line management processes in line with Human Resources policy.
- Complaints which have already been investigated and concluded using the NHS procedure (refer to the section of this policy covering Parliamentary and Health Service Ombudsman).

The following are not dealt with under the customer services procedure but should be brought to the attention of the Chief Executive's office to ensure a consistent approach.

- Requests for information or to visit a service by an MP, local authority member or Overview and Scrutiny representative.
- Requests for information or to visit a Trust service by Healthwatch.

Duties

The customer services process is supported by:-

The Customer Services Team

The team will ensure processes that support complaints investigation and resolution, for example the complaints toolkit, remain fit for purpose, support staff in the resolution of issues, and service users in an effective complaints management process.

When concerns or complaints are received, the Customer Services Manager will:

- Ensure that the complainant is contacted by an allocated team member to explain the process and discuss the handling of the concern/complaint.
- Ensure the complainant is at the centre of the process, and that a complaint management plan is developed, taking account of the complainant's expectations for resolution and negotiated timescale for investigation.
- Alert the Deputy Director of Corporate Development to serious complaints at the time of initial assessment, for escalation as appropriate to BDUs and the Executive Management Team for consideration for risk registers.

- Ensure written acknowledgement is sent to the complainant within 3 working days.
- Ensure the assigned team member liaises with the relevant clinical lead, manager, or other organisations, to facilitate a response within the agreed timescale.
- Ensure the lead investigator keeps Customer Services updated with the progression of the complaint at all times and at least weekly.
- Receive information from the lead investigator to enable a response to be produced for Chief Executive sign-off.

Where more than one organisation (health or social care) is involved, the Customer Services Manager or Deputy Director of Corporate Development will ensure appropriate consent is obtained, and that a lead person is appointed to co-ordinate the investigation and response.

Where complaints received by the Trust relate to another organisation the complaint will be referred on as appropriate, without delay, following receipt of consent from the complainant.

Director of Corporate Development
The Director of Corporate Development is the lead director for customer services, including complaints management. The Director of Corporate Development will ensure appropriate arrangements are in place to respond to issues raised, in ways that support people to live well in their communities, and that maintain and enhance the Trust's reputation for putting people who use services at the heart of service delivery. The Director of Corporate Development will ensure that arrangements exist at senior level to review complaint findings (via weekly reports to BDUs and quarterly reporting to Trust Board) and escalation of particular concerns as they arise.)

The Chief Executive
The Chief Executive (or nominated deputy) will review and sign all final responses to complainants, having received assurances that the response addresses all points raised in the complaint management plan.

District directors / Deputy district directors
District directors and deputies will ensure appropriate systems are in place to respond to feedback, including the appropriate investigation of concerns and complaints and evidence of learning. District directors / deputies will monitor the delivery of action plans and ensure that corrective action is implemented in response to complaints data and trend analysis provided by Customer Services. Deputy directors will ensure opportunities exist for wards and teams to learn lessons from feedback, whether received at BDU level or in another part of the organisation, through review of reports in local governance processes. Deputies should ensure complaints are appropriately reflected in risk registers, with escalation as required. BDUs should seek guidance and support as appropriate from support services and specialist functions.

Managers / service leads
Customer Services staff will advise managers as appropriate when feedback is received. In relation to complaints, managers will be responsible for:

- Carrying out an objective and thorough investigation in accordance with the procedure, either by investigating the issues in person or by appointing a suitably senior and skilled member of staff to conduct the investigation.
- Ensuring all relevant information to respond to a complaint is collated and provided to the lead investigator, who will complete the complaints toolkit.
- Ensuring adherence to agreed timescales in relations to complaints investigation and management.
- Advising the deputy district director about complaints, and reporting assurance to the Business Delivery Unit in respect of, for example, resolution of issues in relation to care and treatment, and remedial action taken as appropriate.

Appropriate practitioners
Appropriate practitioners, as assigned, will support the investigation of complaints about clinical practice in BDUs.

Clinical leads / general managers / practice governance coaches
The 'trios' will review the insight from complaints and ensure an appropriate service response to feedback and appropriate review of feedback and learning through governance processes. This applies to learning within the BDU and the wider Trust.

Medical Director and Director of Nursing, Clinical Governance and Safety
The Medical Director and Director of Nursing, Clinical Governance and Safety are responsible for providing objective clinical advice to support the investigation of complaints, either directly, or through clinical leads and practice governance coaches. The Trust's Medical Director will assign investigators where a complaint relates to medical staff.

The Nursing Directorate will ensure appropriate support where complaints highlight professional issues for nursing or allied health professions.

Specialist advisors
Specialist advisors are responsible for reviewing the insight provided through the management of complaints, concerns, comments and compliments pertinent to their remit.

Complaints Procedure (Local Resolution)

All complaint investigations should follow the pathway for complaint management as set out below.

- Every effort must be made to support people who wish to make a complaint. This could include language support, support in documenting the issues, signposting to advocacy services or providing mediation.
- Written complaints received by the Chief Executive's office will be notified to Customer Services. Written complaints will be stamped indicating the date received. Written complaints received in other Trust locations should be forwarded to Customer Services.

- Complaints will be managed and coordinated by Customer Services in conjunction with the lead investigator. The Customer Services Team will agree the desired outcome with the complainant.
- Complaints that span two or more organisations will be managed and coordinated by the organisation that has the majority of issues, or the highest risk issues. The lead organisation will coordinate a single comprehensive investigation and response to the complainant, in accordance with joint inter agency protocols for dealing with complaints.
- Complaints received electronically will be coordinated by Customer Services. Contact will be made to obtain the complainants official mailing address and telephone number and an explanation provided that, due to issues of confidentially, the final response to the complaint will be sent in hard copy via the postal system.
- All complaints will be coded and logged onto Datix web. Customer Services will maintain up to date Datix web records at all times, recording all activity. Demographic data will also be captured on Datix web, including address and standard equality data.
- All records relating to complaints should be stored confidentially by the Customer Services team, and should be readily accessible via the team if required. No other files relating to complaints should be held by the organisation and complaints correspondence should not be part of the clinical record. Clinical staff must be appraised of actions taken to resolve complaints to promote learning.
- Customer Services will initiate the complaint management plan. This will include contacting the complainant to identify the concerns, resolution expectation and agreed timescale for the investigation.
- If the complainant requires access to medical records/patient information, Customer Services will provide appropriate contact information in accordance with the Data Protection Act / Access to Health Records Act.
- If the complaint includes a request for information under the Freedom of Information (FOI) Act, the request should be referred to the Customer Services Manager or Deputy Director of Corporate Development to action.
- If a complaint makes reference to a claim for compensation, this will not automatically exclude the issues from being investigated through the complaint process. However, the Customer Services Manager must be informed to ensure due consideration and collaboration with the Head of Legal Services. If there is no indication that a complaint investigation will prejudice any legal proceedings, the complaint will be registered through the complaints process.
- Complaints will be acknowledged by letter outlining the agreed complaint management plan. This will be done within three working days. Complaints made by third parties will require written consent from the service user before confidential information is released. However, investigation into the issues can commence pending receipt of consent to ensure a prompt response can be offered when appropriate.
- The Customer Services Coordinator will record the progress of the complaint investigation onto Datix web, which will include copies of all correspondence to the complainant, staff, details of telephone calls, face-to-face conversations and electronic correspondence.
- The complaint management plan must be maintained in real time by Customer Services staff.

- All records relating to complaint investigation are confidential and must be kept in one master complaint file separate from any medical records. Care should be taken with accuracy, legibility and language used. In accordance with the Data Protection Act (1998), a complainant has the right to access all correspondence contained within the file.
- All complaint records must be kept by the Trust in a secure environment for 10 years.
- Customer Services must maintain contact with the complainant regarding progress and must renegotiate timescales as necessary.
- Consideration must be given to the following:
    - If a complaint involves clinical issues that require urgent attention or raises issues that could potentially compromise public or service user safety, the appropriate district director should be informed immediately.
    - Complaints that could fall into the Serious Untoward Incident category (SUI) must be referred for advice to the Patient Safety Support Team.
    - Where a complainant indicates they intend to take legal action, the matter should also be referred to the Head of Legal Services. The Trust will take legal advice and in some, but not all, circumstances it may be appropriate to cease action under the complaints procedure. This is consistent with national guidance.
    - Complaints / concerns highlighting professional practice issues should be referred to the medical or nursing directorate as appropriate.
    - Complaints about members of staff that involve accusation of misconduct should be referred to Human Resources. Staff have the right to be dealt with fairly in such cases, and complainants do not have the right to information about specific action taken against staff members.
    - Issues that could potentially attract media attention should be referred to the Communications Team.
    - Issues relating to child protection should be referred to the Trust's Named Nurse for Child Protection, and dealt with under joint agency protocols for child protection.
    - Issues relating to Vulnerable Adults should be referred to the Trust's Vulnerable Adults Specialist Advisor, and dealt with under joint agency protocols for vulnerable adults.
    - Where a complaint alleges a criminal offence, the complainant will be advised of their right to report the matter to the police, and will be supported to do so. If the complainant chooses not to report a serious matter which may be criminal, the Trust may choose to notify the police. Advice should be sought from the Caldicott Guardian where such action might be in breach of a person's confidentiality.
    - Investigators should always alert Customer Services at an early stage if a complaint is proving particularly complex or difficult to resolve. Revising the approach may prevent a complaint escalating to Ombudsman Review.

Effective inter team working between Customer Services, Patient Safety Support Team and Legal Services must be established to ensure a consistent approach and to avoid duplication and confusion for the complainant.

A conciliatory approach to issues resolution should be adopted; supported by full information to the complainant about the process and appropriate contact and updates.

Investigation must be proportionate to the level and complexity of the complaint. The lead investigator will be independent of the service area to which the complaint relates. Investigation will include:

- Meeting with the complainant if appropriate.
- Taking statements from the people involved.
- Ensuring staff involved in complaints are aware of support mechanisms and how to access same.
- Reviewing health care records, policies and procedures as appropriate (documenting evidence to support statements wherever possible).
- Taking expert advice, if needed, for example from specialist functions or the Nursing Directorate.
- Completing the complaints toolkit and forwarding same to Customer Services.
- Ensuring that the evidence in the toolkit addresses all the issues identified in the complaint management plan
- Assessing the severity grading of the complaint at the end of the investigation.
- Consideration of the need to reimburse expenses or losses where fault has been identified. This might include, for example, the cost or part cost of lost property or incurred expenses.
- Developing an action plan for every complaint (even where the plan indicates no action required) and forwarding same to Customer Services.
- Ensuring all relevant documents, including staff statements, policy documents and file notes, are collated for inclusion into the complaint file.
- Keeping contemporaneous records of the investigation within the complaint management plan.

Customer Services will prepare a response to the complainant based on the information provided in the toolkit. Responses will be reviewed by the Deputy Director of Corporate Development and the Director of Corporate Development (or designated director), before sign-off by the Chief Executive.

All responses to MPs will be reviewed and prepared for Chief Executive's signature.

All response letters must inform the complainant of their right to ask the Parliamentary and Health Service Ombudsman to review their complaint if they are dissatisfied with the Trust's response.

Satisfaction surveys will be discussed with or sent to every complainant following the Trust response being offered. Survey feedback will be analysed and taking into account in service planning and delivery.

BDUs (through practice governance coaches) have lead responsibility for ensuring follow up and monitoring of action plans and demonstration of learning from complaint trends, both from BDU and Trust wide issues. Deputy district directors will ensure processes are in place to provide governance and assurance in this area.

Parliamentary and Health Service Ombudsman Review

All avenues must be explored to resolve issues at local level, including further meetings and lay conciliation. However, if a complainant remains dissatisfied after

local resolution they can ask the Parliamentary and Health Service Ombudsman (PHSO) to undertake a review of their case. The PHSO will assess the complaint using the Principles of Remedy, Good Administration and Good Complaint Handling. These principles provide guidance to organisations on how they should handle complaints. The overarching principles are:

- Getting it right.
- Being customer focused.
- Being open and accountable.
- Acting fairly and proportionately.
- Putting things right.
- Seeking continuous improvement.

The PHSO review will seek to demonstrate that the Trust has acted appropriately when assessing the complaint to identify if there is evidence of maladministration or service failure. The PHSO will request the Trust to provide a copy of the complaint file and health care records. After undertaking the review, the PHSO will inform the Trust whether it can close the case, or whether it intends to progress to formal investigation. In response to recommendations in the Francis Report and subsequent reviews of the NHS complaints procedure, the Ombudsman has indicated an intention to significantly expand the number of cases considered.

The PHSO has the authority to propose financial remedy to Trusts as a mean of resolving complaints. The Deputy Director of Corporate Development will monitor the impact of this, report on the numbers of cases and financial implications on a case by case basis to the Director of Corporate Development, and reference this in the quarterly complaints reporting to Trust Board and BDUs.

