South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (business and risk)
Tuesday 19 July 2016 at 9:00
Boardroom, Kendray, Doncaster Road, Barnsley, S70 3RD

AGENDA

1. **Welcome, introduction and apologies** (verbal item)

2. **Declaration of interests** (verbal item)

3. **Minutes and matters arising from previous Trust Board meeting held on 28 June 2016** (attached)

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

5. **Supporting a culture of safety and respect** (attached)

6. **Risk appetite statement** (attached)

7. **Strategic overview of business and associated risks** (attached)

8. **Care Quality Commission inspection report** (attached)

9. **Performance reports month 3 2016/17**
   9.1 Quality performance report month 3 2016/17 (to be presented at the meeting)

   9.2 Finance report month 3 2016/17 (attached)

   9.3 Customer services report Q1 2016/17 (attached)

10. **Equality and diversity annual report** (attached)

11. **Assurance framework and risk register** (attached)

12. NHS Improvement return for Q1 2016/17 and Board self-certification (attached)

13. Assurance from Trust Board committees (attached)

13.1 Audit Committee 12 July 2016
13.2 Remuneration and Terms of Service Committee 7 July 2016
13.3 Equality and Inclusion Forum 21 June 2016
13.4 Information Management and Technology Forum 28 June 2016

14. Date of next meeting

The next meeting of Trust Board will be held on Tuesday 20 September 2016 in rooms 49/50, Folly Hall, Huddersfield, HD1 3LT.

Minutes of Trust Board meeting held on 28 June 2016

Present:	Ian Black	Chair
	Laurence Campbell	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Chris Jones	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Rob Webster	Chief Executive
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Mark Brooks	Director of Finance
	Alan Davis	Director of Human Resources and Workforce Development *
Apologies:	Rachel Court	Non-Executive Director
	Julie Fox	Deputy Chair
In attendance:	Kate Henry	Director, Marketing, Engagement and Commercial Development
	Dawn Stephenson	Director of Corporate Development (Company Secretary) (author)
Guests:	Claire Holden	Head of Partnership Team
	Bob Mortimer	Publicly elected governor (Kirklees), Members' Council

** Also interim Deputy Chief Executive*

TB/16/34 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting, in particular; Rob Webster (RW), Chief Executive, who joined the Trust on 16 May 2016, and Mark Brooks (MB), Director of Finance, who joined the Trust on 1 June 2016. He also welcomed Claire Holden, Head of Partnerships Team, and Bob Mortimer, Members' Council. The apologies from Rachel Court (RC) and Julie Fox (JF) were noted. IB outlined his intention to focus a large part of the agenda on the performance part of the agenda and the Care Quality Commission (CQC) report.

TB/16/35 Declaration of interests (agenda item 2)

The following declarations were made over and above those made in March 2016 and subsequently.

Name	Declaration
CHIEF EXECUTIVE	
Rob Webster	➢ Independent Chair of Panel for assessing clinical commissioning group learning disability commissioning (NHS England) ➢ Visiting Professor, Leeds Beckett University ➢ Honorary Fellow, Queen's Nursing Institute ➢ Honorary Fellow, Royal College of General Practitioners ➢ National champion on adoption of innovation for accelerated access review
EXECUTIVE DIRECTORS	
Mark Brooks	No interests declared
OTHER DIRECTORS	
James Drury	No interests declared

There were no comments or remarks made on the Declaration; therefore, **it was**

RESOLVED to formally NOTE the Declarations.

TB/16/36 Minutes and matters arising from previous Trust Board meeting held on 28 April 2016 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 28 April 2016 as a true and accurate record of the meeting. There were no matters arising.

TB/16/37 Chair and Chief Executive's remarks (agenda item 4)

IB began his remarks by referring to the European Referendum and noted that the NHS will not get an extra £350 million per week. There are 55,000 EU staff working in the NHS. RW has sent a message to reassure Trust staff, welcoming diversity and their contribution. Whilst the Trust will need to work through any potential impact, including any impact on, for example, the development of Castleford, Normanton and District Hospital (CNDH), the Trust will need to continue with its plans this year focusing on what it is able to control and influence.

IB went on to express his shock and sadness at the death of Jo Cox, MP for Batley and Spen. The Trust recognises her contribution as a strong, local politician. Her death is a great loss to the system, her family and the country. There is media speculation regarding the alleged perpetrator and the Trust is working with the relevant authorities as appropriate. The Trust has a PREVENT lead and Trust Action Group, which ultimately reports into Clinical Governance and Clinical Safety Committee. The Trust continues to provide training around the PREVENT agenda to staff alongside safeguarding training and also reports to NHS England on the uptake of PREVENT training.

IB noted he had also attended to Trust 'shadow board' the day before and received a number of insights into Trust and Trust Board performance.

RW updated on his recent attendance at the NHS Confederation conference, which brings together the whole system, along with politicians. He highlighted three key messages from the conference.

- The political focus from the Secretary of State for Health, Jeremy Hunt, was on hotspots in the system, which tend to be acute hospitals. Further work is needed to look at why people attend accident and emergency services to focus on getting the system to work for emergency care around hospitals supported by community and mental health services.
- The message from NHS Improvement (Jim Mackey) related to delivery and 'grip'. Providers know what to do and need to get on and deliver the five-year forward view. NHS Improvement is aiming to give a provider voice in the system.
- NHS England (Simon Stevens) focused on this year being about investment in the sustainability of acute hospitals to try and reset finances. One percent will be top sliced from commissioners to create a risk pool (£32 million in West Yorkshire) to cover trusts that do not hit their control totals. If acute finances are rebalanced, then investment can be made in the future in other areas such as prevention, primary care, mental health and community services.

RW also outlined the progress on the Sustainability and Transformation Plans (STPs). The Trust is involved in two planning footprints in both South and West Yorkshire and

submissions are due this week. The priorities in both areas are very similar, including mental health, digital and workforce. The next step is a meeting with NHS England, looking at closing the gap on health inequalities, care and finance. There is significant work to do to narrow the gap around finances, with formal submission of finance plans due in September 2016. The Trust has received a revised control total from NHS Improvement of £1.85 million, which it has accepted. This includes £1.35 million sustainability and transformation fund money. It was noted that, whilst this money is not available in respect of revenue expenditure, it does help the Trust's cash position.

TB/16/38 Care Quality Commission inspection report (agenda item 5)

Tim Breedon (TB) took Trust Board through the key points. Fourteen individual reports and an overall summary report were published on 24 June 2016 following a factual accuracy checking process. During this process, teams were addressing any immediate actions required. TB went on to outline the key messages from the reports.

- Without exception, staff were found to be caring.
- Two areas were found to be outstanding and 70% of areas as good.
- There were no inadequate scores, compliance actions or return visits by the CQC.
- Areas for improvement were areas the Trust raised at the start of the inspection around staffing, access to services and operability of the Trust's clinical information system, RiO.
- The Trust has been given an overall rating of 'Requires Improvement'. The Trust maintains a governance rating of green and financial risk rating of 4.
- The Quality Summit will take place later this summer and this is expected to be the week beginning 15 August 2016. *[This was subsequently amended at short notice to 14 July 2016.]* This will bring partners and stakeholders together with a focus on the Trust's action plan.
- The Trust is currently reviewing its existing action plans to ensure alignment with the CQC findings. This includes:
    - safer staffing, where the Trust already has a plan in place, which is scrutinised by the Clinical Governance and Clinical Safety Committee;
    - clinical supervision, where a passport has been developed and rolled out, which was reported to the Clinical Governance and Clinical Safety Committee;
    - detailed reports on child and adolescent mental health services (CAMHS) to Trust Board, with a robust and comprehensive action plan in place, which is monitored through the Clinical Governance and Clinical Safety Committee;
    - Mental Health Act/Mental Capacity Act training, which is now mandatory, and is scrutinised through the Mental Health Act Committee.

The Chair invited comments from Trust Board.

- IB commented that he was disappointed with the overall outcome as the Trust had been targeting a 'good' rating; however, it is important that Trust Board has a discussion at this meeting and reaches agreement on next steps.
- Laurence Campbell (LC) questioned the reaction from partners and staff. TB responded that most were surprised, given the number of 'green' ratings, that this has led to a 'requires improvement' rating. Most wanted to see specific detail regarding individual services. RW commented that, at briefing sessions, staff had acknowledged the areas identified as requiring improvement and liked the definition of 'requires improvement', meaning services are safe, some areas require improvement and the organisation has the capacity to improve.
- LC asked if the information was now in the public domain. IB replied it was and also on the CQC and Trust website. The publication date and the Quality Summit date are not in the Trust's control as these are set by the CQC.

- Charlotte Dyson (CD) asked if the Trust was doing enough in each of the areas requiring improvement, such as safer staffing. TB responded that action plans are in place for each area, for example, a safer staffing plan is already in place with reports into the Clinical Governance and Clinical Safety Committee. RW commented that action plans are a reflection of the things the Trust needs to do differently, ensuring a stronger link between operational delivery and strategy.
- CD asked what briefings had been given to stakeholders. TB responded that key stakeholders had been briefed by both telephone and email in advance of the publication. The areas requiring improvement were recognised and there were no surprises. IB added that stakeholders were supportive, encouraging the Trust to make the required improvements. In the absence of a Lead Governor, IB advised that he had spoken to (or left messages with) three potential Lead Governor candidates. The Members' Council will be fully briefed at its next meeting on 22 July 2016.
- RW stated that the insight gained was invaluable in supporting the Trust to improve its services.
- Jonathan Jones (JJ) asked how Trust Board would have an overview of the plan and input into the monitoring progress. TB stated that the Trust continues its improvement journey incorporating any additional points raised by the CQC into existing action plans. A full draft will be presented to the Executive Management Team (EMT) and then the Clinical Governance and Clinical Safety Committee, with highlight report to Trust Board setting out progress against plan.
- Chris Jones (CJ) asked that Trust Board's thanks be passed on to all involved in the inspection process. He felt it had been managed well before, during and after the inspection. TB agreed to pass the message on to the teams.

It was RESOLVED to NOTE the update report.

TB/16/39 Performance reports month 2 2016/17 (agenda item 6)

TB/16/39a Performance report month 2 2016/17 (agenda item 6.1)

MB presented the new style report and it was noted that CJ and RC had been involved in its development. A combined monthly performance and finance report is under development, incorporating key quality metrics, aligned with Trust priorities. The report will be more forward looking identifying key hotspots. This includes the development of real time data through the data warehouse programme. IB asked for subsequent feedback to be sent direct to MB to ensure continuous improvement.

- CD stated she would like to see the report more linked to the Trust's strategic objectives with more assurance on 'red' areas with, possibly, a deep dive at a locality level. She felt it was important to see more outcome data included in the report and more assurance provided to Trust Board around data accuracy. RW responded that there would be stronger links to strategic objectives and a clearer approach to data quality.
- CJ confirmed he was happy to continue to work with the group and would like to see data owners for each key area.
- MB advised that the report would be refined over the next three months.

MB highlighted a number of issues.

- The Trust may fail the target for Improving Access to Psychological Therapies (IAPT) for three consecutive quarters, which may trigger NHS Improvement intervention with the potential to impact on the Trust's green governance rating. The main issue is in Barnsley relating to the recruitment and retention of staffing. The Trust is looking at short- and medium-term plans to attract and retain staff. IB asked about the national picture. TB noted other Trusts are struggling and are further away from target. MB

stated that the Trust has seen improvements over recent weeks reaching over 80%. RW reported that the EMT was fully engaged with the issue and a recovery trajectory is needed with a medium-term plan to address the underlying issues, which include looking at treatment models. IB asked if the Clinical Governance and Clinical Safety Committee was providing an overview. TB confirmed this was the case with a recent report highlighting staffing issues and providing assurances around recruitment plans.

- MB noted small risk around Care Programme Approach (CPA) review target; however, he believed it would be achieved in quarter 1.
- The Trust is currently not achieving its trajectory to meet the 'service users on CPA supported back into employment' target. The EMT has discussed the relevance of this indicator and is looking to undertake further work in this area to develop a more meaningful indicator that would cover all service users.
- Delayed transfers of care (DToC) in Barnsley have increased due to seven specific individuals and individual care plans are now in place.
- Trust Board noted the staffing issues in Wakefield, which had been added to the organisational risk register together with the mitigating actions being taken.
- Bed pressures are impacting on service delivery and levels of acuity are increasing, with a corresponding increase in violence against staff. Trust Board noted that this is in line with national trends.

It was RESOLVED to RECEIVE the report noting the specific issues and remedial actions being taken, and to SUPPORT the new format and vision for the report going forward.