The PHSO produces an annual review of complaints handling in the NHS and undertakes specialist reviews, for example ‘Breaking Down the Barriers’ – a review of older people raising concerns about NHS services. The PHSO shares all investigation reports with the relevant commissioning body and NHS England. Learning from these reviews will be shared in the organisation via Customer Services reporting processes.

Unreasonable or persistent complaints

Most complaints are entirely reasonable; however a few are not. Some may, for example, abuse or threaten members of staff or continue to raise the same concerns when these have already been addressed. The following are examples of behaviour which might be regarded as unreasonable:

- Abusive or threatening behaviour – whether in person or in writing.
- Persistent telephone calls or letters on the same issue, which do not allow time for an investigation to be concluded, or do not acknowledge that a response has already been offered.
- Persistent verbal complaints which cannot be resolved through the informal complaints procedure.

Trust staff should acknowledge that, at times, people might find it difficult to express their frustration and might behave in a way that makes resolution difficult. Staff should support people to raise their issues in a constructive manner, manage expectations, and work towards a satisfactory outcome. However, the Trust has a responsibility to protect its staff from people who behave in an abusive or malicious manner, and to avoid inappropriate use of resources through dealing with persistent or unreasonable complaints.

If an investigation lead or customer services co-ordinator becomes concerned that a complainant is becoming unreasonable, they must seek assistance from the Customer Services Manager. It is vital that any restrictions placed on a complainant should be as a result of a fair and consistent process. Any request to cease or limit an investigation about a complaint that is considered unreasonable or persistent, needs to be considered in consultation with the appropriate district director and the Director of Corporate Development.

It may be necessary to request that the complainant only makes contact with a named individual, by one contact method only, for example either by telephone, email or in writing. Where a named individual is assigned they should ensure a comprehensive record of all contact is maintained in the complaint management plan.

The complainant must be advised that issues already responded to will not be re-opened or re-investigated. If appropriate, the complainant should be informed that abusive correspondence, or threatening behaviour, will not be responded to. The complainant should be offered information regarding independent advocacy support.

Letters or telephone calls received during the formal investigation stage will be acknowledged and any new issues included in the overall investigation. A meeting may be offered to clarify the issues to be investigated and confirm the process. The complainant should be advised if new issues are likely to affect the timescale for providing a final response to the complaint.

The final decision regarding ceasing all contact with a complainant lies with the Chief Executive.

Reporting Feedback

The Customer Services Team and Director of Corporate Development will monitor compliance with this procedure, and report non-compliance to the BDUs and Executive Management Team.

The Customer Services Team will provide weekly reports to BDUs, advising open and closed complaints in the period and progress on complaints investigation.

The Customer Services Team will provide quarterly reports to Trust Board and to BDUs, covering the number of issues raised, issues referred to the Parliamentary and Health Service Ombudsman, including any financial redress, a breakdown of complaints, concerns, comments and compliments, identification of themes and

evidence to demonstrate that lessons have been learned as a result of service user feedback.

This report will be shared with the Mental Health Act Committee to alert to complaints relating to application of the Mental Health Act, and with the Members' Council Quality Group for review and information.

The Report will also be shared externally with CCGs through contracting and quality monitoring processes and with Healthwatch across Trust geography.

District Directors will be responsible for ensuring systems are in place to investigate complaints and concerns, that feedback received through Customer Services processes is reviewed, that themes are identified, action plans delivered and lessons learned evidenced and reviewed through governance processes.

The Executive Management Team will monitor complaints and ensure lessons are learned. EMT will review the key performance indicator (KPI) in relation to complaints through monthly business intelligence dashboard reporting.

An annual report will be produced for consideration by the Trust Board. The Trust Board is responsible for approving Trust policy in relation to complaints handling, for ensuring compliance with national and local targets in relation to complaints, and that robust systems are in place to enable feedback about services and that lessons learned lead to an improved patient experience.

Customer Services insight forms part of the Trust's evolving service user experience reporting, which includes service user feedback from a range of sources, for example real time feedback, local and national surveys and audit.

The Trust will develop an evidence base to demonstrate how the insight gained from dealing appropriately with issues raised will contribute to improving the quality of the current service, and an increased level of service user satisfaction with services.

Process for monitoring compliance with this policy

The Director of Corporate Development is responsible for monitoring compliance with this policy. This will be achieved through:

- The ongoing monitoring role of the Customer Services team.
- The Customer Services team make data and reports available within the Trust as described above.
- Routine contact with services and investigators regarding the ongoing process for complaints investigation.
- Feedback from Commissioners.
- Contact, as appropriate, with external agencies, for example neighbouring authorities, the Parliamentary and Health Service Ombudsmen, the CQC, the Information Commissioner and Monitor
- The NHS Litigation Authority Assessment process.

Relevant concerns will be reported to the Executive Management Team, with action by the appropriate director.

Associated documentation

There are a number of supporting procedural documents which may be subject to reference as appropriate. These include:

- Investigating and analysing incidents, complaints and claims to learn from experience Policy and Procedures.
- Being Open policy – including duty of candour.
- Claims Management Policy and Procedure.
- Safeguarding Children procedures.
- Safeguarding adults procedures.
- Health and Safety policies, procedures and processes.
- Human Resources and related policies and procedural and related documents.
- Information Governance (and Caldicott Guardian) related policies and procedural documents.
- Media and Communications – related policies and procedural documents.

Equality Impact Assessment

This policy promotes equality of access to the Trust's Customer Services function. See Appendix 1 for equality impact assessment.

The potential for people to have difficulty in accessing this procedure is mitigated by ensuring support is available through Customer Services, the availability of information in different formats on request, and promoting access to advocacy and interpreting services.

Dissemination and implementation

This policy will be promoted through the weekly staff bulletin and accessible via the Trust intranet and internet. Leaflets and posters publicising the ways to offer feedback will be available in all Trust clinical and public areas.

Training and support will be offered to staff to underpin the efficient and effective investigation of issues.

Implementation of the policy will be the responsibility of staff at all levels, and supported by all managers and directors.

Managers are required to monitor compliance with this policy and to ensure a systematic approach to responding to feedback from people who use services and their families / carers.

Managers are required to ensure appropriate support is in place for staff impacted by complaints.

BDUs are required to ensure staff who undertake complaints investigation are skilled and supported to do so, to develop action plans to address areas for improvement, and to monitor delivery of same through governance processes.

Review and Revision arrangements

This policy and procedure will be subject to annual review by the Trust Board, with review instigated in the event of policy change.

Document control and archiving

This policy will be accessible via the Trust's intranet in read only format.

A central electronic read only version will be held by the Integrated Governance Manager in a designated shared folder to which all Executive Management Team members, and their administrative staff, have access.

A central paper copy will be retained in the corporate library.

This policy will be retained in accordance with requirements for retention of non-clinical records.

Revisions / updates to this policy will be stored as above by the Integrated Governance Manager with previous iterations archived.

Appendix 1

Equality Impact Assessment Template to be completed for all Policies, Procedures and Strategies

Date of Assessment: December 2015

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		To provide a framework for ensuring feedback is valued and responded to appropriately. To support effective complaints management processes, consistently applied across all services. People who use services, carers, staff
3	**Who is the overall lead for this assessment?**		Bronwyn Gill
4	**Who else was involved in conducting this assessment?**		Corporate Development - Partnership Team, Customer Services Team
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?**		Customer services processes and procedures are subject to constant evaluation with service users and carers (following their contact with the team) and with staff following involvement in complaints handling or report review. Information used to inform policy
6	**What equality data have you used to inform this equality impact assessment?**		Protected characteristics data collected via the function.
7	**What does this data say?**		
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**No**	It is not anticipated that this Policy will have any negative impact on any of the equality groups. The potential for people having difficulty giving feedback or raising complaints and concerns is mitigated by promoting access to advocacy and / or interpreting services and taking account of information requirements (which will be further enhanced through compliance with the Accessible Information Standard.
8.1	**Race**	**No**	The potential for people having difficulty giving feedback or raising complaints and concerns is mitigated by promoting access to advocacy and / or interpreting services.
8.2	**Disability**	**No**	
8.3	**Gender**	**No**	Average % access 65% female 35% male

8.4	**Age**	**No**	under 21 – 1% 22 - 31 – 12% 32 – 41– 16% 42 – 51 18% 52 – 61 3% Over 62 – 6% Not disclosed 44%
8.5	**Sexual Orientation**	**No**	Gay – 1% Heterosexual – 30% Lesbian – 3% Bisexual – 1% Unknown – 65%
8.6	**Religion or Belief**	**No**	No information available
8.7	**Transgender**	**No**	No information available in the Trust's monitoring data
8.8	**Maternity & Pregnancy**	**No**	No information available in the Trust's monitoring data.
8.9	**Marriage & Civil partnerships**	**No**	No information available in the Trust's monitoring data.
8.10	**Carers*Our Trust requirement***	**No**	It is not anticipated there will be any negative impact on service users or their carers, feedback is captured through service evaluation.
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		The Policy is subject to annual review.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		The policy promotes equality of opportunity as it provides for a supportive, fair and non-discriminatory approach to customer services and complaints management
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		The Trust is committed to eliminating discrimination in all its forms, including those with protected characteristics
9c	**Promotes good relations between different equality groups;**		The Trust's approach to equality promotes good relations including with those from different equality groups.
10	**Have you developed an Action Plan arising from this assessment?**		No
11	**Assessment/Action Plan approved by (Director Lead)**		**Sign:** **Date:** **Title:**
12	***Once approved, you must forward a copy of this assessment/Action Plan to the Partnersips Team:***		

	inclusion@swyt.nhs.uk **Please note that the EIA is a public document and will be published on the web**	

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 January 2016
Agenda item 9

Title:	**Board self-certification and assessment of operational, clinical and quality risks (Monitor Quarter 3 return 2015/16)**
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 and assurance received by Trust Board through performance 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.

The in-year governance declaration on behalf of Trust Board will be made to confirm compliance with governance and performance targets.

The attached report is a first draft of the exception report to be submitted to Monitor in respect of Quarter 3.

Foundation Trust sector comparison

As at 23 November 2015, there were 151 Foundation Trusts authorised by Monitor. Of these, 43 are mental health trusts.

Monitor has published the Quarter 2 Performance Report for 2015/16 for the sector. This allows us to place Trust performance in a national context. The tables below show that the Trust remains in the upper quartile with a Continuity of Service Rating of 4 and a Green Governance rating. The key headlines are as follows.

- Foundation Trust deficit amounts to £729 million, which is £169 million worse than planned. This is against a quarter 1 figure of £445 million. The forecast deficit is £1.01 billion, which is £80 million worse than planned. The most challenged Trusts financially (47 trusts) are subject to a review of their plans.
- Of 152 foundation trusts, 110 reported a deficit (118 at quarter 1).
- The main reason continues to be pay expenditure pressures arising from the requirement to utilise agency staff to cover shortages in permanent staff.

All Foundation Trusts

		Governance rating			
		No evident concerns	Issues identified	Enforcement action	Total
Continuity	4	**35**	2	2	**39**
	3	41	14	4	**59**
	2	8	8	8	**24**
	1	2	2	25	**29**
	Total	**86**	**26**	**39**	**151**

Mental Health Trusts

		Governance rating			
		No evident concerns	Issues identified	Enforcement action	Total
Continuity	4	**21**	0	1	**22**
	3	14	3	0	**17**
	2	2	1	1	**4**
	1	0	0	0	**0**
	Total	**35**	**5**	**3**	**43**

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.**
Private session:	Not applicable

Trust Board self-certification – Monitor Quarter 3 return 2015/16
Trust Board 29 January 2016

Compliance with the Trust's Licence

The Trust continues to comply with the conditions of its Licence.

Trust Board

The process to recruit to the Chief Executive post following the retirement of Steven Michael, at the end of March 2016 continues. The application process closed at the beginning of January 2016 and fifteen applications were received. The Trust has appointed Harvey Nash to support its process and an initial sift of applications took place to inform a longlist for consideration on 11 January 2016. Harvey Nash has since undertaken further engagement with, and assessment of, longlisted candidates to inform the shortlisting process on 29 January 2016.

The formal interview process will take place on 10 and 11 February 2016 with a series of meetings with stakeholders groups on the 10 (service users and carers, senior clinical staff, senior staff and staff side representatives, and Non-Executive and Executive Directors). This will be followed by a formal interview on the 11, which will include a ten-minute presentation. The interview panel will consist of:

- Ian Black, Chair of the Trust (and Chair of the interview panel);
- Julie Fox, Deputy Chair of the Trust;
- Stephen Dalton, Chief Executive, Mental Health Network, NHS Confederation (External Assessor);
- Michael Smith, publicly elected governor for Calderdale and Lead Governor; and
- Lesley Smith, Chief Officer, NHS Barnsley Clinical Commissioning Group.