TB/16/39b Finance report month 2 2016/17 (agenda item 6.2)

MB introduced the finance report. The Trust is £100,000 ahead of plan at month 2, with achievement of the cost improvement programme below plan. Calderdale, Kirklees and Wakefield BDUs are forecasting a year-end overspend, with underspends in support and specialist services. Further work will be undertaken to triangulate finance data with performance data to make sure the Trust delivers the year-end position in a more effective way. The Trust currently has a £2.89 million risk in delivery of its cost improvement programme with a contingency of £2 million in place. JJ expressed concerns over the £2.89 million 'red' rated cost savings and the need for more grip. MB responded that the weekly Operational Requirement Group meeting focuses on the 'red' and 'amber' schemes ensuring a lead is in place and progress is monitored against milestones. An update will be provided at the July Board.

MB highlighted the following.

- It is anticipated that the Trust will overspend against its agency cap if the current trajectory continues, although the Trust is below budget on total pay costs. The Trust has incurred high levels of agency spend in learning disability services due to the special needs of a small number of service users. The Trust is analysing the data around agency spend and will write to NHS improvement setting out its position. The Trust is aware that other trusts have been successful in negotiating a revised cap in order to maintain safe services. This will be supported by a clearer workforce plan by BDU.
- IB expressed his view that Trust Board needs to take a strategic approach rather than be driven by targets on individual lines in the income and expenditure account. The Trust places more significance on the achievement of the overall risk rating and control total.
- CD stated it was important to have a longer-term view. Alan Davis (AGD) agreed the need to make a stronger connection between the workforce plan and annual planning.
- Adrian Berry (ABe) outlined three approaches to the use of medical locums. Firstly, planned use, as in the case of learning disability services whilst undergoing transformation. Secondly, specialty doctors where there is national difficulty in

recruitment. The Trust needs to change in its use of speciality doctors as part of its workforce strategy. Thirdly, there are specific specialties where there is difficulty in recruitment, such as CAMHS, where it is made harder by the current tender position until the outcome is more certain.

- RW agreed with the hierarchy of targets with safety first. The Trust needs a sustainable and affordable workforce plan that is not reliant on agency staffing. This will be development through the EMT and presented to Trust Board as part of the wider work on workforce strategy being led by AGD.
- LC asked about service specific contributions to margins and overall fit with strategic objectives. RW responded that all business opportunities are reviewed by the EMT using a decision tree produced by James Drury around strategic fit. A draft Commercial Strategy will come to Trust Board in September 2016.
- RW noted that one Commissioning for Quality and Innovation (CQUIN) target for flu vaccine uptake was worth £350,000. He asked Trust Board to support best practice to support the health of the workforce and service users. Trust Board confirmed it was happy to be part of the vaccination programme at the September 2016 meeting.

It was RESOLVED to RECEIVE the report and NOTE the items highlighted and the plans in place to mitigate the issues.

TB/16/39c Exception reporting and action plans (agenda item 6.3) – Transformation update
MB introduced the paper prepared by James Drury and set out the key headlines.

The acute and community (mental health) consultation is complete and changes will be implemented from September 2016. Commissioners are moving towards reaching agreement on a proposed model for rehabilitation and recovery services. Learning disability services are now recruiting to new roles and the transformation board is now looking to move the programme into mainstream delivery. It was noted that transformation workstreams report to the EMT and a summary report setting out the highlights will be included in future Trust Board performance reports.

- CD asked how engaged staff were. RW reported that, through the staff listening events and service visits, the majority of staff were in agreement with the strategic direction and models of care and now wanted to see implementation move at pace. ABe stated there were some concerns from medical staff around specific implementation issues, which will require ongoing engagement in developing specific plans.
- AGD commented that he expected some good insight from staff when the current staff survey closes with over 2,000 responses and the ability to drill down to service lines.
- LC asked about the alignment with the Sustainability and Transformation Plans and any potential conflicts with Trust transformation plans. RW responded that this was not currently a specific issue. In general, there will be a need for more collaboration around specialist services, such as forensic services, and how services support a more joined up community offer.

It was RESOLVED to NOTE the progress and the next steps in each of the projects.

TB/16/39d Exception reporting and action plans (agenda item 6.4) – Incident management annual report
TB introduced the report highlighting the key points in the context of the patient safety strategy. The Trust is seeing an improvement in the reporting culture with a 13% increase in number of incidents reported over the previous year. The number of serious incidents (SI) has reduced from last year. The Trust has had no 'never events' or Section 28 Letters from the Coroner, which is significant given the Trust's size and complexity. The CQC feedback was positive in respect of learning lessons, closing the feedback loop and seeing the

benefits of receiving feedback. The learning lessons report will be included in the future patient safety strategy report in the context of improving patient safety.

- RW asked what the Trust's ambition is in terms of being a high reporting organisation or 90% of staff saying they get feedback following an incident. TB responded that the Trust's aims are set out in the overarching Patient Safety Strategy and will be included in the annual report in future.
- JJ asked whether there was any learning from Southern Health NHS Foundation Trust that the Trust can take on board. MB responded the key is Board assurance that the Trust is learning lessons and embedding best practice across the organisation.
- RW queried the spike in incidents in Q4 and asked if this was due to the upgrade to RiO. TB responded that some were but not all. The last three quarters will be reviewed to identify any trends and any action required.
- RW asked if pressure ulcers were seen as a high priority to address. TB stated they are one of the Trust's top priorities within the patient safety strategy.
- IB asked TB if an update could be provided to Governors at a future Members' Council meeting on the Patient Safety Strategy.

It was RESOLVED to RECEIVE the annual report on incident management and NOTE the next steps.

TB/16/39e Exception reporting and action plans (agenda item 6.4) – Customer services annual report

Dawn Stephenson (DS) introduced the report, which provided an overview of issues raised through Customer Services during 2015/16 and set out how the Trust aims to improve the experience of people who use services by responding positively to feedback and resolving issues as they happen where possible. Processes are in place to allow the triangulation of service user Friends and Family Test results with those of staff.

- CJ asked that the section on actions taken is amended so that Trust Board could be assured that the individual actions have been completed and closed off.
- RW noted that more than half the complaints are around staff communication and staff attitude, which also came up at the listening events. This will need to be an area for improvement over 2016/17.

It was RESOLVED to RECEIVE the annual report and NOTE the management of issues raised through Customer Services during 2015/16.

TB/16/39f Exception reporting and action plans (agenda item 6.5) – Safety management and contingency planning annual report

AGD introduced the report, which brings together three previously separate reports around health and safety, fire safety, and security and emergency planning. The report provided updates on the work in train to update the director on-call arrangements, health and safety training and the action plans in place around the key health and safety risks identified in the report.

It was RESOLVED to APPROVE the Safety Management and Contingency Planning Annual Report and AGREE the action plans for 2016/17.

TB/16/40 Governance matters (agenda item 7)

TB/16/40a Annual report, accounts and quality accounts (agenda item 7.1)

IB identified that the Audit Committee, under delegated authority from Trust Board, reviewed and approved the annual report, accounts and Quality Report for 2015/16 at its meeting on 23 May 2016. These will be presented to the Members Council on 22 July 2016.

It was RESOLVED to RECEIVE and ADOPT the annual report, accounts and Quality Report for 2015/16.

TB/16/40b Corporate Governance Statement (agenda item 7.2)
DS introduced the report and, from the assurance provided, advised Trust Board that it was able to make the required self-certifications under its Licence conditions, the Risk Assessment Framework and the Health and Social Care Act 2016.

It was RESOLVED to CONFIRM that Trust Board was able to make the required self-certification in relation to the Corporate Governance Statement and training for governors, and NOTE the outcome of the self-assessment against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance.

TB/16/41 Assurance from Trust Board committees (agenda item 8)

TB/16/41a Audit Committee 23 May 2016 (agenda item 8.1)
LC reported the last meeting had considered and approved the Trust's annual report, accounts and Quality Report.

TB/16/41b Clinical Governance and Clinical Safety Committee 17 May and 14 June 2016 (agenda item 8.2)
CD reported on JF's behalf. The key areas were CAMHS waiting lists and data accuracy, and the focus required on these. A presentation received on the Duty of Candour, an update on safer staffing and the challenge's currently presenting in the system, and the challenge in Barnsley to meet the community services cost savings non-recurrently.

TB/16/41c Mental Health Act Committee 17 May 2016 (agenda item 8.3)
CJ reported on JF's behalf. The main items noted were the increased use of Section 49 (court orders) and its impact on the Trust and a presentation on the impact of the transformation of learning disability services on use of the Mental Health and Mental Capacity Acts.

TB/16/41d Remuneration and Terms of Service Committee 24 May 2016 (agenda item 8.4)
IB reported the Committee received an update on the management and administration review, and the Directors' performance related pay scheme. It had been agreed, in line with the agreed objectives and the outcome of the CQC report, that there would be no payment under the scheme for 2015/16.

TB/16/41e Estates Forum 7 June 2016 (agenda item 8.5)
JJ reported on the work on the capital plan for 2016/17, the development of community hubs and the non-secure estate development on the Fieldhead site.

TB/16/41f Equality and Inclusion Forum 21 June 2016 (agenda item 8.6)
IB updated on a pilot with other Trusts to increase BME representation on Boards through attendance at meetings, mentoring by Non-Executive Directors and increasing experience and exposure. The Trust is working with Gatenby Sanderson on the programme.

TB/16/41g Membership of Committees from 1 July 2016 (agenda item 8.7)
IB outlined the changes to Committee membership, which he had discussed and agreed with individual Non-Executive Directors as part of the annual review process. The revised arrangements are as follows.

Audit Committee – membership remains as it is currently pending a further review later in 2016. *Laurence Campbell (Chair), Chris Jones and Jonathan Jones*

Clinical Governance and Clinical Safety Committee – membership remains as it is currently; however, the Chair will review his membership later in the year with a view to ensuring strong Non-Executive Director links between Committees. *Julie Fox (Chair), Ian Black and Charlotte Dyson*

Mental Health Act Committee – membership will remain as it is currently with a move to appoint Chris Jones as Chair from November 2016 or March 2017. *Julie Fox (Chair), Chris Jones and Jonathan Jones*

Remuneration and Terms of Service Committee – membership will remain as it is currently with a move to appoint Rachel Court as Chair from October 2016. *Ian Black (Chair), Rachel Court and Jonathan Jones*

Charitable Funds Committee – membership of this Committee will change from 1 July 2016 with the appointment of Charlotte Dyson as Chair and Ian Black and Laurence Campbell remaining as members.

There is no change to Executive Director membership of Committees at the current time.

IB also updated on the process for the appointment of the new Lead Governor.

It was RESOLVED to SUPPORT the changes proposed by the Chair.

TB/16/42 Use of Trust seal (agenda item 9)

It was RESOLVED to NOTE the use of the Trust's seal since the last report in March 2016.

TB/16/43 Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 19 July 2016 in the Boardroom, Kendray, Doncaster Road, Barnsley, S70 3RD.

Signed …… Date ……

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 19 July 2016
Agenda item 4

Title:	**Chief Executive's Report**
Paper prepared by:	Chief Executive
Purpose:	To describe the context within which we work to help frame the conversation at the Board
Mission/values:	The organisation can only deliver its mission if it understands the context within which it operates. In doing so, we must live our values.
Any background papers/ previously considered by:	West Yorkshire and South Yorkshire Sustainability and Transformation Plans (STPs) NHS Confederation and NHS Providers' 'Brexit' Briefing Papers
Executive summary:	➢ Political uncertainty continues, which may have a material impact upon the NHS in the future. ➢ A national focus on finances in 2016/17 will have an impact on the Trust directly and indirectly. ➢ The latest gateway submissions for STPs for West and South Yorkshire have been submitted, setting a future vision and direction for services. ➢ Significant service change continues to be planned by local partners. ➢ We are developing as a Trust in response to our context and the Care Quality Commission. ➢ We will celebrate success more visibly and consistently to help build staff resilience.
Recommendation:	**Trust Board is asked to NOTE the context within which we operate to help guide the judgements we will need to make.**
Private session:	Not applicable

Chief Executive's Report

Trust Board 19 July 2016

1. This paper helps to frame the conversation for the Board meeting. It sets out the context in which we operate and key developments which will affect our strategy and our operational delivery.

National context

2. **Following the Brexit vote in June, we have had a period of significant political uncertainty and change.** A new Prime Minister, Theresa May, will begin her tenure on 13 July and will announce her new Cabinet subsequently. This may lead to changes in the Department of Health, notably the Secretary of State. We will see some changes imminently as the Minister of State for Community and Social Care, Alistair Burt, has resigned. His portfolio includes our service lines and issues like integration, local government, mental health, older people, physical and learning disabilities, allied health professions and primary care. This role has been pivotal in the past to the development of policies such as 'parity of esteem' for mental health and developments around the Better Care Fund.

3. **The NHS is a significant political issue and these political changes can directly impact on the day-to-day operations of the NHS and its strategic direction.** Each Secretary of State brings a little of their agenda to the role, for example, Jeremy Hunt has had a focus on safety and transparency. The creation of the Five Year Forward View should act as a constant as it determines much of the policy agenda. The next few weeks will test this as debates about public sector resourcing and our ability to tackle the collective issues in 2016/17 continue.