The Members' Council will consider a recommendation for appointment from the panel at its meeting on 12 February 2016.

Alongside this process, the Trust has appointed an interim Director of Finance, Jon Cooke, from 4 January 2016 following the split of the role of Deputy Chief Executive/Director of Finance (Alex Farrell), which was reported to Monitor in quarter 2. The process to recruit a substantive Director of Finance has begun and the new Chief Executive will be involved in this appointment, which it is hoped will be concluded by the end of February 2016.

The Trust was successful in appointing to the substantive role of Director of Forensic and Specialist Services and Carol Harris (currently Acting Director of Operations at Manchester Mental Health and Social Care Trust) will join the Trust on 21 March 2016; in the meantime, the interim operational support at Director level to cover the child and adolescent mental health services (CAMHS), forensic services and specialist services portfolio continues.

Members' Council

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

- Barnsley – one seat (currently vacant);
- Calderdale – two seats (both retirement by rotation);

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

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

Care Quality Commission (CQC)

- The Trust informed Monitor that the CQC will carry out an inspection of its services starting on 7 March 2015. The Trust has provided background information to support the inspection. A pre-inspection meeting was held with the lead Inspector with the Chief Executive and Director of Nursing was held on 18 January 2016.
- 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 but has not received a response.
- There were three CQC Mental Health Act visits in Q3 made to Chippendale ward, Newton Lodge (Wakefield), The Poplars, Pontefract (Wakefield) and Elmdale ward, the Dales, Halifax (Calderdale).
- Within the quarter, five Mental Health Act monitoring summary reports have been received relating to visits made to Sandal ward, Bretton Centre, Fieldhead (Wakefield), Fox View, Dewsbury (Kirklees), Ashdale ward, the Dales, Halifax (Calderdale), Enfield Down, Huddersfield (Kirklees) and Chippendale ward, Newton Lodge (Wakefield) ward.
- 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:

    - matters relating to the environment and refurbishment;
    - issues with recording and, in particular, the recording of capacity and consent and patients' rights.

Care Quality Commission (CQC) Intelligent Monitoring

Intelligent Monitoring is used to assign trusts providing mental health services into four priority bands for inspection. It is intended to raise questions about various aspects of care which, alongside inspection findings and local information (from partners, the public, and trusts through their specialist knowledge), provides a basis on which final judgements are made. It should be noted that many of the indicators included in the report are also Trust-wide rather than just mental health, such as staff survey results.

The January 2016 intelligent monitoring report has seen the Trust's risk rating increase from a 7 from 5. This is due to five identified 'risks' relating to:

- patients that die following injury or self-harm within three days of being admitted to acute hospital beds;
- the proportion of discharged patients without a recorded crisis plan;
- a composite indicator to assess bed occupancy;
- a composite indicator in relation to the proportion of Mental Health Act and hospital in-patient episodes closed by the provider; and
- a composite indicator in relation to the proportion of missing or invalid entries in the Mental Health learning disability data set employment status and accommodation status fields.

Work is underway to review the risks identified to understand the increase in the rating and a response will be sent to the CQC.

There is one 'elevated risk' that relates to a snapshot of whistleblowing alerts received by the CQC. This has been closed by the CQC but delays in its systems mean it remains on the Trust's report.

Absent without Leave (AWOL)
There were no CQC reportable cases during Q3.

Eliminating Mixed Sex Accommodation (EMSA)
NB figures relate to Q2
There have been no reported breaches in Q2. The Trust continues to monitor (via DATIX) where service users are placed in an individual room on a corridor occupied by members of the opposite sex. The EMSA annual audit will take place in Q3.

Infection prevention and control
- Barnsley BDU has been set a locally agreed C difficile Toxin Positive Target of six. There have been no cases in Q3. To date, there has been a total of three cases of C difficile in Barnsley.
- There have been no MRSA bacteraemia cases reported in the Trust during Q3.
- In Q3, there have been no outbreaks within the Trust.

Information Governance
There has been one incident in Q3 meeting the mandatory reporting criteria to the Information Commissioner's Office. This resulted from a complaint received by the Trust from a solicitor acting on behalf of the mother of a child that was a previous service user. This was reported as an incident on 15 January 2016 and related to an incorrectly addressed letter containing sensitive information. Some of this information has since been uploaded to social media. An investigation has started and is ongoing.

Safeguarding Children
Information to follow.

Safeguarding Vulnerable Service Users
Information to follow.

Serious Incidents
- During the course of Q3 there have been fifteen SIs reported to commissioners, which is a decrease from Q2 (23). This is made up of two in Barnsley (mental health and substance misuse), one in Barnsley (general community services), three in Calderdale, three in Kirklees, five in Wakefield and one in corporate support services.
- 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.

Duty of Candour (Q2 2015/16 figures)
The Trust aims to deliver the highest standards of healthcare to all its service users. The promotion of a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. This communication is open, honest and occurs as soon as possible following a patient safety event. It should be noted that the severity of the incident as recorded on the Trust's Datix system is different from the National Patient Safety Agency definition of harm; therefore, this set of data is not comparable with other data.

- Total number of incidents meeting NPSA definition of moderate, severe harm or death = 53 (2014/15 Q2 – 38, Q3 – 31, Q4 – 30; 2015/16 Q1 – 45)
- Number reported on STEIS as SIs = 11 (2014/15 Q2 – 23, Q3 – 28, Q4 – 16; 2015/16 – 11)
- Other (all moderate) = 42 (2014/15 Q2 – 15, Q3 – 3, Q4 – 14; 2015/16 Q1 – 34)

Customer Services
- The Trust received a total of 72 formal complaints in Q3. The breakdown is as follows:
  - Barnsley – 21;
  - Calderdale and Kirklees – 21;
  - Wakefield – 11;
  - Specialist services – 15;
  - Forensic – 3;
  - Trust-wide – 1.
- The number of complaints relating to child and adolescent mental health services was thirteen (twelve in Q2). Most related to access and wait time in Calderdale and Kirklees services.
- Across all complaints, communications was identified as the most frequently raised negative issue (26). This was followed by patient care (22), values and behaviours (staff) (22), appointments (twelve), access to treatment or drugs (eleven) and Trust admin/policies/procedures (ten). Most complaints contained a number of themes.
- In quarter 3, three complainants asked the Parliamentary and Health Service Ombudsman to review their complaint following contact with the Trust. Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. All requested information was provided within the prescribed timeframe. During the quarter, the Trust received feedback from the Ombudsman regarding four cases. Three were closed with no further action required. One case (Wakefield in-patients adults) was subject to review and partially upheld with recommendations to the Trust including the preparation of an action plan and an appropriate apology to the complainant.

Third party reports
The Audit Committee does not meet until 2 February 2016 when an update on internal audit reporting will be received.

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.

Service issues
Child and adolescents mental health services (CAMHS)
The CAMHS 'summit' held on 18 December 2015 was positive with recognition from commissioners that the position has moved from one of recovery although this does remain a challenge for the Trust. The CCGs have reiterated their commitment to contracting with

the Trust in 2016/17 following the expiry of the original three-year contract. This remains the intention of both parties although the exact contractual mechanism to enact this intention remains to be finalised before 1 April 2016. Commissioners and the Trust have reviewed the recovery plan and agreed that this phase of work is now complete. The Trust is now developing a revised action plan with commissioners, which reflects the action now needed to improve the service given the investment, commissioner visits and the transformation agenda.

A 'Deep Dive' into CAMHS, proposed by Kirklees Council to the Kirklees Safeguarding Board in September 2015, was agreed and will cover all aspects of CAMHS and not just the Tier 3 services provided by the Trust. This will take place in 2016 to support a whole systems CAMHS transformation process. The Trust is involved in developing the terms of reference for the review.

As reported above, the post of Director of Forensic and Specialist Services, whose responsibilities will include CAMHS, has been filled substantively.

Trust Board has also agreed that ongoing monitoring will be through the Clinical Governance and Clinical Safety Committee.

Barnsley Healthy Child Programme (0-19 services)

The Trust advised Monitor of the position with 0-19 services in Barnsley in the quarter 2 return. Following detailed discussion at Trust Board in December 2015, work is ongoing to test options for the safe and viable continuation of 0-19 services in Barnsley. Progress to date includes:

- the establishment of a Joint Project Board, which is meeting frequently;
- development of a shared project plan and risk management arrangements;
- legal advice on public procurement and partnership arrangements sought;
- a joint commissioner/provider review of the service specification and 'key deliverables';
- joint service modelling, including identification of key dependencies and assumptions regarding other children's services (education, social care, primary care, etc.).

Southern Health

At its December 2015 meeting, Trust Board requested a paper on the implications for the Trust arising from the concerns raised in the leaked Mazars' report on Southern Health NHS Foundation Trust and assurance of the robustness of the Trust's systems and processes. A paper was presented to Trust Board on 29 January 2016 outlining the Trust's approach and providing assurance to Trust Board about its systems and processes in the areas of concern outlined in the report.

At the Trust, there is a comprehensive policy on the reporting and investigation of incidents that operates in accordance with national guidance and standards and which includes a proactive and positive approach to engagement and communication with families. The Trust will fully comply with the findings of the national review commissioned by the Department of Health and any further action taken by Monitor as a result of its improvement actions at Southern Health. In the interim and on an ongoing basis, the Trust will continue to monitor its compliance with national guidance and ensure that the quality of its investigations and serious incident reports remains high.

Learning disability services

The Trust has been working with local clinical commissioning groups on the relocation of a small-bedded unit for people with learning disabilities at Fox View in Dewsbury to the Horizon Centre at Fieldhead, Wakefield, to ensure clinical sustainability and reduce the risks

associated with staffing a small, standalone unit. Due to concerns arising from staff sickness and inability to staff the unit, and the potential impact on clinical safety, Fox View closed to new admissions just before Christmas. One remaining patient was transferred to the Horizon Unit. Any new admissions from Kirklees are being admitted to the Horizon Centre in line with usual protocols. Commissioners, local authorities and the Overview and Scrutiny Chair have been briefed accordingly. Fox View remains open but is empty of patients at present.

Trust Board 29 January 2016
Agenda item 10

Title:	**Assurance framework and organisational risk register Q3 2015/16**
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:	**Assurance framework 2015/16** The Board assurance framework provides Trust Board with a simple but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's corporate 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 in place or that need to be in place, for managing the principle risks and providing assurance to Trust Board. The strategic corporate objectives for 2015/16 were approved by Trust Board and form the basis of the assurance framework for 2015/16. In respect of the assurance framework for 2015/16, the principle high level risks to delivery of corporate objectives have been identified and, for each of these, the framework 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. A schematic of the assurance framework process is set out as an attachment. 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. The assurance framework for 2015/16 has been reviewed following feedback from Deloitte as part of the well-led review of the Trust's governance arrangements. A new format with 'RAG' ratings has been constructed, which is designed to paint a picture on a page on the level of assurance the Trust Board can obtain in respect of risk mitigation for each of the key strategic corporate objectives. In order to facilitate the identification of gaps in control and assurance, a colour coding scheme has been adopted to identify the following types of control and assurance: - purple – Trust Board governance/setting strategic direction; - peach – EMT governance/execution; - pink – partnership working/independent review; - grey – performance framework/monitoring; - Burgundy – service strategy; - blue – enabling strategy. The new assurance framework is work in progress and will be further refined through discussions with individual directors and Chairs of Board Committees and reviewed through the Executive Management Team (EMT) over the next quarter as the well led review action plan is implemented. As part of the well led review, one action identified was the production of an assurance and escalation framework to identify and set out the information flows supporting the assurance process. A draft Framework is appended to this report. **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 EMT 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. EMT reviewed the risk register at its meeting on 14 January 2016 and agreed the following. - An increase in the original risk rating in terms of likelihood for risk no. 275 (local authority as a provider) from 'likely' to 'almost certain'. - Risk 522 in relation to the Trust's financial viability has been downgraded to amber (consequence 5 (catastrophic) and likelihood 2 (unlikely)) as the risk has been managed during 2015/16. - Risk 668 in relation to child and adolescent mental health services has been downgrade to amber (consequence 4 (major) and likelihood 3 (possible)) given the outcome of the summit in December 2015 and the decision by Trust Board in December 2015 for ongoing monitoring and scrutiny to be undertaken by the Clinical Governance and Clinical Safety Committee. A new risk has been added in relation to the sustainability of funding for CAMHS. - A new risk has been added in relation to information governance incidents.