4. There have been significant debates about the impact of Brexit on the NHS. **At this stage, I have been advising the leadership within the Trust that we should focus on the things we can control and influence rather than speculate** about potential changes. Both NHS Providers and the NHS Confederation have produced briefings on the areas where change may occur. The NHS Confed briefing is available here NHS Confederation Brexit. Interestingly Simon Stevens has led the campaign to publically demand that the promises made by the Brexit leave campaign on extra funds for the NHS should be honoured.

5. Away from party politics and Brexit, during the last month the ballot on the new junior doctors' contract has taken place. **Unfortunately junior doctors voted to reject the new contract which has led to a decision by the Government to press ahead with imposing it.** The junior doctors' committee of the British Medical Association is considering its response, which may include further industrial action. The junior doctors also have a new leadership following the resignation of Dr Johann Malawana. **Trust Board should note that** we will keep close to the consequences for the Trust under the leadership of the Medical Director and Director of Human Resources.

6. **Against this backdrop, a national focus is emerging on two broad themes.** The first is the delivery of a "financial re-set in 2016/17" that put the service on a more sustainable footing. The second is delivery of medium-term plans through

Sustainability and Transformation processes. These reflect the fact we are in the second of the five years of the Forward View and that finances, performance and resilience in the wider health and care system are under threat.

7. NHS Improvement is consulting on changes to its regulatory framework in the light of these developments. **Trust Board should note that we are submitting a response from the Trust, as well as contributing through the representative bodies.**

2016/17

8. NHS England and NHS Improvement have followed up their announcements at the NHS Confederation conference on the outlook for this year with a series of letters setting out tougher rules for 2016/17 on access to funding based on service and financial performance. We expect there to be a further announcement this week on additional measures to tighten control over NHS performance and **a verbal update will be provided to Trust Board.**

9. There are risks for the Trust and our local system in this approach. If we fail to secure performance against our targets, including the cap on agency spend, we may not receive a portion of our sustainability funding of £1.35 million. This would increase pressure on us to deliver greater efficiencies in pursuit of our control total. In addition, across West Yorkshire, clinical commissioning groups have been asked to set aside 1% of their resource into a contingency pot to offset financial pressures within the region. **This is covered under the financial section of the agenda.**

10. It is likely that **different parts of West Yorkshire will end up covering the risks of Trusts with significant pressures even if they are outside of their footprint**. Some of these resources may be intended for transformation programmes in future years. As a Trust, we are not expecting any access to these top-sliced funds this year. Trust Board will recall that the national bodies have suggested this financial reset will create resources next year for investment in primary care, mental health and community services within our portfolio. This means we are bound in the success of local acute organisation in a material way.

11. **The upshot is that we require a degree of maturity and transparency between organisations in the system.** This is starting to become apparent and sets out a stronger role for the STP leadership, who are expected to hold the ring on financial risk.

Sustainability and Transformation Plans

12. **The latest 'gateway' submissions on STPs were submitted on 30 June 2016.** We have a material interest in the West and South Yorkshire STPs and **copies of the submissions have been circulated to Trust Board separately.**

13. Trust Board will note that there is a strong focus on prevention, new models of community services and mental health in both STPs. It is also notable that learning disability services are absent. The substantial detail in the STPs covers a common narrative as set out below.

It's easier to be well

- Every borough is a healthy place to live, with a focus on the wider determinants of health: housing, education, employment and the environment
- We have focused prevention programmes that operate at scale, driving up the health of our workforce, bringing further reductions in smoking and changing the life course of children to reduce the numbers that become looked after.

We have supported self-care as standard

- Technology is used to facilitate supported self-care, backed by peer groups, expert patient programmes and innovative approaches like Creative Minds, Robin Lane Wellbeing Practice and the learning from the pioneer programmes

Joined up community based services are the norm for people who need help

- Primary care is transformed as a modern service that wraps health & social care around patients in their homes and in every community.
- We will build larger 'place based' community services that offer integrated physical, mental health and social care services at the right scale, working closely with housing, the third sector, independent sector and our acute providers to provide appropriate services responses to patient needs.

Acute needs are met through services that are "safe-sized"

- Higher acuity, local acute care will be organised across the system to allow for care to be located and delivered in local acute settings. Better outcomes will be delivered by reducing unwarranted variability in clinical care
- World class specialist acute mental and physical health services will be delivered through a strengthened set of tertiary provider arrangements.

We use our natural resources to innovate and build a better future

- We will support the delivery of innovative care through partnerships built out of Y&H AHSN and its members, Local Enterprise Partnerships and innovation hubs.
- We will use the capability of our existing leaders, and develop our up and coming leaders, to take on roles outside of their immediate organisational responsibilities in order to ensure that we have capability at both organisational and system level
- Patients, carers, service users and citizens will be active players in the delivery, design and development of care.

14. **There have been significant developments in our leadership capacity and maturity in West Yorkshire.** Commissioners have come together to collaborate in recent years and this has been formalised through the creation of a Collaborative Forum supported by an Memorandum of Understanding, moving to a formal Joint Committee with delegated authority in the Autumn. Alongside this has seen a shift in the working arrangements of local providers. The creation of the West Yorkshire Association of Acute Trusts (WYAAT) marked the start of this journey and we have seen a real shift in 2016 of true collaboration and the need to ensure sustainability of services on a West Yorkshire

footprint. The mental health providers have also come together to collaboratively look at creating sustainable services for people across West Yorkshire. There is a general commitment to sustainability for patients over organisational form and priorities **in line with our Trust Board position in principle**.

15. The establishment of a Clinical Forum across commissioners and providers and a **Leadership Team composed of all Chief Executive Officers across our partner organisations** brings together all of these groups to discuss our collective plans. We recognise that our structure needs to become leaner as our relationships grow further and decision-making structures for our provider collectives, within local authorities and shared across the leadership team, will be developed over the summer months. **Trust Board should note that there have been no changes to our statutory duties or our decision-making authority as a Trust as part of these changes.**

16. **There is a significant cross-cutting theme of the 'workforce'** recognising the changes that will be required in service delivery and the way that we deploy our people. There have been some changes to Health Education England to reflect this. They have created a local workforce advisory board (LWAB) for each STP to support workforce reform at a local level. The details of this have yet to be agreed and we will need to consider carefully any role that the Trust plays in the arrangements. **Trust Board will be engaged in any material changes.**

17. Meetings are taking place on 13 July 2016 to discuss our submission with the national ALB CEOs. **I will provide verbal feedback to the Board.**

Local Context

18. **The emerging strategy for West Yorkshire is founded on local plans having primacy and the principle of subsidiarity.** Each of the Boroughs that we work with has created its own STP often based on the local health and wellbeing strategy. This means that we need to be sensitive to the requirements of local partners. For example:

    - there is a desire to create an accountable care system in Barnsley that brings together commissioners and providers;
    - leaders in Wakefield are considering how we develop a multi-speciality community provider building on the West Wakefield vanguard. This could be seen as a step towards another accountable care system;
    - services for 0-19 year olds in Kirklees are being tendered later this year in an attempt to deliver more joined up care across providers;
    - child and adolescent mental health services in Calderdale are being tendered in an attempt to improve care;
    - federations of general practices are emerging in every patch and helping to create opportunities for closer working and integration with community services.

19. Trust Board should note that we will need to ensure that we are positioned to respond to these developments, the developments that emerge from the STP, and developments that emerge from national commissioning of specialised services. Our Operational Plan and priorities have been reviewed to ensure that this is the case.

20. There have been some changes to **local leadership** in recent weeks.

    a. Dr Sarah Munroe has been appointed as Chief Executive of Leeds and York Partnership NHS Foundation Trust.

b. Simon Large has resigned as Chief Executive for Bradford District Care NHS Foundation Trust with effect from September and an interim will be in place for the interregnum.

Trust Context

21. **The Trust continues to develop and improve as we prepare for future change whilst delivering care every day**. Following the listening events with staff, my objectives have been agreed with the Chair and shared across the organisation. They have been seen by the Remuneration and Terms of Service Committee and reflect my priorities, the business plan and the views of staff. Alongside my objectives, I have been conducting a review of director portfolios, which is now nearing completion and will be shared with Board colleagues when complete. One of the significant changes will be that the Director of Human Resources and Workforce Development will be responsible for Organisational Development within the Trust. This reflects the need to focus on improving the organisation in this current context in a planned and coherent way.

22. **The Care Quality Commission action plan is being finalised and is a subject of conversation at Trust Board.** The Quality Summit with partners and stakeholders, chaired by the CQC, takes place on 14 July 2016 and verbal feedback will be given to Trust Board. This quality emphasis is a significant part of the agenda of the Trust, the Executive Management Team and Trust Board.

23. The **finance, performance and risk papers** demonstrate where we are in terms of current delivery. Alongside this, Trust Board has a good **PESTLE and SWOT** analysis and a review against **commercial opportunities** currently in play.

24. **During this period, we continue to have a focus on innovation and change.** This is reflected in decisions to implement the Transformation Programme for older adults, the launch of a crowdsourcing approach to innovation and engagement through the i-Hub, the development of a draft digital strategy, genuine engagement in integrated care in Wakefield and Barnsley, and local innovations through staff-led programmes, like the development of the supervision passport.

25. **We will continue to deliver change to reflect organisational need and the findings of the staff wellbeing survey.** Over 2,000 staff responded to the survey, up from last year by more than 10%, securing a rich set of data for us to use in preparing our response. Having engaged staff is an indicator of organisational success and the delivery of improved outcomes. The results of the survey will be shared with Trust Board alongside the organisational response. They are a critical part of the deal we have done with staff and should symbolise the relationship that we have with each other.

26. **Recognising success and celebrating our achievements will be part of the regular workings of the Trust.** I have asked the team to work up a proposal to turn the long service awards into a celebration of success for the organisation. This will take place in November and will include a number of team and individual awards as well as the presentation of learning certificates and long service awards. There will also be opportunities for sharing successes more widely through the use of film. I have also reinstated the market place for staff at induction giving the opportunity for services to share and learn. This is important as we are constantly achieving significant successes and have a wealth of information to share. In the last month, we have won national awards including Health Service Journal success for Rightcare Barnsley, gained accreditations in our ECT services and seen national recognition for one of our health visitors. We have also had staff speaking at national and international conferences on

topics ranging from Occupational Therapy, Psychiatry and Mental Health and Dance, and achieved a number of milestones that should be celebrated.

27. Trust Board should note the development of the event in November.

Conclusion

28. The context within which we work is the most difficult and unpredictable for a generation. We have an opportunity to develop services that can flourish and succeed in these tough times and we have an opportunity to help lead the system through these tough times. Our service portfolio, our relative strength and our ambition for service users and patients make us well placed to achieve this. Doing so will require strong leadership from Trust Board in setting the tone for the organisation and making fine judgements in uncertain times.

Rob Webster

Chief Executive

July 2016

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board: 19 July 2016
Agenda item 5

Title:	**Supporting a culture of safety and respect (Raising Concerns at Work including Whistleblowing Policy)**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	Creating a culture where staff feel safe to raise concerns at work, requires strong and clear commitment from Trust Board. The purpose of this paper is to introduce Trust Board to a self-assessment tool for organisations on supporting staff to raise concerns at work. The self-assessment tool uses the recommendations from the Francis Report to provide a framework for organisations to critically examine their current arrangements and help them identify gaps and actions. A key recommendation is the appointment of or designating an individual as a Freedom to Speak Up guardian. This paper also seeks support from the Trust Board to progress the appointment of a Freedom to Speak Up Guardian role in the organisation.
Mission/values:	This paper supports directly and indirectly all of the Trust's values, particularly being Open, Honest and Transparent and Respect.
Any background papers/ previously considered by:	The current Whistleblowing Policy was approved in April 2015. In addition, the Audit Committee and Clinical Governance and Clinical Safety Committee have both been involved in reviewing the Trust's approach to raising concerns at work.
Executive summary:	The Trust has, over the years, introduced a number of approaches to enable staff to feel safe to raise concerns at work including malpractice, service user and staff safety, harassment and bullying, and fraud. All staff were sent a copy of the Raising Concerns at Work leaflet last year, which is attached in Appendix 1, outlining the various ways issues that concern them at work can be raised including use of the Whistleblowing Policy. This is also included in induction and available on the intranet. The Francis report identified the importance of a culture of candour, openness and honesty which enables staff to raise concerns for the safety of patients. This paper proposes the use of the NHS Employers raising concerns Self-Assessment Tool, Draw the Line, to identify gaps in the Trust's current arrangements. To ensure an inclusive approach to the Self-Assessment, it is proposed it will be completed in partnership with Staff Side by September 2016. The self-assessment tool is attached in Appendix 2 and it covers sixteen indicators under four broad headings shown below. • Organisational Commitment • Support for managers and staff • Communications and Staff Engagement • Continual Review and Assurance

	A priority from an initial scan of the self-assessment tool is the appointment of a Freedom to Speak Up Guardian. The role of the Guardian is typically defined as helping to raise the profile of raising concerns, providing confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns has been handled. Nationally, the purpose and key principles of the role outlined is attached in Appendix 3. An action plan to develop and review the role and function of the Freedom to Speak Up Guardian will go to the Executive Management Team in July with a view to agreeing the final arrangements at October's Trust Board. The action plan will include any workforce and financial implications of any proposals.
Recommendation:	**Trust Board is asked to SUPPORT both the use of the self-assessment tool on raising concerns at work and the development of proposals to progress a Freedom to Speak Up Guardian role.**
Private session:	Not applicable

GMC performance procedures

Though not a Trust procedure, there is a process set out by the General Medical Council (GMC) for assisting doctors. Where a doctor's professional performance is seriously deficient the GMC's performance procedure should be invoked. Details of this procedure may be obtained from the GMC or through the human resources department. Associate medical directors are available to be approached in confidence to discuss concerns about medical staff.

Professional bodies

Through being a member of a professional body, staff are expected to adhere to the standards set by that organisation. The standards of practice are set out in their code of conduct. In addition to the systems outlined above, professional staff also have a duty to encourage good practice and raise concerns when professional practice, or performance, is below standard.

A safety-net for patient care

What if something goes wrong and you feel the existing system does not appear to be working?

If the mechanisms outlined above have been tried and/or are not appropriate, then you have the right to contact any director of the Trust. You will be heard in confidence and your concerns will be listened to and taken seriously.

Additionally you may also wish to consider whether approaching a staff side organisation could also be beneficial in resolving the concern. Some staff organisations have specific guidance on this issue, which may help you in deciding on appropriate action.

Ways that develop and encourage good practice

Appraisal interviews

Appraisal interviews are the process where all staff agree annual objectives which identify their personal part in helping the Trust fulfil its stated aims. Their achievement against these objectives is reviewed on a regular basis with their line manager and their training needs discussed in order to meet these objectives.

Professional meetings

Professional meetings (both uni and multi professional) provide an opportunity to raise matters concerning good and bad practice, as well as sharing learning/experience and enabling issues on standards to be raised.

Managerial supervision

All managers of staff, particularly clinical staff, should have processes in place by which they can be confident they can appraise the clinical practice of the staff that they manage. They may do this via various means, including feedback from peers, reviewing records, or utilising audit information.

Clinical supervision

All clinical staff within the Trust are encouraged to seek out clinical supervision from whoever they feel can help them to reflect on clinical practice issues. This process is strongly encouraged, as it enables self-learning.

Staff consulting and counselling service

The Trust offers a range of staff support mechanisms, including individual counselling designed to help staff to deal with and resolve work related problems. There are also group support activities which involve team development, focusing on resolving conflicts and handling difficult situations. To access these services you can contact the occupational health or HR department.

Conclusions

This leaflet indicates that poor practice must be tackled as soon as it is identified. The emphasis is not to take a punitive approach in improving the situation, unless serious issues are identified eg. fraud, service user abuse etc.

There are several processes listed above in the Trust, which are designed to assist individuals and address these issues.

A key part of ensuring good practice is the effective and supportive management of staff together with staff taking responsibility for their own actions.

For further advice, contact the human resources department on 01977 605305

More information about whistleblowing is available on the intranet.

Job no. 4919 > 5325 April 2013

South West Yorkshire Partnership NHS
NHS Foundation Trust

Raising concerns at work

What can you do if there are issues that concern you at work

With all of us in mind

Introduction

This leaflet outlines the various ways that you can address concerns at work. Issues can be raised whether you are an employee, an agency worker, a volunteer or a student working in the Trust. These concerns may be about professional conduct, standards of care, or an issue you feel concerned about in the workplace. It also lists systems that already exist, which encourage good practice.

The Trust is committed to maintaining high standards and promoting good practice. It also has a responsibility for the wellbeing and care of its patients.

All staff have a responsibility to raise concerns where they think practice does not match expected standards. Additionally, professional bodies lay down standards which their members are expected to observe.

The Trust has a 'whistleblowing' policy, which is available to all staff. Policies such as this one are developed as a valuable way to raise concerns at work.

With all of us in mind

The 'whistle blowing' policy

This policy was specifically designed to provide a way for members of staff to raise concerns. It enables issues to be resolved quickly and appropriately.

The policy starts with an informal stage, where you can talk to your manager about your concerns. This is designed to resolve the issue in a less official way. If it is not resolved at this stage it can then progress further up the organisation by formal stages through the designated senior manager, to the Trust's chair.

A copy of the policy can be found on the intranet, the Trust's website or from your manager.

Experience indicates that problems are best resolved early on, when they are first identified. This not only leads to less distress for people using our services (where it involves patient care), but also leads to more effective results. Problems, which could usually be resolved easily and quickly at an early stage, can often develop into more serious issues when ignored.

There are other existing mechanisms, outlined below, which enable issues to be addressed and resolved. These systems are listed in two sections below. The first covers measures that enable concerns to be raised and the second, ways of developing good practice.

Other ways of enabling concerns to be raised

Direct discussion with the person concerned
If you have doubts about a colleague's conduct or performance, it may be appropriate to first raise the matter tactfully with them direct. This may enable any concerns to be resolved at an early stage.

Safeguarding children and vulnerable adults policy
The Trust has policies to protect children and vulnerable adults. These policies must be used where there is concern about the inappropriate care of these particularly vulnerable groups of patients. See the Trust's intranet for more information.

Uni and multi disciplinary audit
A wide range of uni and multi disciplinary audits are undertaken within the Trust which helps identify aspects of clinical performance in individuals and teams that can be improved.

Reporting to line management
Direct contact with line managers enables concerns to be discussed by both the manager and the member of staff. If an individual has specific concerns about practices in agencies that the Trust works closely with, then these should also be discussed with their manager. Where the manager is not available (eg. out of hours) then it may be appropriate to contact the 'on call' manager.

Incident reporting
Staff are actively encouraged to record adverse incidents which occur within the organisation. This enables problems to be identified, trends to be evaluated and improvements to be made. Incident forms are accessible throughout the Trust.

The Trust's harassment and bullying policy
This policy enables members of staff to address harassment and bullying in the workplace. Issues raised will be taken seriously even if the harasser works for another organisation.

The Trust's fraud policy and bribery act policy
The Trust has policies outlining the responsibility of all staff in the specific areas of fraud and bribery. All staff have a duty to be aware of the possibility of these acts and report any suspicions. Any concerns of fraud should be reported to the Trusts director of finance (01924 327016) NOT a line manager.

The Trust's grievance procedure
This procedure enables staff to raise a matter with their immediate supervisor. If issues are not resolved they can then progress through several stages in order to resolve the issue.

NHS Employers

NHS England

DRAW THE LINE

RAISING CONCERNS

TOGETHER WE CAN MAKE A DIFFERENCE

RAISING CONCERNS: Organisation self-assessment tool

Having a healthy open culture where staff feel empowered and supported to challenge, debate and raise concerns as part of normal employment practice, enables organisations to deter wrongdoing and pick up problems early. It also demonstrates to regulators, staff, patients and the public that they are accountable, well managed, and are willing to listen and respond to issues raised. Many NHS organisations have policies and procedures in place to support staff to raise concerns but their effectiveness will depend on a variety of factors. Following the publication of the Freedom to Speak Up report in February 2015, and subsequent recommendations for implementation including the introduction of the Freedom to Speak Up guardian role, many organisations will want to take time to reflect on where they are as an organisation in relation to supporting staff to raise concerns. This tool can help you assess what you are doing well, and where you might need to focus some more attention. For further information and to access online resources, case studies and the rest of the Draw the Line toolkit, please visit the NHS Employers website at: www.nhsemployers.org/raisingconcerns.

We use the term 'staff' throughout this document, but you should also consider how you engage, communicate and support all workers in your organisation including undergraduates, trainees and volunteers.

ORGANISATIONAL COMMITMENT: Being able to show the board or other appropriate governance structure commitment to the principles of your whistleblowing or raising concerns arrangements gives a strong message to staff about the type of culture and behaviours that are acceptable within your organisation. Having buy-in and leadership from management and staff side is important in achieving this.

INDICATOR:	Yes	More work required	Unsure	No
The board are committed to promoting and championing the importance of raising (whistleblowing) concerns.				
As an organisation, we are committed to investigating and taking appropriate action where concerns are raised with us, and have arrangements, including a Freedom to Speak Up guardian or equivalent in place to ensure staff who raise concerns are fully supported to do so.				
Our organisation takes a zero tolerance approach to bullying and clearly communicate the sanctions we will take where staff (at any level) bully or victimise colleagues as a result of them raising concerns.				
We make clear that staff are not required to evidence proof of their concern and will not be penalised if their concern is subsequently found to be misdirected.				
We have clear sanctions in place to deal with concerns that are raised with malicious intent.				

SUPPORT FOR MANAGERS AND STAFF: Formal policies and arrangements are an important starting point, but it is equally important to make sure that managers and staff fully understand their roles and responsibilities, and know how to proceed and respond appropriately to resolve issues quickly. Support such as training, mediation, counselling, and stress management are key to success.

INDICATOR:	Yes	More work required	Unsure	No
Our organisation has a separate policy which clearly differentiates between a grievance and a (whistleblowing) concern so that staff are clear about which process to use.				
Our organisation offers a range of support to staff who raise concerns such as mediation, counselling, stress management and signposting to where they can seek additional independent advice and support e.g. the national Whistleblowing Helpline, legal advice etc.				
Our organisation offers a number of informal and formal platforms which enable staff to raise concerns openly, confidentially and anonymously (e.g. team meetings, staff briefings, as part of the appraisal process, confidential helpline etc.).				
Our organisation offers training for managers and staff to clearly prepare and outline responsibilities to report concerns, and encourage early intervention as part of normal employment practice, before the issue escalates into something more serious.				
We provide all employees with a route map that clearly outlines suitable internal and external reporting routes.				

COMMUNICATIONS AND STAFF ENGAGEMENT: Raising staff awareness about your whistleblowing or raising concerns arrangements is important to ensure that staff know when and how to use them. Clear statements from senior management about the organisation's support for the reporting of wrongdoing through appropriate channels, and openly reporting the type and level of concerns raised and resultant actions, will help to build staff confidence to speak up.

INDICATOR:	Yes	More work required	Unsure	No
Our organisation regularly communicates with *all* staff (including permanent staff, other contracted workers and volunteers) to raise the profile and understanding of our raising (whistleblowing) concerns policy and arrangements.				
We communicate key findings to staff about the level and type of concerns raised and any resultant actions taken, as is appropriate under the scope of confidentiality.				
Staff are consulted and encouraged to feed into any review of the raising (whistleblowing) concerns arrangements to ensure they are fit for purpose and fully support staff to raise concerns and managers to respond professionally and appropriately to concerns raised with them.				
We actively promote good news and success stories at staff briefings, team meetings and on the intranet to encourage and reassure staff.				

CONTINUAL REVIEW AND ASSURANCE: A well-run organisation will periodically review its whistleblowing arrangements to ensure that all staff are aware of them, confident to use them, and are kept up to date with current employment law and best practice. Monitoring the arrangements will also help the board or other appropriate governance structure to demonstrate to regulators that their arrangements are working effectively.

INDICATOR:	Yes	More work required	Unsure	No
Our organisation has systems in place to ensure that all concerns raised are appropriately logged, detailing how each concern has been progressed, and any actions taken as a result of that issue being raised.				
We have appointed a designated officer or freedom to speak up guardian who has lead responsibility to ensure the appropriate training and handling of concerns is in place, and the effectiveness of local systems is discussed at board meetings.				
Arrangements are periodically reviewed as part of our internal audit process to ensure staff are aware of arrangements, are willing to use them and have confidence in the system.				
Data is correlated with information available from other risk management systems – such as: key findings from reviews/surveys, exit interviews, adverse incidents and near misses to identify trends and areas for improvement.				

USEFUL LINKS:

Visit the NHS Employers web pages on:

- Raising concerns at work (whistleblowing): for information about the Draw the Line campaign, the Freedom to Speak Up review, and to access our online toolkit for managers, case studies and further guidance.
- Recruiting for values: to access the values mapping tool, podcasts and case studies.
- Do OD: organisational development: see the latest articles, blogs and case studies which are focused on driving system-wide change in the NHS.
- Staff engagement: to access our staff engagement toolkit, webinars, and guidance on using social media to increase staff engagement.