	The risk register now contains the following risks: - Trust sustainability declaration; - transformational service change programme – Trust's transformation programme, its implementation and staff engagement; - transformational service change – wider health economy transformation and engagement and alignment with commissioners; - impact on services as a result of continued local authority spending cuts and changes to the benefits system in relation to local authorities in their role as commissioners; - commissioning risks – local commissioning intentions and impact of national developments; - impact on services as a result of continued local authority spending cuts and changes to the benefits system in relation to local authorities in their role as providers; - mechanisms for contracting and pricing for mental health and community services; - capture of clinical information; - bed occupancy; - inability to secure sufficient funding to support a sustainable child and adolescent mental health service; and - information governance incidents.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the controls and assurances against corporate objectives for Q3 2015/16;** ➢ **REVIEW the draft Assurance and Escalation Framework and comment upon its fitness for purpose;** ➢ **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

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

Our mission: enabling people to reach their potential and live well in their community.

The Operational Context of the BAF
Purpose: to provide a comprehensive method for the effective and focused management of the principal risks to achieving the corporate delivery objectives.
Provides direct evidence for: Annual Governance Statement and the Head of Internal Audit Opinion

Strategic direction: Ambition, values, goals, strategic objectives forming annual Plan, linked to wider health economy and regulatory requirements

Corporate delivery objectives Approved by Trust Board and reviewed regularly

Controls
- Accountability
- Regular performance measures
- Operational plans
- Policy and procedure
- Systems and structures

Assurances
- Audit (inc clinical audit) reports and opinions
- Actual performance measurement
- External and internal reports

Gaps
- Audit report, opinion and recommendations to be implemented
- Poor performance management and related actions

Principal risks linked to corporate objectives

Controls in respect of risks and corporate objectives

Assurances in respect of the controls and corporate objectives

Gaps in controls and assurances and actions required to address the gaps

Strategic level risks (15+) into organisational risk register

Risks at directorate and local level identified and scored through DATIX in line with risk management strategy and procedure. These **may** include gaps identified in the BAF

Exec Management Team

Individual director/BDU assurance arrangements

Trust Board Committees

TRUST BOARD

Closure of gaps
- Time bound responsibilities identified plus lead

Corporate review of the Assurance Framework
- Trust Board quarterly review of the BAF in terms of the adequacy of assurance processes and the effectiveness of the management of principal risks and gaps
- Audit Committee review of process for development of BAF annually

Assurance Framework 2015/16

Board governance/setting strategic direction, **EMT Governance/execution** **Partnership working/Independent review,** **Performance framework/monitoring,** **Service Strategy,** Enabling strategy

Principle Delivery Objective: - Strategy Embedded person-centred delivery system, delivering safe services, efficiently and effectively across the Trust	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	CEO	CG & CS	A/G	A/G	A/G	

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
S1	Continued uncertainty of strategic partnership landscape, including commissioning, acute partners and local authorities linked to the Five-Year Forward View leading to unsustainable organisational form.	A/R
S2	Failure to understand and respond to changing market forces leading to loss of market share and possible de-commissioning services.	A/G
S3	Failure to deliver the Estates Strategy and capital programme for 2015/16 leading to health and safety/compliance issues, poor service user and staff experience.	A/G
S4	Trust Plans for service transformation are not aligned to the multiplicity of stakeholder requirements leading to inability to create a person-centre delivery system	A/G
S5	Failure of transformation plans to realise appropriate quality improvement leading to development of a service offer that does not meet service user/carer needs and/or commissioning intentions	A/R
S6	Changing service demands and external financial pressures in local health and social care economies have an adverse impact on ability to manage within available resources	A/R

Controls – systems and processes (what are we currently doing about the Strategic Risks?)	
1	Trust Board sets the Trust vision and corporate objectives as the strategic framework within which the Trust works (S1)
2	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (S2)
3	Production of annual 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 (S1)
4	Director leads in place for revised service offer through transformation programme, work streams and resources in place, overseen by project boards and EMT, key change management projects linked to corporate and personal objectives, with resources and deliverables identified (S4, S5)
5	Executive Management Team ensures alignment of developing strategies with Trust vision and strategic objectives (S1, S3)
6	Monthly review by EMT of stakeholder and partnership position through rich picture and risk assessment (S1)
7	EMT production and review of market assessment against a number of frameworks including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power.(S2)
8	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services (S6)
9	Development of joint QIPP plans with commissioners to improve quality and performance, reducing risk of decommissioning. CCG/Provider performance monitoring regime of compliance with QIPP plan and CQUIN targets in place (S6)
10	SWYPFT performance management system in place with KPIs covering national and local priorities (S6)
11	IM & T strategy in place supporting delivery of strategic objectives, agile working, estates strategy, underpinned by IM&T Forum, with defined terms of reference, chaired by a NED (S3)
12	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (S4)
13	Estates Forum in place with defined Terms of Reference chaired by a NED, Estates TAG ensuring alignment of Trust strategic direction, with estates strategy and capital plan with identification of risk and mitigating action to meet forward capital programme (S3)
14	Annual Business planning guidance in place standardising process and ensuring consistency of approach (S2)
15	New leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services (S4, S5)

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
1	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken.	Quarterly reports to Trust Board
2	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance presented to each Committee
3	Assurance reports to Clinical Governance and Clinical Safety Committee covering key area of risk in the organisation seeking assurance on robustness of systems and processes in place	November 2015 – transformation, improving clinical information, Quality Accounts (standing item), creating a smoke-free environment, child and adolescent mental health services (standing item), Horizon review, emergency planning review of IT virus incident, clinical audit and practice effectiveness progress report, Care Quality Commission (inspection and Mental Health Act visits), nurse re-validation, exceptional cases update, and incident management reporting.
4	Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources	October 2015 – Internal Audit Charter, approval of Charitable Funds annual report and accounts, Trust arrangements for whistleblowing, data quality, pricing strategy, service line reporting and reference costs, currency development, triangulation of risk, performance and governance (standing item), Treasury Management (standing item), internal, external and counter fraud reports (standing items), procurement report (standing item) and losses and special payments report (standing item)
5	Annual plan and budget and five-year strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by Monitor	Annual plan and budget approved by Trust Board and submitted to Monitor (March and May 2015). Supported by monthly financial reporting to Trust Board and Monitor and quarterly exception reports. External review of Trust plan undertaken by Deloitte (February/March 2015).
6	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 April 2015.
7	Monthly/Quarterly quality/integrated performance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	Monthly performance and finance reporting to EMT and Trust Board. Exception reporting – child and adolescent mental health services, serious incidents quarterly reporting, learning lessons from incidents, community mental health survey 2015/16, IT virus incident, assessment and treatment for people with learning disabilities, and Barnsley Healthy Child Programme.
8	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	Quarterly exception reporting and self-certification to Trust Board. Quarterly review meeting with Monitor supported by Monitor's formal letter in response to quarterly submission.
9	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	Bi-monthly meetings of EMT (general) provide focus for the Trust's transformation plans.
10	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
11	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	Bids and tenders report (standing item delivery EMT), Public Health Education Team (October 2015), Meridian productivity proposal (October 2015), resuscitation (November 2015), records management and scanning (November 2015), Fieldhead non-secure business case (EMT and Trust Board October, November and December 2015), disclosure and barring checks (November 2015), ASD adult services diagnostic (November 2015), adult ADHD specialist services QIPP workstream (December 2015), Barnsley Healthy Child Programme (EMT and Trust Board standing item to March 2016). Child and adolescent mental health services (October and December 2015), Transformation update (Trust Board December 2015), possible Tier 4 CAMHS development services (October and December 2015)
12	Strategic overview and analysis of partnerships by EMT, review of stakeholder and partnership position through rich picture and risk assessment	Bi-monthly meetings of EMT (general) include an assessment and analysis of Trust relationship and partnership with its stakeholders. This includes an analysis of risk and mitigation.

13	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested	Monthly performance and finance reporting to EMT and Trust Board.
14	Independent PLACE audits undertaken and results and actions to be taken reported to EMT, Members' Council and Trust Board	
15	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Programme of visits to services by CE during Q2. Middleground 4 (rolling programme) with involvement of CE, Executive and Non-Executive Directors. Changes instigated to approach to communications with staff. Involvement and engagement with service users/carers through Friends and Families test. Staff wellbeing and national surveys, which includes Friends and Families test for staff. Planned programme of service user/carer events, including transformation, and planned Insight events in Q4. Equality and diversity engagement events for service users/carers in Q3.

Gaps in control and what do we need to do to address these and by when	Date
Risk register no 275 and 772 impact on services as a result of continued local authority spending cuts, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 463 and 773 – transformational service change, implementation and staff engagement, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 695 – Trust sustainability declaration, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 812 – commissioning intentions, being mitigated through action plans as set out in the organisational risk register	Ongoing

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Workforce plans require on-going development as transformation standard operating procedures are being finalised to deliver the revised service offers, transformation reports to EMT setting out time lines for changing workforce plans, skills and competencies to deliver revised service offers.	Monthly EMT

Rationale for current assurance level
Independent Well Led Review assessed the Trust as Green in 2 areas and amber/green in 8 areas with action plan in place to move towards green by March 2016. Governance rating green and financial rating of 4 in line with Monitor's Risk Assessment Framework. Ongoing overview at strategic level of Trust's market position and response at strategic and service line level.

Principle Delivery Objective: - execution Well governed, legally constituted, well-led and financial sustainable Trust, clear consistent messages are articulated and communicated at all levels in the Trust	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	Direct. Corp. Dev/ Dir of Fin	Audit Co. B & R TB	A/R	A/G	A/G	

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
E1	Failure to deliver level of transformational change required impacting on ability to deliver resources to support delivery of the annual plan	A/R
E2	Unexplainable variation in clinical practice resulting in differential patient experience and outcomes and impact on Trust reputation	A/G
E3	Lack of capacity and resources not prioritised leading to non-delivery of key organisational priorities and objectives	A/G
E4	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	A/R

Controls – systems and processes (what are we currently doing about the Strategic Risks?)	
1	Trust Board approved strategic objectives supporting delivery of Trust mission, vision and values monitored through appraisal process down through director to team and individual team member (E1, E3)r
2	Independent “Well led” review of governance arrangements commissioned and action plan in place (E1)
3	Director leads in place for transformation programme and key change management projects linked to corporate and personal objectives, with resources and deliverables identified (E1)
4	Risk assessment and action plan for delivery of CQUIN indicators in place (E2)
5	Project Boards for transformation workstreams established, with appropriate membership skills and competencies, PIDs, Project Plans, project governance, risk registers for key projects in place (E3)
6	Risk assessment and action plan for data quality assurance in place (E4)
7	Weekly Operational Requirement Group chaired by Chief Executive providing overview of operational delivery, services/resources, identifying and mitigating pressures/risks (E1,E3)
8	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services (E2, E4)
9	Performance management system in place with KPIs covering national and local priorities reviewed by EMT and Trust Board (E2, E4)
10	Process in place for systematic use of benchmarking to identify areas for improvement and identifying CIP opportunities (E3)
11	Values-based appraisal process in place and monitored through KPI’s (E3)
12	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (E1, E3)
13	Complaints policy and complaints protocol covering integrated teams in place (E2)
14	Cross-BDU performance meetings established to identify performance issues and learn from good practices in other areas (E2)

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
1	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	Quarterly exception reporting and self-certification to Trust Board
2	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken	Quarterly reports to Trust Board
3	Assurance reports to Clinical Governance and Clinical Safety Committee covering key area of risk in the organisation seeking assurance on robustness of systems and processes in place	November 2015 – transformation, improving clinical information, Quality Accounts (standing item), creating a smoke-free environment, child and adolescent mental health services (standing item), Horizon review, emergency planning review of IT virus incident, clinical audit and practice effectiveness progress report, Care Quality Commission (inspection and Mental Health Act visits), nurse re-validation, exceptional cases update, and incident management reporting.

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
4	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance presented to each Committee
5	Annual report to Trust Board to risk assess changes in compliance requirements and achievement of performance targets, in year updates as applicable	Trust Board report April 2015
6	Medical staff appraisal and revalidation in place evidenced through annual report to Trust Board and supported through Appraisers forum	Independent desk-top review of revalidation process during Q3, which found the process in place is robust, comprehensive and fit for purpose. Annual report to Trust Board June 2015. Appraisers' Forum held three times/year.
7	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
8	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	Bi-monthly meetings of EMT (general) provide focus for the Trust's transformation plans.
9	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	Bids and tenders report (standing item delivery EMT), Public Health Education Team (October 2015), Meridian productivity proposal (October 2015), resuscitation (November 2015), records management and scanning (November 2015), Fieldhead non-secure business case (EMT and Trust Board October, November and December 2015), disclosure and barring checks (November 2015), ASD adult services diagnostic (November 2015), adult ADHD specialist services QIPP workstream (December 2015), Barnsley Healthy Child Programme (EMT and Trust Board standing item to March 2016). Child and adolescent mental health services (October and December 2015), Transformation update (Trust Board December 2015), possible Tier 4 CAMHS development services (October and December 2015)
10	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested	Monthly performance and finance reporting to EMT and Trust Board.
11	Data quality improvement plan monitored through EMT deviations identified and remedial plans requested	Included in monthly performance reporting to EMT and Trust Board. Regular reports to CG&CS Committee and report to Audit Committee October 2015.
12	Serious incidents from across the organisation reviewed through the Clinical Reference Group including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation	Process in place with outcome reported through quarterly serious incident reporting to EMT, Clinical Governance and Clinical Safety Committee and Trust Board. Learning lessons report presented quarterly to Trust Board.
13	Quarterly quality/integrated performance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	Quarterly quality performance reporting to EMT and Trust Board with supporting, more detailed compliance report.
14	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.	December 2015 92.8% B6+ (target 95% in Q1) and 83.5% B5- (target 95% in Q2)
15	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities	Clinical audit and practice effectiveness annual report to CG&CS September 2015 and Q2 report November 2015.
16	Sustainability action plans monitored through Sustainability TAG, deviations identified and remedial plans requested.	Sustainability TAG minutes. Sustainability Strategy update to Trust Board June 2015.
17	Rolling programme of staff, stakeholder and service user/carer engagement events to ensure we capture and respond to service user and carer needs	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Programme of visits to services by CE during Q2. Middleground 4 (rolling programme) with involvement of CE, Executive and Non-Executive Directors. Changes instigated to approach to communications with staff. Involvement and engagement with service users/carers through Friends and Families test. Staff wellbeing and national surveys, which includes Friends and Families test for staff. Planned programme of service user/carer events, including transformation, and planned Insight events in Q4. Equality and diversity engagement events for service users/carers in Q3.

Gaps in control and what do we need to do to address these and by when	Date
Risk register no. 267 - capture of clinical information, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 522, 695 - Trust's financial viability and long term sustainability, being mitigated through action plans as set out in the organisational risk register	Ongoing
MH Act audits identified issues with recording around capacity and consent, being addressed through BDU action plans working with MH Act officers,	March 2016
Internal audit report – patient property partial assurance with improvement requirements being addressed through BDUs.	March 2016
Risk register (new) – information governance incidents	Ongoing

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Further updates to CG&CS and Audit Committees on capture of clinical information and impact on data quality	February 2016
Achievement of appraisal targets – ongoing monitoring through Remuneration and Terms of Service Committee	

Rationale for current assurance level
Independent Well Led Review assessed the Trust as Green in 2 areas and amber/green in 8 areas with action plan in place to move towards green by March 2016.
Currently assessing governance rating as green and financial rating of 4 in line with Monitors Risk Assessment Framework.
Internal audit report – performance indicators significant assurance with minor improvement opportunities.
Internal audit report – asset safeguarding and existence significant assurance with minor improvement opportunities.
Ongoing scrutiny of CAMHS through Clinical Governance and Clinical Safety Committee

Principle Delivery Objective: - Culture Embedded mission and values across the Trust, focussing not just on what we do but how we do it	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	D of N Med. Dir HR Direc.	CC & CS	A/G	A/G	A/G	

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
C1	Failure to create and communicate a coherent articulation of Trust Mission, Vision and Values leading to inability to identify and deliver against strategic objectives	G
C2	Failure to engage the workforce	A/G
C3	Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation	A/G
C4	Staff and other key stakeholders not fully engaged in process around redesign of service offer, leading to lack of engagement and benefits not being realised through delivery of revised models and ability to deliver best possible outcomes, through changing clinical practice	A/R
C5	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	A/G

Controls – systems and processes (what are we currently doing about the Strategic Risks?)	
1	Trust Board approved strategic corporate objectives supporting delivery of Trust mission, vision and values monitored through appraisal process down through director to team and individual team member (C1)
2	Independent “Well led” review of governance arrangements commissioned and action plan in place (C1)
3	OD Framework re support objectives “the how” in place with underpinning delivery plan (C, C5)
4	Partnership Boards established with staff side organisations to manage and facilitate necessary change (C2, C4)
5	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 (C3, C5)
6	Values based Trust Welcome event in place covering mission, vision, values, key policies and procedures (C2, C4)
7	Creative Minds Strategy and action plan in place approved by Trust Board, promoting different ways of working and partnership approach (C4)
8	Involving People Strategy and action plan in place approved by Trust Board, promoting and developing key relationships (C4)
9	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 (C2)
10	Communications and Engagement Strategies and approaches in place for service users/carers, staff and stakeholders/partners (C4)
11	Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training (C3)
12	Mandatory training standards set for each staff group (C3)
13	New leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services (C5)

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
1	Staff engagement plan approved by Trust Board, Action Plan reviewed through EMT	Staff engagement strategy (Trust Board June 2015)
2	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives	Quarterly strategy sessions in place
3	Assurance reports to Clinical Governance and Clinical Safety Committee covering key area of risk in the organisation seeking assurance on robustness of systems and processes in place	November 2015 – transformation, improving clinical information, Quality Accounts (standing item), creating a smoke-free environment, child and adolescent mental health services (standing item), Horizon review, emergency planning review of IT virus incident, clinical audit and practice effectiveness progress report, Care Quality Commission (inspection and Mental Health Act visits), nurse re-validation, exceptional cases update, and incident management reporting.
4	Service user survey results reported annually to Trust Board and action plans produced as applicable	Community mental health survey (December 2015)

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
5	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
6	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested	Monthly performance and finance reporting to EMT and Trust Board.
7	Monitoring of organisational development plan through General EMT group deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
8	Serious incidents from across the organisation reviewed through the Clinical Reference Group including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation	Quarterly reports to EMT, Clinical Governance and Clinical Safety Committee and Trust Board and learning lessons report.
9	CQC registration in place and assurance provided that Trust complies with its registration	Trust is registered with the CQC and assurance process in place through the Director of Nursing to ensure continued compliance.
10	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans	Unannounced and planned visits programme in place.
11	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events, listening and responding to needs	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Programme of visits to services by CE during Q2. Middleground 4 (rolling programme) with involvement of CE, Executive and Non-Executive Directors. Changes instigated to approach to communications with staff. Involvement and engagement with service users/carers through Friends and Families test. Staff wellbeing and national surveys, which includes Friends and Families test for staff. Planned programme of service user/carer events, including transformation, and planned Insight events in Q4. Equality and diversity engagement events for service users/carers in Q3.

Gaps in control and what do we need to do to address these and by when	Date
Mandatory training standards not being delivered in all areas, routine reports to teams identifying individuals out of compliance. Achievement of appraisal targets – ongoing monitoring through Remuneration and Terms of Service Committee	Ongoing Ongoing

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Delivery of staff engagement strategy action plan and improvement in staff survey scores Risk register no. 527 – bed occupancy pressures, being mitigated through action plans as set out in the organisational risk register. Meridian review of work flow in community and in-patient services being commissioned to work with front line teams, increasing productivity. Risk register (new) – CAMHS sustainability of funding Risk register (new) – IG incidents	March 2016

Rationale for current assurance level
Recent Well Led Review undertaken by independent reviewer, demonstrated through stakeholder engagement that the Trusts mission and values were clearly embedded through the organisation, staff living the values as evidenced through values into excellence awards.

Principle Delivery Objective: - Structure Delegated decision making to the front line, improving quality and use of resources, embedded meta, macro, meso and micro view of the external and internal environment.	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	Director of HR	CG & CS B & R TB	A/G	A/G	A/G	

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
St1	Unclear lines of accountability and responsibility within Directorates and between BDUs and Quality Academy impacting on ability to deliver safe, effective and efficient services	A/G
St2	Failure 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	A/G
St3	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	A/G

Controls – systems and processes (what are we currently doing about the Strategic Risks?)	
1	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 (St1)
2	Standing Orders, Standing Financial Systems, scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities (St1, St2)
3	Production of annual 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 (St1)
4	Director leads in place for transformation programme and key change management projects linked to corporate and personal objectives, with resources and deliverables identified (St1)
5	Through General EMT, Executive Management Team ensures alignment of developing strategies with Trust vision and strategic objectives (St3)
6	Policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval (St1)
7	Standardised process in place for producing businesses cases with full benefits realisation (St2)
8	Creative Minds Strategy and action plan in place approved by Trust Board, promoting different ways of working and partnership approach (St3)
9	Annual Business planning guidance in place standardising process and ensuring consistency of approach (St1)
10	IM&T Strategy in place and assured through IM&T Forum (St3)

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
1	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	Bids and tenders report (standing item delivery EMT), Public Health Education Team (October 2015), Meridian productivity proposal (October 2015), resuscitation (November 2015), records management and scanning (November 2015), Fieldhead non-secure business case (EMT and Trust Board October, November and December 2015), disclosure and barring checks (November 2015), ASD adult services diagnostic (November 2015), adult ADHD specialist services QIPP workstream (December 2015), Barnsley Healthy Child Programme (EMT and Trust Board standing item to March 2016). Child and adolescent mental health services (October and December 2015), Transformation update (Trust Board December 2015), possible Tier 4 CAMHS development services (October and December 2015)
2	Annual Governance Statement reviewed and approved by Audit Committee and Trust Board and externally audited	Approved by Audit Committee May 2015. Audit Committee also received confirmation of effectiveness of the Annual Governance Statement from the Trust's external auditor. Received by Trust Board June 2015 and Members' Council July 2015.
3	Monthly review and monitoring of integrated and quality performance reports by Trust Board with exception reports requested around risk areas	Monthly performance and finance reporting to Trust Board.

	Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)	Date
4	Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources	October 2015 – Internal Audit Charter, approval of Charitable Funds annual report and accounts, Trust arrangements for whistleblowing, data quality, pricing strategy, service line reporting and reference costs, currency development, triangulation of risk, performance and governance (standing item), Treasury Management (standing item), internal, external and counter fraud reports (standing items), procurement report (standing item) and losses and special payments report (standing item)
5	Annual plan and budget and five-year strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by Monitor	Annual plan and budget approved by Trust Board and submitted to Monitor (March and May 2015). Supported by monthly financial reporting to Trust Board and Monitor and quarterly exception reports. External review of Trust plan undertaken by Deloitte (February/March 2015).
6	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
7	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	Bi-monthly meetings of EMT (general) provide focus for the Trust's transformation plans.
8	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	IM&T TAG minutes. Presentation to Extended EMT November 2015. Weekly risk scan (Director of Nursing/Medical Director; EMT), internal audit (October 2015), revised approach in place (THINK IG) to raise staff awareness
9	Monitoring of organisational development plan through EMT, deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
10	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested	Monthly performance reports to EMT
11	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities	Clinical audit and practice effectiveness annual report to CG&CS September 2015 and Q2 report November 2015.

Gaps in control and what do we need to do to address these and by when	Date
Risk register no. 527 – bed occupancy pressures, being mitigated through action plans as set out in the organisational risk register. Meridian review of work flow in community and in-patient services being commissioned to work with front line teams, increasing productivity. Risk register (new) – CAMHS sustainability of funding	On-going Feb 2016

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
SITREP reports being reviewed by ORG and assurance provided through EMT Completion of review of decision-making framework (Scheme of Delegation) to inform delegated authority at all levels (to Audit Committee)	Nov 2015 February 2016

Rationale for current assurance level
Embedding of new Trio model, bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. Positive feedback re training and performance.

Principle Delivery Objective: - partnerships Co-production is the Trusts way of designing and delivering services.	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	CEO Med. Dir	B & R Strategic Audit Co.	A/G	A/G	A/G	

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
P1	Failure to develop required relationships or commissioner support to develop new services/expand existing services leading to contracts being awarded to other providers	A/R
P2	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	A/G
P3	Failure to clearly articulate intent and purpose of relationships leading to misunderstanding and conflict	A/G
P4	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	A/G
P5	Risk of lack of stakeholder engagement needed to drive innovation resulting in key stakeholders not fully engaged in process around redesign of service offer	A/G
P6	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	A/G

Controls – systems and processes (what are we currently doing about the Strategic Risks?)	
1	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 (P4)
2	Member Council engagement and involvement in working groups (P3, P5)
3	Production of market assessment against a number of frameworks including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power (P5)
4	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services (P1)
5	Development of joint QIPP plans with commissioners to improve quality and performance, reducing risk of decommissioning (P1)
6	Care Pathways and personalisation Project Board established with CCG and Local Authority Partners (P1, P3)
7	Member of local partnership boards, building relationships, ensuring transparency of agenda's and risks, facilitating joint working, cohesion of policies and strategies (P1, P3)
8	CCG/Provider performance monitoring regime of compliance with QIPP plan and CQUIN targets in place (P1)
9	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 (P4)
10	Involving People Strategy and action plan in place approved by Trust Board, promoting and developing key relationships (P4, P6)
11	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 (P2)
12	Public engagement and consultation events gaining insight and feedback, including identification of themes and reporting on how feedback been used (P4)
13	Staff wellbeing survey conducted, with facilitated group forums to review results and produce action plans (P5)
14	Complaints policy and complaints protocol covering integrated teams in place (P4)
15	Creative minds strategic partnering framework in place securing alternative capacity to support service offer (P4)

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
1	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board	CQC Mental Health Act visits – outcome reported to each Mental Health Act Committee and issues and follow up action agreed. Clinical and environmental issues reported to Clinical Governance and Clinical Safety Committee at each meeting. Preparation for CQC visit (beginning of March 2016) standing item on EMT, Trust Board and Clinical Governance and Clinical Safety Committee agenda.