Gateway number 02948

Blank for supporting information: *Please use this space to evidence strengths and weaknesses against each of the indicators – using local information available to you such as staff and patient experience surveys; notes from staff briefings, meetings, discussions and other relevant information. Our other Draw the Line campaign tools can help facilitate conversations and identify ways to improve these indicators.*

Freedom to Speak Up Guardians – Purpose and key principles of the role

Purpose
The Freedom to Speak Up Guardian will work alongside trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

Key principles	…what this means
Independent	… in the advice they give to staff and trust's senior leaders, and free to prioritise their actions to create the greatest impact on speaking up culture … and able to hold trusts to account for: creating a culture of speaking up; putting in place processes to support speaking up; taking action to make improvements where needed; and displaying behaviours that encourage speaking up
Impartial	… and able to review fairly how cases where staff have spoken up are handled
Empowered	… to take a leading role in supporting staff to speak up safely and to independently report on progress on behalf of a local network of 'champions' or as the single role holder
Visible	… to all staff, particularly those on the frontline, and approachable by all, irrespective of discipline or grade
Influential	… with direct and regular access to members of trust boards and other senior leaders
Knowledgeable	…in Freedom to Speak Up matters and local issues, and able to advise staff appropriately about speaking up
Inclusive	… and willing and able to support people who may struggle to have their voices heard
Credible	… with experience that resonates with frontline staff
Empathetic	… to people who wish to speak up, especially those who may be encountering difficulties … and able to listen well, facilitate constructive conversations, and mediate to help resolve issues satisfactorily at the earliest stage possible
Trusted	… by all to handle issues fairly, take action as necessary, act with integrity and maintain confidentiality as appropriate
Resilient	… and able to handle difficult situations professionally, setting boundaries and seeking support where needed
Forward thinking	… and able to make recommendations and take action to improve the handling of cases where staff have spoken up, and freedom to speak up culture more generally
Supported	… with sufficient designated time to carry out their role, participate in external Freedom to Speak Up activities, and take part in staff training, induction and other relevant activities … with access to advice and training, and appropriate administrative and other support
Effective	… monitoring the handling and resolution of concerns and ensuring clear action, learning, follow up and feedback

Trust Board 19 July 2016
Agenda item 6

Title:	**Risk Appetite Statement**
Paper prepared by:	Director of Corporate Development
Purpose:	To set out clear guidance on the level of risk Trust Board is prepared to tolerate
Mission/values:	Supports the Trust in delivering safe, effective and efficient services which underpins the Trust's mission of helping people reach their potential and live well in their community. Supporting delivery of a key value around improvement and the aim to be outstanding as a Trust.
Any background papers/ previously considered by:	Risk Management Strategy
Executive summary:	The Trust aims to provide high quality, safe services which help people reach their potential and live well in their community. Trust Board recognises risk is inherent in the provision of the services it provides. A defined approach to risk-taking in pursuit of delivery of the Trust's mission and its strategic objectives is required. This statement sets out Trust Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds and supports delivery of the Trust's Risk Management Strategy and procedures. Trust Board should be sufficiently informed when it is making key strategic decisions around the impact of that decision on the delivery of the organisations strategic objectives and the principle risks to delivery. When Trust Board considers meeting clinical need/statutory requirements, it will have a low tolerance to risk. When Trust Board is considering a speculative development, there will be a higher tolerance to risk. It is recognised that the Trust may have limited influence on external factors that can impact on the Trusts ability to manage a risk down to the risk target. The risk target is just that: a target the Trust is trying to manage down to; however, on occasions, it may have to revise that target to the least worst option. The Executive Management Team, through its monthly review of the organisational and directorates risk registers, will consider if there is a likelihood of a risk not being managed down to the right level. A risk exception report will be presented to the relevant sub-committee or forum of Trust Board setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. The attached report sets out the framework and some worked examples.
Recommendation:	**Trust Board is asked to CONSIDER and SUPPORT the approach set out in the framework.**
Private session:	Not applicable

Trust Board 19 July 2016
Risk appetite statement

Introduction

This report has been produced to ask Trust Board to give consideration to its 'appetite' for risk as an organisation. The organisation's risk appetite will be described in its Risk Management Strategy and future annual governance statements.

Risk Appetite, definition and purpose

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives. It goes to the heart of how an organisation does business and how it wishes to be perceived by its key stakeholders. The amount of risk an organisation is willing to accept will depend on the business it is in, its systems and policies and the internal and external environment it is facing.

A risk appetite enables Trust Board to formally communicate to the organisation the level and type of risks it is willing to accept to achieve the Trust's mission, strategic objectives and organisational priorities. It will assist decision-makers in understanding the degree of risk to which they are permitted to expose the Trust whilst encouraging enterprise and innovation. The Public Accounts Committee (PAC) supports well managed risk taking recognising that innovation and opportunities to improve public services often requires risk taking providing the organisation has the ability, skills, knowledge and training to manage those risks well. The statement of risk appetite is by its nature dynamic and its drafting will be an iterative process that reflects the challenging environment facing the Trust and the wider NHS. The Trust will review its risk appetite at least annually as part of the review of its Risk Management Strategy.

Process

It is recognised that the Trust may have limited influence on external factors that can impact on the Trust's ability to manage a risk down to the risk target. The risk target is just that: a target the Trust is trying to manage down to; however, on occasions the Trust may have to revise that target to the least worst option. The Executive Management Team, through its monthly review of the organisational and directorates risk registers, will consider if there is a likelihood of a risk not being managed down to the right level. A risk exception report will go to the relevant sub-committee or forum of Trust Board setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level.

Trust Board will review its activities at the quarterly Business and Risk meeting, ensuring any risks, emerging risks, changes in activities or key risk indicators are reviewed in accordance with the risk appetite of Trust Board. This may involve taking considered risks into account where the long-term benefits outweigh any short term losses. The impact of these risks will be reflected through the Board Assurance Framework.

The Trust's Risk Management Strategy sets out the Trust's risk scoring approach, which is based on the likelihood of an event happening multiplied by the consequence of the action. Appendix 4 of the strategy (attached as an appendix to this report) provides detailed guidance on the risk grading matrix with examples of descriptors covering a number of domains:

- impact on the safety of patients, staff or public (physical/psychological harm);

- quality/complaints/audit;
- human resources/organisational development/staffing/competence;
- statutory duty/inspections;
- adverse publicity/reputation;
- business objectives/projects;
- finance including claims;
- service/business interruption/environmental impact.

	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

Trust Board Risk Appetite Statement

Background

As an NHS Foundation Trust, the Trust's Unitary Board acts as custodian of the interests of our current and future service users, our staff and our members.

Our Mission: We exist to help people reach their potential and live well in their community.

Our strategic objectives are to:

1. *improve the health of the people we serve and reduce health inequalities;*
2. *improve the quality and experience of the care we provide;*
3. *improve our use of resources.*

We must deliver our Mission and strategic objectives in a manner which ensures as far as reasonably possible that this is done safely. We therefore seek a prudent position for our risk appetite that could compromise the delivery of high quality, safe services. Acknowledging that the outcomes may, on occasions, result in a negative impact on our reputation or in a lower level of financial return.

Risk appetite target scores

We have defined our risk appetite in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix aligned to the Trust's own risk assessment matrix as shown in the table below.

Note: The target score is that after the risk has been mitigated through relevant action plans.

Good Governance Institute matrix	Risk appetite level	Risk target score (range)
Avoid: Avoidance of risk and uncertainty is a key organisational objective	**None**	**Nil**
Minimal: (ALARP: As low as reasonably possible) Preference for ultra-safe delivery options with low inherent risk and only for limited reward potential	**Low**	**1-3**
Cautious: Preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward.	**Moderate**	**4-6**
Open: Willing to consider all potential delivery options and choose, whilst also providing an acceptable level of reward (and VFM)	**High**	**8-12**
Seek: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	**Extreme**	**15-20**
Mature: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.	**Extreme**	**25**

Application

Within our Risk Management Strategy, we have defined the following four broad areas of risk which have been used to frame the Trust's risk appetite statement. *Note: The risk appetite and risk targets noted are indicative and for discussion at Trust Board.*

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.

Delivering transformational change whilst ensuring a safe place to receive services and a safe place to work.	**Risk appetite Open/high**	**Risk target 8-12**
Developing partnerships that enhance Trusts current and future services.	**Risk appetite Open/High**	**Risk target 8-12**
Innovating and safely changing practices.	**Risk appetite Seek/Extreme**	**Risk target 15-20**

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.

Risks to service user/public safety.	**Risk appetite Minimal/low**	**Risk target 1-3**
Risks to staff safety	**Risk appetite Minimal/low**	**Risk target 1-3**
Risks to meeting statutory and mandatory training requirements, within limits set by the Board.	**Risk appetite Minimal/low**	**Risk target 1-3**

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.

Financial risk associated with plans for existing/new services as the benefits for patient care may justify the investment	**Risk appetite Open/High**	**Risk target 8-12**
Reputational risks, negative impact on perceptions of service users, staff, commissioners.	**Risk appetite Cautious/Moderate**	**Risk target 4-6**
Risk of breakdown in financial controls, loss of assets with significant financial value.	**Risk appetite Avoid/none**	**Risk target Nil**
Risks to recruiting and retaining the best staff.	**Risk appetite Cautious/Moderate**	**Risk target 4-6**

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.

Risk of failing to comply with Monitor requirements impacting on license	**Risk appetite Minimal/Low**	**Risk target 1-3**
Risk of failing to comply with CQC standards and potential of compliance action.	**Risk appetite Minimal/low**	**Risk target 1-3**
Risk of failing to comply with health and safety legislation	**Risk appetite Minimal/low**	**Risk target 1-3**
Meeting its statutory duties of maintain expenditure within limits agreed by the Board.	**Risk appetite Minimal/Low**	**Risk target 1-3**

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)

Trust Board 19 July 2016
Agenda item 7

Title:	**Strategic overview of business and associated risks**
Paper prepared by:	Interim Director of Strategic Planning and Contracting
Purpose:	Trust Board is asked to note the contents of the report and to contribute to the shared view of the Trust's strategic positioning.
Mission/values:	The process of analysing the external environment and our own readiness and capability to respond, is a key aspect of the strategy development process. The Trust's strategy supports the achievement of our mission. The way in which we develop strategy in an open and inclusive manner demonstrates how we live the values.
Any background papers/ previously considered by:	This paper updates and replaces the PESTLE and SWOT analyses which were considered by the Trust Board meeting which took place in April 2015.
Executive summary:	• The Trust is currently undertaking a strategy refresh exercise, which will lead to the publication of a renewed strategy later in 2016, in line with the Chief Executive's agreed objectives. • To support the above strategy re-fresh exercise the Trust's SWOT and PESTLE analyses have been revised to reflect the renewed priorities and the changing external environment. This paper summarises these analyses. • The **PESTLE** analysis has been approached in the context of the Trust's Strategic Plan. New and changed factors include: - Continued policy emphasis on collaborative place based approaches to improvement (Vanguards, Sustainability and Transformation Plans (STPs), etc.) which may lead to changes in organisational form (Accountable Care Organisations, Multi-speciality community providers, etc.), which may indicate a subtle shift away from market based drivers of improvement. - Emerging gap between policy direction (sub-regional place based collaboration) and existing legal frameworks (Clinical Commissioning Groups, public procurement regulations, etc.). - Recognition of the uncertain impact of recent European Union membership referendum on the NHS and associated changes related to political leadership. Key issue of note regarding workforce. - Changing landscape of regulation and approaches from regulators – NHS Improvement's emerging framework and alignment with Care Quality Commission. More focus on earned autonomy and system-wide view of quality and governance. • The **SWOT** analysis has been revised in the context of the above analysis of the external environment and the Trusts strategic objectives and priorities. In summary: - the strengths of the Trust largely remain consistent, with particular

elements such as the caring nature of service delivery by our colleagues, being emphasised;

- the major opportunities for development reflect the learning from the recent listening exercise led by the Chief Executive, and crucially also from the recent CQC inspection which has largely reinforced the Trust's own self-assessment of the areas to improve;
- the threats reflect a mixture of internal factors that will be addressed by the delivery of the Trust's plan for 2016/17, and a range of external issues as described in the PESTLE analysis and on the Trust risk register;
- the above PESTLE and SWOT analyses have been checked against the Trust's **Risk Register**, and consistency and completeness has been verified.

- Overall the high level of change and uncertainty in the wider system means that the assumptions on which financial and strategic plans are based require frequent review. This is reflected in the work described below which will lead to the refresh of our Trust Strategy.
- Current progress and next steps include:

Action	Status
Trust-wide listening exercise led by the Chief Executive	✓
Agreed priorities for action, based on our three strategic objectives	✓
Creation of a single comprehensive action plan for the year which integrates our published 2016/17 Operational Plan	✓
Development of director objectives in line with our strategic objectives and priorities for action	✓
Review of the Trust risk register to reflect the challenges to delivery of our strategic objectives	✓
A dashboard for the measurement and reporting of delivery against the Plan is currently being developed.	Due end July
Agreement of governance and reporting arrangements to support achievement of the Plan	Due end July
Refresh of Strategic Plan	Due October

Recommendation:	**Trust Board is asked to:** • **NOTE the progress to date and proposed action plan;** • **REVIEW the analyses presented above and contribute to the shared view of the Trust's strategic positioning.**
Private session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

Strategic overview of Business and Risks

Trust Board 19 July 2016

Interim Director of Strategic Planning and Contracting

With **all of us** in mind.