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
2	Service user survey results reported annually to Trust Board and action plans produced as applicable	Community mental health survey Trust Board December 2015
3	Equality and Inclusion Forum established to drive improvement in delivery of equality, involvement and inclusion agenda reporting into Trust Board	Equality and Inclusion Forum established May 2015 with approved terms of reference and chaired by Non-Executive Director. Key issues reported to Trust Board after each meeting.
4	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
5	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	Bi-monthly meetings of EMT (general) provide focus for the Trust's transformation plans.
6	Monitoring of organisational development plan through Chief Executive-led group deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
7	Strategic overview and analysis of partnerships in line with Trust vision and objectives provided through EMT and Trust Board	Bi-monthly meetings of EMT (general) include an assessment and analysis of Trust relationship and partnership with its stakeholders. This includes an analysis of risk and mitigation. Formal quarterly report on stakeholder relationships at Trust Board with regular updates on any key issues through Chair and Chief Executive remarks at Trust Board. Key part of Trust Board strategy meetings.
8	Market analysis reviewed through EMT, market assessment to Trust Board ensuring identification of opportunities and threats	Bi-monthly meetings of EMT (general) provide focus for the Trust's stakeholders and market position. Quarterly reports to Trust Board on Trust's market position, its business and strategic risks.
9	HealthWatch undertake unannounced visits to services providing external assurance on standards and quality of care	Healthwatch has the 'power' to enter and view Trust services. This is mostly managed by service lines who are approached directly. Examples of 'corporate' activity are from Barnsley Healthwatch who follow up on all Healthwatch England special enquiry agenda items. In 2015, Barnsley Healthwatch reviewed young people's services through the Children and Young People Engagement Officer at Voluntary Action Barnsley. The action plans were owned within the service and shared with Healthwatch. Barnsley Healthwatch has been commissioned by NHS England to look at how the Friends and Family Test is embedded in mental health services in Barnsley. This review will look at CAMHS, community mental health services and Kendray Hospital services.
10	QIPP performance monitored through delivery EMT, deviations identified and remedial plans requested	Monthly performance and finance reports to EMT
11	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans	Unannounced and planned visits programme in place.
12	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Programme of visits to services by CE during Q2. Middleground 4 (rolling programme) with involvement of CE, Executive and Non-Executive Directors. Changes instigated to approach to communications with staff. Involvement and engagement with service users/carers through Friends and Families test. Staff wellbeing and national surveys, which includes Friends and Families test for staff. Planned programme of service user/carer events, including transformation, and planned Insight events in Q4. Equality and diversity engagement events for service users/carers in Q3.

Gaps in control and what do we need to do to address these and by when	Date
Risk register no. 270 – contracting mechanisms and pricing for mental health and community services, being mitigated through action plans as set out in the organisational risk register and development of pricing strategy.	On-going

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Co-ordinated approach to stakeholder engagement in each locality, addressed through horizon scanning at EMT, quarterly strategic Trust Board meetings and quarterly report to Trust Board on strategic overview of business and associated risks, development of Customer Relationship Management system.	On-going

Rationale for current assurance level
Partnership working with Locala securing CC2H contract and establishment of Programme Board. Establishment of locality Recovery Colleges and production of co-produced prospectus. Increasing capacity of Creative Minds, through partnership development. Development of Spirit in Mind partnership network. Regular Board-to-Board meetings with partners (such as Calderdale and Huddersfield NHS Foundation Trust).

Principal Delivery Objective: Leadership Embedded leadership and competency framework across the Trust describing the competencies and behaviours required.	Lead Director(s)		Current Assurance Level			
	Dir of HR		Q1	Q2	Q3	Q4
			A/G	A/G	A/G	

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
L1	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 national and local targets and standards	A/G
L2	Failure to articulate leadership requirements to identify, harness and support talent to drive effective leadership and succession planning	A/G

Controls – systems and processes (what are we currently doing about the Strategic Risks?)	
1	Executive Management Team ensures alignment of developing transformation plans with Trust vision and strategic objectives (L1)
2	OD Framework and plan in place (L2)
3	Partnership Boards established with staff side organisations to manage and facilitate necessary change (L1)
4	Leadership and management development programme in place with on-going evaluation and adaption (L2)
5	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 (L1)
6	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (L1, L2)

Pres		Date
1	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	Presentation of assurance framework and risk register to Trust Board quarterly. Triangulation of risk, performance and governance received as a standing item by the Audit Committee.
2	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board	CQC Mental Health Act visits – outcome reported to each Mental Health Act Committee and issues and follow up action agreed. Clinical and environmental issues reported to Clinical Governance and Clinical Safety Committee at each meeting. Preparation for CQC visit (beginning of March 2016) standing item on EMT, Trust Board and Clinical Governance and Clinical Safety Committee agenda.
3	Remuneration and Terms of Service Committee receive HR Performance Reports, monitor compliance against plans and receive assurance from reports around staff development, workforce resilience	HR performance reporting standing item on Remuneration and Terms of Service Committee agenda. Exception reports received as appropriate.
4	Independent CQC reports to Mental Health Act Committee provided assurance on compliance with Mental Health Act	CQC Mental Health Act visits – outcome reported to each Mental Health Act Committee and issues and follow up action agreed. Clinical and environmental issues reported to Clinical Governance and Clinical Safety Committee at each meeting.
5	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
6	Monitoring or organisational development plan through EMT, deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
7	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	December 2015 92.8% B6+ (target 95% in Q1) and 83.5% B5- (target 95% in Q2)
8	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans	Unannounced and planned visits programme in place.

Gaps in control and what do we need to do to address these and by when	Date
Mandatory training standards not being delivered in all areas, routine reports to teams identifying individuals out of compliance. Appraisal targets not met in Q1 and Q2 2015/16, routine reporting to EMT and R&TSC	February 2016

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Workforce plans require on-going development as transformation standard operating procedures are being finalised to deliver the revised service offers, transformation reports to EMT setting out time lines for changing workforce plans, skills and competencies to deliver revised service offers.	For annual plan 2016/17

Rationale for current assurance level
Well-led review of governance arrangements Internal Audit report on leadership development – significant assurance with minor improvement opportunities. Robust and clear plans in place to recruit to Board-level posts led by Chair and Director of Human Resources and monitored through R&TSC

Principle Delivery Objective: - Innovation Evidenced based recovery approach to delivery of services across the Trust.	Lead Director(s)	Key Board of Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	D of H & Inn Med Direc.	Strategic Board CG & CS	A/G	A/G	A/G	

	Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment	Rag Rating
I1	Lack of resources to support development and foster innovation to support delivery of plan	G
I2	Lack of engagement with staff, particularly clinical staff, which means they are unable to participate in research and development, or in development of innovative approaches	A/G
I3	Lack of analytical capacity and skills to support transformation and bids and tenders	A/G

	Controls – systems and processes (what are we currently doing about the Strategic Risks?)
1	OD framework and implementation plan in place (I1)
2	Standardised process in place for producing businesses cases with full benefits realisation (I1, I3)
3	Innovation fund established to pump prime investment to deliver service change and innovation (I1)
4	Innovation Framework in place (I1, I3)
5	Thinking differently training in place tailored to BDU's/Quality Academy (I2)
6	Communications and Engagement Strategies and approaches in place for service users/carers, staff and stakeholders/partners (I2)

	Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)	Date
1	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	Bids and tenders report (standing item delivery EMT), Public Health Education Team (October 2015), Meridian productivity proposal (October 2015), resuscitation (November 2015), records management and scanning (November 2015), Fieldhead non-secure business case (EMT and Trust Board October, November and December 2015), disclosure and barring checks (November 2015), ASD adult services diagnostic (November 2015), adult ADHD specialist services QIPP workstream (December 2015), Barnsley Healthy Child Programme (EMT and Trust Board standing item to March 2016). Child and adolescent mental health services (October and December 2015), Transformation update (Trust Board December 2015), possible Tier 4 CAMHS development services (October and December 2015)
2	Innovation fund allocation approved through EMT with guidance to ensure consistency of approach and alignment with strategic priorities and corporate objectives	Allocation of Innovation Fund monies and guidance on its use agreed by EMT as part of the budget setting process each year.
3	Monitoring of organisational development plan through EMT deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
4	Development of health intelligence manual	Presentation of approach to EMT January 2016.
5	Benchmarking of services and action plans in place to address variation	Trust is member of NHS benchmarking club. Reports considered by EMT and shared with BDUs. Regular reporting of development and introduction of service line reporting to Audit Committee (standing item). Benchmarking information used to inform discussion on caseload and ethnicity Equality and Inclusion Forum December 2015.

Gaps in control and what do we need to do to address these and by when	Date
On-going delivery of thinking differently training, monitoring of take up by Directorate/BDU and Service line.	March 2016

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Development of Health Intelligence Manual (presented to EMT January 2016)	March 2016

Rationale for current assurance level
Involvement of senior leadership team through Extended EMT in innovation framework development and integrated performance report redesign, appetite for co-production and change. Ongoing work to develop Health Intelligence Manual

Principle Delivery Objective: - Talent Developed talent management programme and succession planning for key organisational roles.	Lead Director(s)	Key Board of Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	D of HR	RTSC Business & Risk	A/G	A/G	A/G	

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
T1	Lack of strategic approach to talent management linked to clinical leadership, clinical specialist and senior management roles	A/G
T2	Lack of strategic approach to address potential shortages in certain staff groups	A/G
T3	Lack of strategic approach to success planning	A/G

Controls – systems and processes (what are we currently doing about the Strategic Risks?)	
1	Staff Engagement Strategy approved by Board and action plan in place (T1)
2	Values-based appraisal process in place and monitored through KPI's (T3)
3	OD Framework and plan in place (T1)
4	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 (T2)
5	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 (T1, T3)
6	Medical Leadership Programme in place with external facilitation (T2)
7	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (T2)
8	Values-based Trust induction policy in place covering mission, vision, values, key policies and procedures (T1)
9	A set of leadership competencies developed as part of Leadership and Management Development Plan supported by coherent and consistent leadership development programme (T2)
10	New leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services (T1, T3)

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
1	Staff opinion and wellbeing survey results reported to Trust Board and/or Remuneration and Terms of Service Committee and action plans produced as applicable	Reports to Remuneration and Terms of Service Committee July 2015
2	Medical staff appraisal and revalidation in place evidenced through annual report to Trust Board and supported through Appraisers forum	Independent desk-top review of revalidation process during Q3, which found the process in place is robust, comprehensive and fit for purpose. Annual report to Trust Board June 2015. Appraisers' Forum held three times/year.
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	December 2015 92.8% B6+ (target 95% in Q1) and 83.5% B5- (target 95% in Q2)
4	Monitoring of organisational development plan through General EMT deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
5	External accreditation against IIP GOLD supported by internal assessors, ensuring consistency of approach in the support of staff development and links with organisational objectives	
6	Risk assessment of nurse re-validation proposals	Risk assessment undertaken and reported to EMT, Clinical Governance and Clinical Safety Committee and Trust Board. Trust Board request for inclusion on the organisational risk register until clear guidance available. Removed from risk register following risk assessment by EMT.
7	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Programme of visits to services by CE during Q2. Middleground 4 (rolling programme) with involvement of CE, Executive and Non-Executive Directors. Changes instigated to approach to communications with staff. Involvement and engagement with service users/carers through Friends and Families test. Staff wellbeing and national surveys, which includes Friends and Families test for staff. Planned programme of service user/carer events, including transformation, and planned Insight events in Q4. Equality and diversity engagement events for service users/carers in Q3.

Gaps in control and what do we need to do to address these and by when	Date
Interim Director arrangements in place, addressed through recruitment process.	Dec 2015

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Interim Director of Finance in place with process in place for appointment to substantive post	March 2016

Rationale for current assurance level
Internal Audit report on leadership development – significant assurance with minor improvement opportunities. Appointment made to Director of Forensic and Specialist Services. Interim Director of Finance in post. Recruitment process in place for Chief Executive and substantive Director of Finance

Trust Board 29 January 2016
Board Assurance and Escalation Framework

Introduction

South West Yorkshire Partnership NHS Foundation Trust (the Trust) has developed a range of policies, systems and processes, which, when drawn together, comprise a robust framework for the assurance of quality and escalation of risk within the Trust.

This document describes the risk escalation and assurance framework and demonstrates how the Trust's risk systems and learning from events is monitored and escalated where necessary by an effective governance and committee structure.