1. Background

The Trust's Executive Management Team regularly scans the external environment and cross references this horizon scanning with the risks identified and managed as part of the Trust Risk Register and Board Assurance Framework. In addition the Executive Management Team periodically reviews and refreshes a PESTLE analysis of external factors and a view of the Trust's strengths, opportunities, weaknesses and threats in response to those circumstances.

2. Strategy Refresh

The Trust is currently undertaking a strategy refresh exercise, which will lead to the publication of a renewed strategy later in 2016, in line with the Chief Executive's agreed objectives. The process followed to date has included;

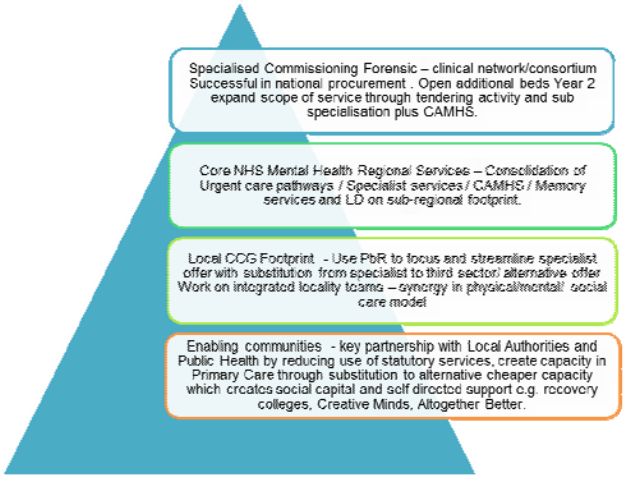
- A Trust-wide listening exercise led by the Chief Executive
- Distillation of agreed priorities for action, based on our three strategic objectives for 2016/17 and the learning from the listening exercise.
- Integration with our published 2016/17 Operational Plan to create one single comprehensive action plan for the year.
- Development of director objectives in line with our strategic objectives and priorities for action, which will in turn enable the cascading of team and individual objectives linked back to the Trust's mission and objectives.
- Review of the Trust risk register to reflect the challenges to delivery of our strategic objectives, and the mitigating actions required.
- A dashboard for the measurement and reporting of delivery against the Plan is currently being developed.

To support the above strategy re-fresh exercise the Trust's SWOT and PESTLE analyses have been revised to reflect the renewed priorities and the changing external environment. This paper summarises these analyses.

Trust Board is asked to review the analyses presented below and contribute to the shared view of the Trust's strategic positioning

3. PESTLE

The PESTLE analysis has been approached in the context of the Trust's Strategic Plan. The Plan stratifies services into four tiers, with each tier requiring distinct approaches and partnerships for sustainability. See below:



3.1 Political

- Party political leadership changes, particularly in respect of the governing Conservative Party, which may have unknown impacts on public policy affecting the NHS, and wider social and economic drivers of health and wellbeing.
- Uncertainty of the impact of the UK referendum decision on EU membership. Potential to alter previous assumptions regarding the quantum and focus of public spending, which underpin current FYFV NHS budget projections. Potential to impact on workforce availability. Longer term potential to impact on public procurement and other public law. Initially has at least re-affirmed the importance of the NHS to the public.
- DoH communications (Confed speech etc) confirm that deeper than planned sustainability crisis in the acute sector requires continued focus, which delays any potential shift of investment towards community and mental health sectors. May be interpreted as reinforcing continued lack of parity of esteem.
- Continued emphasis on collaborative place based approaches to improvement (Vanguards, STPs etc) and associated changes in organisational form (ACOs, MCPs etc) may indicate a subtle shift away from market based drivers of improvement. May also highlight the importance of Trusts having clarity of strategic intent both at organisational and at service line level.
- Impact of continued austerity for councils coupled with perception of strong 'NHS' focus of STP guidance may make local political alliances with elected members more difficult – may manifest through H&WBBs and OSCs etc
- Political stance on NHS employment contracts, starting with Junior Doctors, emphasises potential for continued discontent and disruption

3.2 Economic

- Impact of continued austerity, especially with regard to local authority commissioned services
- Uncertainty regarding public funding settlements post-BREXIT referendum outcome

- Continued (but reduced level of) uncertainty regarding specialised commissioning, with particular impact on Forensic Mental Health and the business case regarding CAMHS Tier 4
- Major CIP requirements of financially challenged NHS providers leading to sub-optimal approaches to pathways and partnerships within local health economies, and unintended consequences associated with services stopping/ failing
- Following Junior Doctors contract negotiation, continued emphasis on reform of NHS employment contracts, may drive more clinical colleagues towards agency work, hindering efforts to deflate the locum market.
- The deployment of Sustainability and Transformation Funding (and CCG 1%) is (in the short term at least) largely being directed towards improvement of the sustainability of acute care provision. This impacts on the prioritisation of community LD and mental health provision in funding terms. May be opportunities within this period to innovate with partners on own terms.

3.3 Socio-cultural

- Impact of demographic change on demand for services and also on workforce age profile
- Changing expectations of services. Public expect greater personalisation, higher standards of customer service and responsiveness, greater level of co-production. Policy makers and commissioners expect more self-care and emphasis on prevention
- All the above drive changed workforce requirements – new skills, new roles, new psychological contract at work

3.4 Technological

- Key enabler and driver of change within the Trust and externally. Continued direction of travel in public service towards digital by default. In addition to political will, individuals and communities drive demand for health and care providers to keep pace with their use of technology in other aspects of their lives.
- Inequalities in technology access, competence, and acceptance are slowly being eroded, but persist as a factor impacting on service design and access. In some ways technology inequalities mirror broader socio-economic inequalities, and as such are of relevance to Trust mission and objectives.
- Continued growth in use of social media by a wide range of demographic groups, changes the way in which customer experience and service quality is evaluated – becoming more open, faster, and comparable – e.g. Patient Opinion. Supports choice agenda, potentially links to commissioner decision making.
- Technology enables improved access and use of data – telehealth monitoring of vital signs, self reported well-being etc. Creates a different dialogue between service user and healthcare service provider – supports personal control, self-care, and movement towards coaching approaches.

- Interoperability of clinical systems, and enhanced analytical functions (data warehouses, big data etc) support evidence based care at system level and in relation to integrated care planning at an individual level. Creates demand for cross-organisational platforms for integrated working. Progress lags behind the vision
- Platform technology potentially allows Trust's to widen the range of offers available to service users e.g. mobile apps, enables more peer to peer support, promotes innovation and provides data on choice. Also platforms have potential to disrupt traditional 'supply chain' based markets – e.g. Uber, Air-BNB, Ebay etc
- Increased use of communications technology for consultation – engagement of carers/ MDTs etc
- Technology opens up wider possibilities in terms of 'remote working', operating over a larger geography, and different option for provision of support services including more self-service, more collaboration and traded services between NHS partners.

3.5 Legal/ Regulatory

- Changing landscape of regulation and approaches from regulators – NHSI's emerging framework and alignment with CQC. Diminished emphasis on previous markers of independence such as FT status and more focus on earned autonomy and system-wide view of quality and governance.
- CQC visit and subsequent publication of ratings of Trust services confirm regulatory position of the trust overall and in relation to specific factors – this shapes future regulatory framework and frequency of review for the Trust.
- Continued requirement to explore organisational form and partnership vehicles suitable for place based solutions (e.g. ACO, MCP), and for service line specific collaboration (e.g. mental health). Some systems (Devo Manc etc) starting to explore changes to the alignment of commissioning responsibilities e.g. between CCGs and local authorities. Anticipate direction of travel to challenge purchaser/ provider split
- Mergers & Acquisitions regulation and guidance – legal and regulatory framework unchanged but the anticipated approach to the practical application of this regulatory framework is uncertain in light of shift towards system based solutions.
- Choice agenda in health remains within NHS plans and policy, but pace of implementation slowed, with far less prominence than previously.

3.6 Environmental

- Change in travel patterns as part of new service models and technological change – e.g. more home based care but fewer trips back to base. More support staff using video conferencing
- Opportunities around renewable energy

4. Summary of SWOT Analysis

In the context of the above analysis of the external environment and the Trusts strategic objectives and priorities, the following strengths, weaknesses, opportunities and threats are highlighted:

4.1 Strengths

- Compelling model for alternative capacity – Creative Minds, Recovery Colleges and Altogether Better is well aligned to 5YFV, STP direction etc and offers opportunities for partnership in local place-based solutions – e.g. Provider Alliance
- Financial track record and cash position, relative to many others, enables a key role in shaping future collaborative models (ACO, MCP, West Yorks Mental Health etc)
- Clear commitment to our mission, good values base, and increased understanding and alignment around strategic priorities within all parts of the Trust
- Integrated approach to quality improvement ensures quality drives everything we do
- Our CQC report confirms how staff treat people with kindness care and compassion
- Our CQC report highlights the outstanding features of childrens health services and end of life care provided by the Trust. It also highlights consistent good ratings in general community health services, our learning disability inpatient services and our mental health crisis services
- Our CQC report highlights that more than 70% of the individual ratings are good
- Our culture of supporting each other and our work with service users and carers makes us different to many other Trusts. This inspires staff and offers potential for building external relationships and engaging with commissioners
- Our partnership relationships and the way in which we conduct ourselves when working collaboratively demonstrates a real focus on the needs of the people who use our services
- The additional external responsibilities taken on by our Chair and CEO in relation to leadership roles in STPs and on national bodies ensure we have high level connections and influence at a strategic level.

4.2 Weaknesses

- Some elements of data quality undersell the true quality and contribution made by the Trust. This is required to maintain stakeholder confidence and therefore impacts on reputation and sustainability. In addition there are some services where access to help can be too slow and needs to improve. E.g. CAMHS and psychological therapies.
- Colleagues do not feel that leaders are always as visible as they need to be
- Sometimes we act in silos, with particular need to address gaps between operations and corporate support, and between strong local identities.
- Internal communications are poor, our external reputation and branding focus too much on MH
- Sometimes our approach is too bureaucratic, and colleagues and partners perceive that we are too slow to make decisions

- Our approach to change takes too long, and is not always as engaging as it needs to be
- We need to better recruit, retain, motivate and value the health and wellbeing of our staff. In common with other Trusts we experience difficulties in ensuring that we have the right workforce in some hot spots. e.g. staff grade doctors, ward based nursing staff, PWPs in IAPT. Opportunity to re-think models of care and roles
- Our IT systems don't always support the desired agile style of working, and in some cases (e.g. RiO) the systems have not been as reliable and resilient as we need, which impacts on effectiveness and morale
- Our CQC Report highlights that there is an opportunity to improve in several areas of service in relation to 'safe, effective, responsive and well-led'

4.3 Opportunities

- We can build upon our relative stability, innovation, and partnership relationships to play a leading role in shaping place based solutions in each of our localities.
- The integrated nature of our organisation with reach into several localities across many different services, means we are well placed to play a leading role in the changing shape of health and care provision, in which further integration is anticipated, of both a place based and a service-specific nature.
- We can use our connectivity to STPs to forge stronger collaboration and promote the delivery and growth of innovation.
- We need a new approach to leadership and OD
- We need focused work on communications and engagement
- We need clearer, more coherent portfolios and simplified TAG arrangements
- We need improved business intelligence, business planning and commercial acumen
- We need an agreed change model and reformed PMO
- We need a revised workforce strategy and a focus on retention and wellbeing
- We need a focus on IT, linked to operational delivery and transformation
- We need a focus on innovation, building on transformation, digital and creative minds, recovery and altogether better
- We need to make a more coordinated offer from the quality academy with clear leadership and standards to improve governance and improve the link between strategy and operations

4.4 Threats

- NHS sustainability agenda focuses primarily on the highly visible challenges to the viability of acute hospital model, which may marginalise the needs of community, learning disability, and mental health services in terms of funding and support.
- Possible that well-developed infrastructure around service delivery and gaps between corporate support and operations may lead to a lack of agility to respond to changing priorities quickly enough.

- Impact of continued austerity on public spending (particularly Local Authorities) leading to additional unplanned pressures on the Trust. This manifests in terms of additional demand for Trust mental health services (e.g. as a result of benefit restrictions); and also through reductions in local authority procured contracts. E.g. public health grant reductions driving service reductions and re-procurement etc. This results in loss of jobs and expertise, reduced income and contribution to running costs, and additional costs associated with redundancies.
- The high level of changing circumstances across the whole system may impact on assumptions and required developments in the Trust's Medium Term Plan that underpin The Trust's sustainability. Therefore a strategy re-fresh is underway and a process to frequently review progress and key assumptions is required.
- Data quality and information governance issues may lead to regulatory action and reputational damage.

5. Correlation with Key Risks and Mitigation

The Trust's Risk Register contains 9 risks rated 15 or more out of 25. All are being actively managed by the Executive Management Team. Those risks have been checked against the PESTLE and SWOT analysis above to ensure consistency and completeness.

The Risk Register is regularly reviewed by Trust Board and is therefore not replicated in this report.

6. Next Steps

As outlined in section 2 'Strategy Re-Fresh' a process is underway to ensure that the Trust prioritises actions in accordance with the Mission, Values and Strategic Objectives of the organisation. This review of the external and internal environment links with the Risk Register as part of the Board Assurance Framework. This ensures that challenges to delivery are addressed.

Current progress and next steps include:

Action	Status

Trust-wide listening exercise led by the Chief Executive	✓
Agreed priorities for action, based on our three strategic objectives	✓
Creation of a single comprehensive action plan for the year which integrates our published 2016/17 Operational Plan	✓
Development of director objectives in line with our strategic objectives and priorities for action	✓
Review of the Trust risk register to reflect the challenges to delivery of our strategic objectives	✓
A dashboard for the measurement and reporting of delivery against the Plan is currently being developed.	Due end July
Agreement of governance and reporting arrangements to support achievement of the Plan	Due end July
Refresh of Strategic Plan	Due October

7. Recommendation

Trust Board is asked to

- Note the progress to date and proposed action plan
- Review the analyses presented above and contribute to the shared view of the Trust's strategic positioning

Trust Board 19 July 2016
Agenda item 8

Title:	**Care Quality Commission Quality Summit and action plan**
Paper prepared by:	Director of Nursing and Professions, Clinical Governance and Safety.
Purpose:	For Trust Board to be updated on the Care Quality Commission (CQC) inspection process and the action plan required to address improvements.
Mission/values:	Honest, open and transparent, respectful, 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:	CQC inspection papers and presentations to Trust Board and Clinical Governance and Clinical Safety Committee
Executive summary:	The Trust was inspected as part of the CQC's routine comprehensive inspection process on the week commencing 7 March 2016. The scope of the inspection was vast looking at services from across the whole Trust and viewing information from all corporate services. Draft reports for fourteen core services and one Trust-wide quality report were received by the Trust on 20 May 2016. The factual accuracy check was finalised on 10 June 2016 and the final reports were issued to the Trust on 20 June 2016. These were published on the CQC website on 24 June 2016. Across these fourteen reports, more than 70% of the individual ratings are 'Good' (green). Overall, there are eight 'Good' ratings across all of our community, mental health and learning disability services. The Trust received 22 regulatory breaches across seven regulations. These are areas where the Trust is seen to be not adhering with the Health and Social Care Act and require immediate attention. The Trust is required to inform the CQC of the actions it is taking to address the breaches and will be monitored on these areas through CQC processes. An action plan has been developed (attached) which addresses the regulatory breaches and 'must do' actions. This was presented to the Executive Management Team (EMT) on 7 July 2016. The plan describes the actions to be taken and indicates the lead allocated for each area. In addition to this plan, a more detailed plan has been developed with individuals assigned to specific actions and milestones agreed. The more detailed action plans will be performance managed through the relevant BDU or quality academy department and report into EMT on a monthly basis. The Clinical Governance and Clinical Safety Committee will monitor progress and

	report to Trust Board. A Quality Summit has been organised for 14 July 2016, where the Trust will be given an opportunity to respond to the concerns raised by the CQC, and time is allocated for a discussion on the proposed actions we plan to take to meet the regulatory breaches. A copy of the presentation to be provided at the Quality Summit is enclosed for information. <u>Next steps</u> The quality improvement and assurance team will ensure that the Trust's current quality improvement plan incorporates the improvements the CQC identified into its existing key work streams, and identify where further work streams may be appropriate to ensure that action is aligned.
Recommendation:	**Trust Board is asked to RECEIVE the draft high level plan and comment as appropriate.**
Private session:	Not applicable

SWYPFT CQC Visit - Requirement Notice Action Plan

Final Version Dated – 8.7.2016

Ref	Issue identified	Action	Lead	Completion date
OVERALL REPORT				
TRN1	Three of the new non-executive directors had not had Disclosure and Barring Service checks in line with the fit and proper person requirement, which came into force for NHS bodies on the 1 October 2014. This is a breach of regulation 5 (3) (a)	The three new non-executive directors have had their Disclosure and Barring Service Checks completed and have been issued with their standard certificates, copies of which are held by Human Resources.	Director of Corporate Development	Completed
TRN2	Mental Health Act and Mental Capacity Act training was not mandatory for any staff and was not monitored for effectiveness by senior management of the trust. This is a breach of regulation 18 (2)(a)	1. In March 2016 Mental Health Act/Mental Capacity Act training was approved by the EMT as mandatory for all staff. 2. In April 2016 a meeting was held with Learning and Development to agree reporting arrangements through the HR performance wall. 3. The proposed MCA training plan (including Deprivation of Liberty Safeguards) was discussed with the Local Authorities in June 2016. A monthly training plan was agreed. Training flyers were completed. A review meeting has been planned for October 2016. 4. We have undertaken a review of the e-learning programme for level 1 MCA training. During June 2016 we received confirmation from SCIE Head of Digital to confirm that we can adapt the SCIE's e-learning programme. 5. We are developing training plans for MCA using core training guidance that was issued by NHS England. Training flyers are available and training information will be advertised in weekly bulletins during July and August 2016. 6. E-learning packages are to be developed for the Mental Health Act. This training will interface with the MCA training. Training plans and	Assistant Director of Legal Services	31st October 2016

Ref	Issue identified	Action	Lead	Completion date
		dates have been put in plan. 7. There is an internal Trust Training plan for MHA/MCA for all registered staff working within mental health services. Training dates are available and are advertised on the trust intranet. 8. Reporting compliance with the MHA/MCA training will be sent to the Trust Board and senior managers. Reporting compliance via performance will be sent to individual staff and managers on a monthly basis. These reporting structures will feed into the MHA Committee. 9. A new MHA/MCA sub-group has been established and will report into the MHA Committee. 10. The MHA/MCA training plan will be reviewed in October 2016. 11. We will be looking at the continued implementation of the training plan including refresher dates. 12. There are plans to establish practical scenario based refresher training for all registered and support staff (clinical) by October 2016. 13. Plans have been developed to include mental capacity in the medics induction programme. This will include training on assessment of capacity and consent, best interests, advance decision-making, lasting power of attorney and DOLS.		
TRN3	The 2015 MHA code of practice had not been implemented across all services of the trust. This is a breach of regulation 17(2)(a)	As a trust wide approach we are going to take the following actions: 1. We are commissioning a MHA/MCA clinical reference group. 2. All areas have removed outdated MHA Code of Practice information. 3. We have sent reminders to staff that the MHA Code of Practice 2015 is available on the intranet. Information will also be provided in weekly bulletins during July and August 2016. BDU Deputy Directors will include the MHA Code of Practice as an agenda item within their respective BDU meetings. 4. MHA Code of Practice training is now mandatory and training is in place. New doctors will attend induction training which now incorporates a dedicated MHA session. 5. In April 2016 we developed a MHA Code of Practice policy action plan that was sent to all identified leads for review. 6. BDU's were asked to review all operational procedures to ensure	Director of Nursing Clinical Governance & Safety	July 2016 and then ongoing until 31st March 2017

Ref	Issue identified	Action	Lead	Completion date
		compliance with the MHA Code of Practice 2015. From this BDU's provided a list of their local procedures and assurances about their compliance with the code. 7. We are also planning a baseline audit of awareness of the current MHA Code of Practice. These audits will be carried out every 3-6 months. There will be an overall overview in 12 months' time and this will be aligned to the training plan.		
TRN4	Care records were both electronic and paper based and staff did not have access to contemporary, accurate and comprehensive patient's records. This is a breach of Regulation 17(2)(c)	The Trust has an improving clinical information working group and action plan. 'Multiple records' as described above, is one of the areas that the Trust has identified for action. The aim is to ensure our clinical record keeping system RIO is the one place for storage of all clinical records. Actions 1. Agree a policy standard and procedure around the use of RIO as the single storage point for all clinical information and records 2. Communicate the policy and procedure to eliminate risk caused by this practice	Director of Nursing, Clinical Governance & Safety	31st December 2016
Acute wards for adults of working age and psychiatric intensive care units				
AIRN1	Patients on ward 18, Priestley Unit, Dewsbury did not have risk assessments that had been fully completed or completed within trust policies and procedures. Staff did not have clear lines of sight on Trinity 2, Fieldhead Hospital and Ashdale and Elmdale wards at The Dales. Not all ligature risks had been identified on Beamshaw and Clarke ward at Kendray	**Wakefield (Trinity 2 and Fieldhead Hospital)** Lines of sight • We are carrying out an environmental risk assessment to look at where additional mirrors are needed to help line of sight. • Once improvements have been identified, we will liaise with the Estates department to install the mirrors in the areas identified. **Kirklees (ward 18)** Risk Assessments • We have emphasisied the need for fully documented risk	Deputy Director of Operations	30th September 2016

Ref	Issue identified	Action	Lead	Completion date
	Hospital. This is a breach of Regulation 12 (2)(a)(b)	assessment information within the trust policies and procedures with all qualified practitioners through targeted communication i.e. directly by e-mail and within staff meetings. • procedure is to be completed to determine if any latent issues exists or if the procedure can be improved in terms of clearly informing staff of potential and actual environmental risks. • A review of the content of the current assessment tool will be completed with the Health and Safety Department to determine if the assessment tool could be improved to aid clarity of use and clarity of interpretation • [Alongside other actions we will review the *Guidance notes: Environmental suicide and ligature point risk assessment tool* to ensure that it is fully compatible with the assessment tool and provides appropriate and up to date evidence based guidance. • On completion of the review re: assessment tool and guidance notes complete an environmental ligature risk assessment of Beamshaw and Clark Wards. • On completion of the review we will complete a risk management plan to manage or mitigate any ligature points identified. • Disseminate ligature point assessment and risk management plan to all ward staff – consideration should be given to maintaining an attendance list or log for all staff receiving a safety briefing re environmental ligature point risk assessment. • Ensure that ward 18 have updated risk assessments completed within trust policies and procedures which informs the current care plan. • Communication with all qualified practitioners (e-mail & staff meeting) • Implement risk assessment and care plan standards. • A BDU inpatient discharge planning group is being formed to learn from SI incidents to improve discharge planning which includes updating risk assessments, working in a whole systems way. • The Community and Acute Practice Governance Coaches are setting up a small working group to review how the whole system		

Ref	Issue identified	Action	Lead	Completion date
		achieves best practice standards for improving risk assessments, especially at the discharge planning stage. **Calderdale (Ashdale and Elmdale)** Lines of sight • A review is being undertaken with our Estates department to fit mirrors to improve lines of sight. • Fitting of appropriate mirrors **Barnsley (Beamshaw and Clark wards)** Ligature risks • We will be undertaking a review of the environmental ligature risk assessment and management process and post review complete an environmental risk assessment for Beamshaw and Clark wards. • Complete a review of the risk assessment tool [this is required as obviously the CQC misunderstood the purpose of the risk assessment tool and other individuals may also suffer from this misapprehension: the assessment tool is to assist in the identification of environmental risks within the premises as opposed to individual patient risk]. Therefore clarity of use and clarity of interpretation must be ensured: • To achieve this, a process mapping exercise of the assessment procedure is to be completed to determine if any latent issues exists or if the procedure can be improved in terms of clearly informing staff of potential and actual environmental risks . • A review of the content of the current assessment tool will be completed with the Health and Safety Department to determine if the assessment tool could be improved to aid clarity of use and clarity of interpretation • [Alongside other actions we will review the *Guidance notes: Environmental suicide and ligature point risk assessment tool* to ensure that it is fully compatible with the assessment tool and provides appropriate and up to date evidence based guidance.		