A robust governance framework is essential for the organisation as it provides assurance to the Trust Board, the Members' Council, senior managers and clinicians that the essential standards of quality and safety are being met by the Trust. It also provides assurance that the governance processes are embedded throughout the organisation.

This framework describes the responsibility and accountability for the Trust's governance structures and systems, through which Trust Board receives assurance or escalates concerns and risks related to quality of services, performance targets, service delivery and achievement of strategic objectives. It also addresses under-performance and ensures that potential performance problems are identified early, and action plans developed to rectify or mitigate the issues.

Culture

The Trust has an open, honest and learning culture, which is set out in its mission and values and underpinned in its Being Open policy. The Trust encourages the reporting of all adverse incidents by its staff and the reporting of complaints and concerns by service users, their carers and relatives, supported through an independent advocacy process if required.

Staff Involvement

The Trust has an overarching staff engagement strategy and a number of policies and mechanisms which encourage staff at all levels to be involved in performance monitoring and to raise concerns about any risk issues. Examples include Raising Concerns (Whistleblowing) Policy, Being Open Policy, Risk Management Strategy, Incident Reporting and Management Policy, Customer Services Policy, safeguarding policies and procedures, staff surveys and through the Staff Partnership Forum.

Service user/carer/public involvement

The Trust encourages service users, their carers and the public to make comments and/or raise concerns both formally and informally via a number of mechanisms, such as customer services, patient experience surveys, friends and family test, service line specific service user and carer groups, Patient Led Assessments of the Care Environment (PLACE), 'CQC type' walk rounds and service user led 15 steps visits. The Trust has been independently accredited to Customer Service Excellence, a nationally recognised standard of customer focused service delivery.

Internal and External Sources of Assessment and Assurance

The Trust has a number of internal and external sources of assessment and assurance, including the following.

Internal

Board and Committee Assurance Reports
Trust Action Group reports
Corporate Performance Report
Minutes (of key meetings)
Internal Audit Reports
Local Counter Fraud Reports
Incident Reports
Staff Survey Results
Serious Investigations (SIs) Reports
Annual Governance Statement
Information Governance Toolkit
Quality Impact Assessments
Members' Council Quality Group

External

External visits/inspection reports such as CQC visits
Independent Reviews (such as Ombudsman Reports)
External accreditations such as Customer Services Excellence, IIP, Clinical Network Reviews
Quality Accounts and its independent audit
Annual Audit Letter
National Staff Surveys
National Patient Satisfaction Surveys (Friends and Family Test)
PLACE Inspection reports
Healthwatch reports
External Audit reports

The Trust also commissions additional external reviews of activities, services and events where a need for independent assessment and assurance has been identified such as the Deloitte review of the deliverability of the Trust's annual plan.

Commissioners and Regulators

In addition to the internal routes for raising concerns and escalating risk, there are formal mechanisms which can be used by key stakeholders, such as commissioners and regulators to raise concerns such as contract and performance review meetings with CCGs, specialty commissioning meetings, board-to-board meetings with other NHS providers/commissioners, CCGs Quality Board, Monitor's formal response to Trust quarterly submissions.

Trust's Internal Quality and Performance Monitoring

The Trust has a number of fora where quality and performance is discussed. The key performance meetings are the Operational Requirement Group (weekly) and Executive Management Team Delivery meeting (monthly) both chaired by the Chief Executive. Trust Board Committees provide assurance regarding performance.

Performance is managed at a local level through monthly BDU performance meetings which are chaired by the BDU Director. Each BDU considers its performance against key

performance targets and reviews the performance of individual service lines within the BDU against these indicators. Where performance issues are identified, actions plans are developed and implemented to address the issues.

Reporting of key issues adversely affecting performance is done on an exception basis at the ORG and any key risks or areas of performance requiring escalation are elevated to the EMT to be managed accordingly.

The Clinical Governance and Clinical Safety Committee receives performance information and intelligence relating to all aspects of quality, safety, risk and regulation, and patient experience; likewise the Mental Health Act Committee has a specific focus on aspects relating to the Trust's implementation of the Mental Health Act. Any significant risks or issues are reported through to the Trust Board through the monthly Committee assurance report and the Board Assurance Framework, which is submitted quarterly to the Board.

Trust Board receives an integrated performance report each month. It details a range of indicators with the most recent month's performance against target on a 'RAG' rated basis. Any areas of adverse performance are reported to Trust Board via more detailed exception reports.

A 'ward-to-board' dashboard is in operation which gives specific information on key performance indicators on a service line basis, ensuring through the trio partnership of clinician, general manager and practice governance coach, all areas are providing safe, effective care and a positive patient experience.

Cost Improvement Plans

The Trust has in place a process for the development, evaluation and monitoring of Cost Improvement Plans (CIPs) which includes a robust Quality Impact Assessment for each individual scheme, that sets out an independent assessment of the quality and risk to services of implementing the project. Projects evaluated as high risk require further work on mitigation of risks or substitution of alternative schemes.

Quality Strategy and Account

The Trust has in place a Quality Strategy, which sets out the seven key priorities for quality improvement as determined by our service users and carers. The delivery of the continuous quality improvement described by the strategy and plan is underpinned by the Trust's seven step Quality Improvement Framework.

The Trust's annual Quality Accounts, which is prepared in line with the requirements of the NHS Act 2009, Health and Social Care Bill 2012 and our regulator Monitor, provides a report to the public about the quality of services the Trust provides and the progress against its strategic and annual quality objectives. It provides an opportunity for scrutiny on how the Trust performs in relation to quality and sets out the focussed areas for quality improvement for the forthcoming year. Independent assurance is obtained on the Trust's Quality Account from commissioners, other external stakeholders and the Trust's external auditors.

Compliance with Regulators

Care Quality Commission

As a provider of health services the Trust is registered with the CQC and has systems in place to ensure compliance with its fundamental standards. This includes internal inspections based on five key questions in relation to whether services safe, effective,

caring, responsive and well led. A self-assessment tool kit is available for teams to benchmark against each of the fundamental standards.

The Clinical Governance and Clinical Safety Committee receives exception reports on any areas of noncompliance or with compliance concerns. Exception reports also provide assurance against the steps being taken to ensure compliance is achieved.

The CQC also undertakes a mixture of announced and unannounced inspections, leading to ratings of individual services and the provider overall.

Monitor

Trust Board confirms compliance with Monitor regarding the conditions of the provider licence in relation to all targets and national core standards, on an annual basis as part of the Annual Plan submission and through the submission of Board governance statements to Monitor on a quarterly basis. The organisation receives a formal response from Monitor, which is used as the basis for a quarterly review with Monitor.

In line with Monitor's Well-led Governance Framework, Trust Board commissions an independent review of its governance arrangements on a three-yearly basis, the first concluding in September 2015.

Risk Escalation Framework

Risks are assessed using the methodology described in the Risk Management Strategy. Risk assessments are entered onto the Datix Risk Management System to inform the organisation's risk registers.

The Organisational Risk Register is reviewed and updated by the Executive Management Team (EMT) on a monthly basis, and reviewed on a quarterly basis by the Board in conjunction with the Trust's Board Assurance Framework.

Board Assurance Framework (BAF)

The Board Assurance Framework underpins the delivery of its strategic objectives and incorporates the highest risks faced by the organisation. It, therefore, aligns the Trust's principal risks with key controls and assurances for each of the Trust's strategic objectives. Where gaps in assurance are identified, mitigating actions are developed to reduce the risk of non-delivery of these key objectives.

The BAF is reviewed on a quarterly basis by Trust Board. Strategic risks are identified by the Board and reviewed quarterly on receipt of the BAF and annually against the Trust's strategic objectives. The Board Assurance Framework provides a vehicle for Trust Board to be assured that the systems, policies and people in place are operating in a way that is effective and focussed on the key risks which might prevent the Trust's objectives being achieved.

Assuring Board Effectiveness

There are a number of ways in which Trust Board assures itself that it is fulfilling its duties effectively. These include:

Self-assessments such as Monitor's Well Led Framework;
External effectiveness reviews
Annual assessment against the Annual Governance Statement, completed in accordance with Monitor's annual reporting manual

Board strategy and development sessions
Scrutiny of Trust Board minutes, robust monitoring and follow up of the Board's action points and forward plan
Board director induction and appraisal
Annual review and assurance reports from the sub-committees of the Board.

Learning Lessons

The Trust is committed to learning lessons in an open and transparent way. It does this through the examination of complaints, serious incidents, staff feedback, service user and carer feedback, internal reports, external reviews, assessments, inspections and the review of national reports and reviews. The Customer Experience Group triangulates complaints, incidents and reports to consider themes and trends, ensures review, monitoring and feedback loops are in place, such as "You said, We did" and ensures targeted training and development is in place.

Conclusion

The Board Assurance and Escalation Framework will be reviewed on an annual basis by Trust Board to ensure it is effectively utilised. Trust Board Committees will retain oversight of its implementation through their forward plans, review of escalated issues, and, specifically, through the review of risk registers by EMT. The Audit Committee will also ensure the framework remains fit for purpose by reviewing, as appropriate, the systems and processes contained within it.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Risk profile 29 January 2016

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)		= Trust sustainability declaration made in five-year strategy plan (695) = Transformation programme (463) = Trust transformation aligned with commissioners' transformation programmesand intentions (773) = Reduction in local authority funding to commission services (772) = Local commissioning intentions (812) ! Sustainable child and adolescent mental health service funding	
Major (4)			< CAMHS Calderdale and Kirklees (668)	= Mechanisms for contracting and pricing for mental health and community services (270) = Data quality and capture of clinical information on RiO (267) = Bed occupancy (527) ! Information governance incidents	> Reduction in local authority funding to provide services (275)
Moderate (3)					
Minor (2)					
Negligible (1)					

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

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

ORGANISATIONAL LEVEL RISK REPORT

DATE: Trust Board 29 January 2016

	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
695			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk of adverse impact on clinical, operational and financial risk if the Trust is unable to manage the transition in year 3 of the five-year plan, as the plan states that the Trust would be operationally, clinically and financially unsustainable by the end of 2016/17 in its current configuration.	Risk scenario modelled in five-year plan submitted to Monitor in June 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 Major	4 Likely	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 Trust Board every quarter. ➢ Recruitment to key areas of expertise to enable five-year plan to be realised through health intelligence, marketing and commercial skills, strategic planning and programme management. ➢ Increased used of service line reporting information. ➢ Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models and sustainable services.		EMT	Plan submitted to regulator May 2015	Monthly review EMT Transformation Board review Quarterly updates to Board	12	Amber/ high (8-12)			Trust Board January 2016
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 review at EMT and ORG 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 internal engagement events programme on transformation programme. ➢ Staff engagement strategy approved by Trust Board. ➢ Results of staff wellbeing survey used to target engagement. ➢ Director objectives linked to deliverables in the transformation programme and engagement. ➢ Roll-out of mental health acute commissioning implementation starting January 2016. ➢ Regular updates on progress and implementation through EMT and Trust Board. ➢ Quality impact assessment process well established.	£0.9m	Work stream leads	Annual plan	Bi-monthly focus by EMT on transformation. Trust Board reports as appropriate. Business cases approved by Calderdale, Kirklees and Wakefield commissioners.	16	Red/extreme /SUI risk (15-25)	Yes		Trust Board January 2016
773			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 is not aligned to CCG and LA commissioning intentions and will increase clinical, operational, financial and reputational risk through potential implementation of service models which are not supported by commissioners.	➢ Transformation projects required to include engagement with external partners to ensure alignment. ➢ Communications through contract meetings and other working groups to ensure appropriate sharing of information. ➢ Development of team-to-team meetings with commissioner organisations to ensure strategic alignment. ➢ Scheduled review of stakeholder engagement including external relationship management at EMT. ➢ Interim Director of Marketing, Engagement and Commercial Development to increase	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Development of engagement plan by Interim Director of Marketing, Engagement and Commercial Development. ➢ Active participation at all levels in service integration initiatives across all LA/CCG patches, including West Yorkshire urgent care. ➢ Forging stronger links with national bodies to influence local and national systems thinking in relation to mental health and community services, for example, Trust Chair member of NHS Providers Board and Chief Executive Chair of Mental Health Network at NHS Confederation. ➢ Strengthen link between transformation programme and contracting in particular using the transformation programme to identify areas		Deputy CEO, DoF, Workstream leads	Annual plan	Bi-monthly focus by EMT on transformation. Trust Board reports as appropriate. Business cases approved by Calderdale, Kirklees and Wakefield commissioners.	16	Red/extreme /SUI risk (15-25)	Yes		Trust Board January 2016

								capacity and skills to support this agenda.					➢ for QIPP savings. ➢ Agreement of number of key transformation projects in 2015/16 which have also been reviewed by Overview and Scrutiny. ➢ Links strengthened with CCGs to ensure that mental health commissioning intentions are relevant and appropriate. ➢ Consistent alignment of all Trust activity with CCG Service Reviews, and GP Federation provider aspirations in relation to transformation of the Trust's general community services.									
772			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			*Risk related to local authority as commissioner* Impact of continued reduction in Local Authority budgets may have negative impact on level of financial resources available to commission services from NHS providers which represents a clinical, operational and financial risk, in particular for services commissioned by public health, which includes 0-19 services, health and wellbeing and drugs misuse.	➢ District integrated governance boards established to manage integrated working with good track record or co-operation. ➢ In all geographic areas, the Trust is a partner in developing integrated working to reduce overall costs in the system. ➢ Maintenance of good strategic partnerships through maintenance of positive relationships with Local authority staff through EMT and operational contacts and positive engagement of overview and scrutiny and other system 'transformation' boards. ➢ Monthly review through Delivery EMT of key indicators which would indicate if issues arose regarding delivery, such as delayed transfers of care and service users in settled accommodation. ➢ At least monthly review of bids management in relation to services commissioned by local authorities.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Continues to be monitored through BDU/commissioner forums. Given latest round of austerity measures and planning guidance, review of position in progress. ➢ Board-to-Board meeting with Barnsley senior team, where objectives were agreed which should facilitate a system response to current challenges. ➢ Agreement of joint approach to develop model for 0–19 services in Barnsley with local authority. ➢ Joint commissioned work between Trust and Wakefield Council to provide baseline for ensuring joint service provision for mental health service is fit for purpose linked to system wide transformation and MCP Vanguard. ➢ With Calderdale Council, joint working under review through consideration of new ways of working in the MCP Vanguard. ➢ Part of Integration Board which is chaired by Locala and includes local authority to develop wider system integration following award of Care Closer to Home contract for community services in Kirklees.		EMT	Annual plan	EMT (monthly) and Trust Board (monthly). EMT review of 2015/16 contracts each month at Delivery EMT Review of 2016/17 contract by EMT from January to March 2016. Bid management team update to EMT monthly	12	Amber/ high (8-12)	Yes		Trust Board January 2016
812			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk that Trust's clinical operational and financial sustainability will be adversely impacted on in 2016/17 by impact of local commissioning intentions from CCGs and local authorities which include reductions in national funding due to impact of changes in national allocation, level and pace of requirement by CCGs for QIPP savings, and level of priority for spending on mental health and community services versus other system pressures.	➢ 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	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Trust is proactive in involvement in system transformation programmes which are led by commissioners, including four Vanguard programmes. ➢ Internal Trust transformation programme linked to CCG commissioning by including schemes within the QIPP in 2014/15 and 2015/16. ➢ Planned improvement in bid management process including additional skills building and increase in joint bids with partners. ➢ Horizon scanning for new business opportunities. ➢ Increased capacity and skills to support stakeholder engagement in place. ➢ Effective communication of successes to build Trust in delivery and increase likelihood of future business. ➢ Maintain tight control on costs to maximise contribution. ➢ Review of CQUIN income attainment by EMT and ORG and action plan to improve for Q4. ➢ Local CCG finance directors have agreed to review of pricing strategy which supports development of mental health currency and transparency in the contract arrangements. ➢ 2016/17 annual plan and strategy revision is key action for Trust Board to manage this risk. ➢ Review of commissioning intentions by EMT and contract negotiation stances and meetings in place to progress agreement of contracts for 2016/17.	Loss of income could be in the order of £1m - £5m	EMT Senior leads for planning transfor mation and contracting plus Deputy Directors of operations	Annual plan Contract development plans Including in Vanguard action plans	Monthly at EMT. Quarterly risk and business board.	15	Red/extreme /SUI risk (15-25)	Yes		Trust Board January 2016
275			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			*Risk linked to local authority as providers.* Continued reduction in Local Authority funding and changes in benefits system will result in increased demand for health and social care services, which may impact on capacity and resources within integrated teams for mental health and	➢ District integrated governance boards established to manage integrated working with good track record of co-operation. ➢ Agreed joint arrangements for management and monitoring delivery of integrated teams. ➢ Maintenance of good operational links though BDU teams and leadership. ➢ Monthly review through Delivery EMT of key indicators, which would indicate if issues arose	4 Major	5 Almost certain	20	Red/extreme /SUI risk (15-25)	➢ Continues to be monitored through BDU/commissioner forums. Given latest round of austerity measures (July 2015) and current planning guidance (December 2015), review of position in progress and will be reflected in Annual Plan submission. ➢ Board-to-Board meeting with Barnsley senior team where objectives were agreed which should facilitate a system response to current challenges. ➢ Joint commissioned work between Trust and		BDU Directors	Included in annual plan	EMT (monthly) and Trust Board (monthly) EMT review of 2015/16 contracts each month at Delivery EMT Review of 2016/17 contract by EMT from January to March 2016. Bid management team update to EMT monthly	16	Red/extreme /SUI risk (15-25)	Yes		Trust Board January 2016

							community provision. Reduced funding in provision by local authorities will reduce the service capacity within integrated teams and pathways which creates potential service and clinical risks, including impact on waiting times, assessment and management of risk.	regarding delivery, such as delayed transfers of care and service users in settled accommodation.					Wakefield Council to provide baseline for ensuring joint service provision for mental health service is fit for purpose linked to system wide transformation and MCP Vanguard ➢ With Calderdale Council, joint working under review through consideration of new ways of working in the MCP Vanguard. ➢ Use of service line reporting and health intelligence to drill down to facilitate early detection of quality issues. ➢ Weekly risk scan by Director of Nursing and Medical Director to identify any emerging issues reported weekly to EMT.								
270			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Implementation of new currency models for mental health and community services will move the current funding arrangements from block contracts to activity-based contracts. This may present clinical, operational and financial risk if cost and pricing mechanisms are not fully understood at local, regional and national level.	➢ Accountability arrangements in place for delivery of mental health currency. Incorporated into transformation workstream for mental health. Data quality and clinical system linkages picked up through the data quality steering group and the System development Board respectively. ➢ Progress reviewed by Audit Committee and Trust Board. ➢ Key issues/risks and progress monitored through Delivery EMT. ➢ Key representation at national level for development of costing by Chief Executive and Director of Finance.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ All mental health transformation projects consider the impact of mental health clustering and the four-tier pathway for mental health services is cross referenced to the 21 clusters. ➢ Contract agreements and monitoring in place with commissioners for 2015/16. This includes CQUIN targets to incentivise key metrics for the embedding of the mental health clusters in clinical practice. This is currently under review as the Trust is not maximising CQUIN income in this area ➢ Specific case review project in progress to ensure only 'live' caseload included on clinical system. ➢ Monitoring at service line by practice governance coach, general manager and clinical lead with escalation of issues which need Trust-wide response. ➢ Scheduled reviews at EMT on progress and metrics included in monthly performance report. ➢ Mental health currency and service line reporting standing items on Audit Committee agenda, which has included presentation from BDU Directors on implementation within BDUs. ➢ Ongoing review by Operational Review Group (ORG) in January 2016 to monitor effectiveness of action plan		Deputy CEO, DoF, BDU lead director for MH transformation DoN Medical Director	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 ➢ Review on action plans by ORG (meets weekly)	16	Red/extreme /SUI risk (15-25)	Yes		Trust Board January 2016
267			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			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 improvement plans are monitored by the Data Quality Steering group. Chaired by the Director of Nursing. ➢ Accountability for data quality is held jointly by Director of Nursing and Deputy Chief Executive. ➢ 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 Delivery EMT. ➢ Annual clinical audit programme is planned to reflect data quality priorities.	4 Major	4 Likely	16	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 through practice governance coaches. ➢ Upgrade of RiO to version 7 will facilitate data quality compliance though, for example, spine connectivity. ➢ Roll-out plan reviewed by Systems Development Board. ➢ Wider system development network established with clinicians and managers including secondment of consultant medic as advisory post. ➢ Data quality metrics included in monthly performance reports. ➢ EMT agreed additional resources to be managed by BDUs to support clean-up of caseloads in 2015. This is now part of service line management by 'trios'. ➢ Link of clustering data to mental health transformation work in business cases for acute and community to ensure mainstreamed into redesigned services. ➢ Report to Audit Committee October 2015 and standing item on the agenda for Clinical Governance and Clinical Safety Committee. ➢ Five priorities identified for focus (monitoring, supporting with guidance/SOPs, learning from each other's experiences, looking for ways to improve quality, and champion the importance of this work).		Deputy CEO and Director of Nursing	Implementation of national guidance during April 2016	EMT and Trust Board monthly review for data quality indicators. Steering group review for data quality board, Clinical Governance and Clinical Safety Committee and System Development Board. Monthly System Development Board for RiO system. Agreed work plan and prioritisation.	12	Amber/ high (8-12)	Yes		Trust Board January 2016
527			Corporate/ organisation level risk	Trust wide (Corporate support			Bed occupancy is above that expected due to an increase in	➢ Revised bed management protocol. ➢ Review of protocol completed	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Bed management systems in place across all BDUs to manage patient flow, reduce out-of-area		BDU Director	Protocol reviewed	Monthly at EMT	12	Amber/ high (8-12)	Yes		Trust Board January 2016

			(corporate use only EMT)	services)			acuity and admissions, which is causing pressures across all bed-based mental health areas across the Trust.	and action plan developed. ➢ Patient flow system established in BDUs with rest to follow. ➢ Linked to Acute Care Transformation Programme.					placements and reduce delayed discharges of care. ➢ Situation reports monitored weekly at ORG. ➢ Internal audit undertaken on implementation of bed management protocol and action plan in place with monitoring. ➢ Trust-wide bed position available to all relevant Trust staff to enable effective use of Trust bed-base.									
DATIX risk reference TBC			Corporate/ organisation level risk (corporate use only EMT)	Calderdale and Kirklees	CAMHS		Risk in 2016/17 that the Trust will be unable to secure sufficient funding to support a sustainable child and adolescent mental health service	➢ From transfer of service in April 2013 contract management and review arrangements in place with the commissioner. ➢ Joint action plan in place from 2013 to address waiting times, caseload management and data quality. ➢ Intensive support provided internally by Trust to support the action plan and service transferred to RiO system to support data quality. ➢ Cost pressure absorbed internally of £500,000 in 2014/15 and 2015/16 to support recruitment and capacity. ➢ Business case submitted to commissioners to develop crisis team in CAMHS which has been approved and funded non-recurrently.	5	4	20	Red/extreme /SUI risk (15-25)	➢ Introduction of CAMHS summit meetings across all partners in 2015/16 including commissioners and local authority. ➢ Reviewed at regular contract meetings and Quality Board. ➢ This has led to system action plan and identified key issues to address outside the remit of this contract. ➢ Evidence of improvement in delivery of service. ➢ Update on progress reported to Board monthly. ➢ Joint work in place with commissioners as part of 2016/17 contract negotiation to secure sustainable funding.	Income at risk circa £1.3m	BDU Director Deputy CEO DoF	Completion for 2016/17 contract sign off March 2016	Negotiation process monitored through EMT Regular report to Board on progress	15	Red/extreme /SUI risk (15-25)	Yes		Trust Board January 2016
DATIX risk reference TBC			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Reputational risk and financial risk due to increase in reported information governance incidents to Information Commissioner	➢ Trust maintains access to information governance training for all staff and has track record of achieving the mandatory training target. ➢ Trust employs appropriate skills and capacity to advise on policies, procedures and training for Information Governance. ➢ Trust has appropriate polices and procedures in place. ➢ Trust has good track record for recording incidents and all incidents are reviewed weekly by Deputy Director of IM&T and Information Governance Manager. ➢ Data Quality Improvement TAG in place, which is the governance group with oversight of IG issues. ➢ EMT reviews any escalation issues from TAG. ➢ Internal audit perform annual review of IG as part of IG Toolkit ➢ IT forum, which is a sub-committee of Trust Board, reviews implementation of IM&T strategy and any items for escalation.	5	4	20	Red/extreme /SUI risk (15-25)	➢ Increase in incidents noted in 2015/16 including serious incidents. ➢ Additional action taken to review guidance and polices. ➢ Targeted approach to advice and support from Information Governance Manager through proactive monitoring of incidents. ➢ Awareness raising sessions including Extended EMT. ➢ Rebranded materials and advice to increase awareness in staff and reduce incidents. ➢ Increase in training available to teams including additional e–learning and face-to-face training from Q4.	Risk of fine up to £500,000	SIRO Deputy CEO DoN BDU Directors	Internal Audit report due March 2016	Progress monitored through EMT and weekly risk scan	15	Red/extreme /SUI risk (15-25)	Yes	Trust signed an undertaking with the Information Commissioner's Office in June 2015 due to concern about number of incidents related to inappropriate disclosure of information Half year review by ICO repots good progress to date. ICO will undertake audit in 2016	Trust Board January 2016