Ref	Issue identified	Action	Lead	Completion date
		• On completion of the review re: assessment tool and guidance notes, complete an environmental ligature risk assessment of Beamshaw and Clark Wards. • On completion of the review we will complete a risk management plan to manage or mitigate any ligature points identified. • Disseminate ligature point assessment and risk management plan to all ward staff – consideration should be given to maintaining an attendance list or log for all staff receiving a safety briefing re :environmental ligature point risk assessment.		
AIRN2	High dose medication was not routinely monitored across all wards. There were no completed monitoring forms and no information in patient records. This is a breach of Regulation 12 (2)(g)	**Wakefield** • A new form for monitoring for High dose Antipsychotics as suggested by Royal College is to be used in collaboration with pharmacy link professional. • We will be linking this work alongside the physical health monitoring pilot for monitoring purposes.. **Kirklees** • We will be working closely with the Pharmacy team to ensure the medicines code is correctly practiced. This will include reinforcing good practices with staff from inpatient teams (Medics & Registered Nurses) and how we monitor this. • The Clinical Lead (Dr Mathen) has been in communication with all consultants and ward managers about high dose monitoring. Dr Mathen has also provided a trust form for staff to record how high dosages of medication are being monitored. **Barnsley** • We will develop local guidelines on the use and monitoring of High Dose Antipsychotics. • The BDU's Trio, local lead pharmacist, ward mangers and Band 6 staff will form a working group to develop a guidance protocol on	Deputy Director of Operations	30th September 2016

Ref	Issue identified	Action	Lead	Completion date
		the use of and monitoring of High Dose Antipsychotics. Issues or areas to be covered in the guidance will include such aspects as: - rationale for use of high dose and the recording of the same - use of more than one antipsychotic giving an aggregated high dose - assessment of physical risk e.g. cardiac, hepatic ,renal - assessment of potential drug interactions - monitoring arrangements in particular lipids and glucose - monitoring of side effects and side effect management - a description of nursing responsibilities - description of the doctors responsibilities - a description of the pharmacists responsibilities - review arrangements - development of a monitoring form [based on the requirements of the protocol - implementation of the High Dose guidelines		
AIRN3	Staff supervisions had not been completed across all wards for in some cases over 12 months. Staffing levels and staff skill mix did not meet the trust's minimum staffing levels at times on Ashdale and Elmdale wards at The Dales Hospital and Trinity 1 and Priory 2 at Fieldhead Hospital. This is a breach of Regulation 18 (1)(2)(a)	**Wakefield (Trinity 1 & Priory 2)** Supervision • Copies of staff supervision cards have been distributed to all staff. Staff will be expected to record all evidence of supervision sessions. • Supervision tree for each unit for band 6 and 7 grades and other staff. Supervision will be recorded in each staff file. • We will continue to have group supervision sessions which are facilitated by a psychologist. Staffing levels • We are holding twice weekly whole service staff planning meetings to help in the management of acuity/pressures. • We are using the RAG rating system to identify potential deficits. • We are sharing resources across all units to respond to need. • Use of agency/bank when appropriate.	Deputy Director of Operations	30th September 2016

Ref	Issue identified	Action	Lead	Completion date
		• Central recruitment process to fill staff nurse vacancies (over recruitment agreed). **Calderdale and Kirklees** Staff supervision • We will be reinforcing supervision standards in the Acute Service Line Meeting. • Implement updated supervision policy with staff supervision passport • Implement supervision data base • Monitor team compliance in Service Line **Calderdale (Ashdale and Elmdale)** Staffing levels and staff skill mix • Review of the wards Minimum staffing levels and monthly safer staffing reports • Ongoing work with the Trust's Safer staffing Group to promote safer staffing through recruitment and retention with ongoing monitoring. **Barnsley** Staff Supervision • The BDU will comply with the Trusts initiatives to centrally store supervision figures. A database was developed in 2016 (January-March) and is currently under pilot. This is a system that will enable supervisees, supervisors and managers to monitor and manage how supervision is accessed and captured, or where this is not happening across individuals and teams. • The database will facilitate an audit of supervision to be planned and completed against the clear standard stipulated in the policy, including ensuring that where impromptu and a more informal style is accessed, this is supported by		

Ref	Issue identified	Action	Lead	Completion date
		structured approaches with supervisors the supervisee holds a contract with.		
Specialist community mental health services for children and young people				
CAMRN1	Risk concerns had been documented within the clinical record but not been completed using the appropriate risk screening or comprehensive risk assessment tool in all cases. This was the case at each of the community bases. Following assessment and placement upon a waiting list for treatment there was no system to proactively monitor changes in these assessed levels of risk. This was the case at each of the community bases. This is a breach of Regulation 12(2)(b)	We are taking the following actions in response to this regulation: • Implementation of the case recording audit action plan • Implementation of a robust RiO training programme for staff - incorporating guidance/support in completion of comprehensive and risk assessments. • Implementation of a system of case review to proactively manage risk whilst children/young people and their families are waiting. • Implementation of case recording audit requires ongoing support/guidance through staff supervision systems. • A re-audit will also be undertaken by 31 October 2016 - with a specific focus on comprehensive and risk assessment. • Waiting list case review system to be implemented by 30 September 2016. • Progress against action plan led by CAMHS Clinical Governance and Safety Group and routinely reported to Trust Clinical Governance and Clinical Safety Committee.	Deputy Director of Operations	31st October 2016
CAMRN2	Waiting times for treatment were high with an average wait in excess of five months for the Wakefield CAMHS service. The trust could not provide comparable data relating to the Barnsley CAMHS waiting lists. This was because there were problems extracting accurate information. The trust was not regularly undertaking audits to determine new systems and processes were being embedded into practice. This was the case at each of the community bases.	Actions with regard to waiting times include; • Development of shared data set - numbers waiting and average waiting time from referral to choice/initial assessment; numbers waiting and waiting times (0-3 months, 3-6 months, 6-9 months, 9-12 months and 12+ months) from referral to treatment. • Redesign of care pathways to improve process efficiency and service outcomes. This will include review of skill mix. • Implementation of agreed Future in Mind service development plans, specifically in relation to community eating disorder and earlier intervention services. Actions with regard to audit include; • Establish an annually reviewed CAMHS-wide audit programme • Implement the agreed action plan in relation to clinical record keeping	Deputy Director of Operations	31st October 2016

Ref	Issue identified	Action	Lead	Completion date
	Examples of this were the lack of improvement in clinical record standards. Also an admission by a number of staff they were not following the trust lone worker policy and inconsistent understanding of the requirements of the completion and storage of FP10 prescription pads. This is a breach of Regulation 17(2)(a)(b)(c)	Actions with regard to lone working arrangements include; • Review protocols in relation to lone working, specifically in relation to use of the lone worker devices • Implement a robust programme of training regarding lone working arrangements • Undertake an audit of practice against the lone worker protocol Action taken with regard to storage of FP10 prescription pads; • Advice regarding the secure storage of FP10 prescription pads issued by CAMHS Clinical Lead. • Waiting time data available by 29 July 2016 and on monthly basis. • Pathway redesign work completed across all services by 31 October 2016. • Future in Mind plans fully implemented by 30 September 2016. • CAMHS-wide audit programme agreed by 29 July 2016 • Record-keeping action plan implemented and ongoing. • Lone worker protocol agreed and training completed by 30 September 2016 • Audit of lone worker practice completed by 31 January 2017. • FP10 advice issued/completed Progress against action plan led by CAMHS Clinical Governance and Safety Group and routinely reported to Trust Clinical Governance and Clinical Safety Committee.		
Community-based mental health services for adults of working age				
CMHT RN1	The provider did not ensure there was equitable access to psychological therapies across localities or that this was provided in a timely manner. Waiting times to access psychological therapies was high. Within the Barnsley business delivery unit the average wait was 54	**Kirklees Community Services-Adults of Working Age** • Following our transformation process, the psychological therapy resource will be allocated to both the Enhanced and Core Pathways. • The APTS staff will work as integrated team members and be available for not only direct clinical work, but indirect clinical consultation work to ensure care packages are psychologically informed. This will enhance the ability of other practitioners to	Deputy Director of Operations	31st March 2017

Ref	Issue identified	Action	Lead	Completion date
	weeks. Psychological provision to the South Kirklees assertive outreach team was also insufficient. This had the potential to impact upon individual's recovery. This is a breach of Regulation 9 (3) (b)	deliver low level psychological interventions and also improve patients adherence to intervention once psychological intervention commences. • The Assertive Outreach teams will no longer exists as discrete teams but will be incorporated into the Enhanced Pathway where the Flexible Assertive Community Treatment function will provide intensified input where clinical need dictates. This will include psychological therapy and Psychological Therapy consultation where appropriate. • The trio will work closely with the psychology leads to develop a pathway that will adhere to the 18 week pathway where resources are available. **Calderdale** psychological services are not fully funded to deliver services. In this instance there are discussions with the commissioners for appropriate funding to deliver services. The Transformation model will be delivered against a tight implementation plan which will incorporate reviews at three monthly intervals. Flexibility will be built into the model to allow for flexible realignment of all resources but in particular APTS. The programme will have the 18 week Psychological Therapy referral to treatment embedded within it to ensure performance currently at 98% is maintained. **Barnsley Community Services-Adults of Working Age** Within Barnsley additional capacity is being provided through the following actions: • An additional 3.5 therapy posts will be recruited bringing the total up to 14. Posts are currently out to advert and new staff are expected in post by November 2016. Efficiencies are being introduced: • Increased use of group interventions: A Behaviour Therapy skills group and a Mindfulness Based Cognitive Therapy group have been		

Ref	Issue identified	Action	Lead	Completion date
		introduced. • Aligned pathways with IAPT to ensure those whose needs can be managed outside specialist services receive the appropriate care (from September 2016) • Managed Clinics (Lean principles) to replace clinician/admin led process (from September 2016) • An innovative 3-stage recovery pathway (stabilisation/treatment/recovery) aims to provide meaningful support to people waiting for therapy, including interventions to support stabilisation and to help people prepare for therapy Managing the backlog: We are confident that our plans can deliver productivity at a level that meets demand but we have a significant backlog to address. A proposed solution based on a non-recurrent resource is under discussion with the CCG. **Wakefield Community Services- Adults of Working Age** Wakefield have 100% of individuals assessed within 14 days and 100% receiving treatment within 18 weeks.		
Community-based mental health services for older people				
OCMH RN1	Patients were not able to access services in a timely manner. Referral to treatment times exceeded the 18 week target. This is a breach of regulation 9(1)(b	Within our CQC report it was noted that Barnsley and Kirklees Outreach Team were meeting their referral to treatment time's targets. This information was accurate. However, the referral times figures for North Kirklees CMHT and Ossett CMHT were inaccurate and should have stated that referral to treatment times to North Kirklees CMHT was 69 days and to Ossett CMHT 53 days. Therefore all of our teams were meeting the 18 week target. This was explained within our Factual Accuracy Comments following receipt of our draft report, when we said the figures provided at the time of the visit had been miscalculated by the CQC inspector. However, our comments were rejected.	Deputy Director of Operations	Complete

Ref	Issue identified	Action	Lead	Completion date
		Because of the above we are not in breach of the HSCA Regulations 2014 in relation to this specific matter and will strive to continue to maintain and improve our existing standards. As was explained within the CQC report, we continue to respond to risk in a timely manner to make sure our service users receive a safe and responsive service to meet their personalised needs		
Community mental health services for people with learning disabilities or autism				
LDCRN1	We found that waiting times to access psychological therapies was high. This had the potential to impact upon individual's wellbeing. This is a breach of Regulation 9 (3) (b)	Access to Psychological therapies is split into two pieces of work:- **Reducing waiting times for Autism Assessments – Trust wide** • Review existing clinical pathways for diagnosis of Autism Spectrum Conditions (ASC) across the Trust and align to most recent professional and clinical practice guidance for efficient diagnostic procedures. (Apply a tiered approach: Screening, Interview, Observation, MDT discussion). **(Improved Efficiency; Evidence Based Practice)** • Conduct skills analysis of the learning disability MDTs with a view to broadening responsibility for autism diagnosis to the whole clinical MDT rather than solely with clinical psychology services. **(Better Resource Utilisation; Increased Efficiency)** • Establish a robust, multi-disciplinary, ASC diagnostic assessment clinic drawing on clinical resources from across the whole Trust (rather than solely within localities). **(Improved coordination; Increased Efficiency; Better Resource Utilisation)** **Reducing waiting times for Psychological Therapies in Wakefield community team** • More robust application of the eligibility criteria for accessing specialist psychological services for adults with learning disabilities is being adhered to. **(Demand Management: Better aligning of resources with demand for specialist LD services)** • The existing waiting list is being reviewed and triaged by the Wakefield Psychology Team to ensure appropriateness of cases currently waiting for services. **(Demand Management: Clinical**	Deputy Director of Operations	30th September 2016

Ref	Issue identified	Action	Lead	Completion date
		assessment & review to ensure services are provided and offered to those most in need) • The caseloads of Postgraduate Psychologists in Clinical Training working in the Wakefield psychology service will be increased in line with other departments in the Trust. This work will continue to be overseen by a qualified clinical psychologist with appropriate supervision training and skills. **(Increased activity: Improved resource utilisation – increased number of psychological therapy and assessment sessions available)** • Recruitment of a new full-time Assistant Psychologist to the Wakefield community team is underway. This will assist greatly in increasing the number of available *assessment* sessions provided by the service and in turn release some capacity in qualified clinician time to offer increased sessions of psychological therapy. **(Increased Activity: Number of sessions of psychological assessment and therapy will increase and in turn reduce waiting times)**		
LDCRN2	We found that the use of key performance indicators was inconsistent across the service. Teams co-located in local authority teams were not required to provide KPI information beyond the use of CQUIN outcomes to enable the trust to monitor and improve the quality and safety of the services. This is a breach of Regulation 17 (2) (a)	All Learning Disability staff in integrated teams will come back under the line management of SWYPFT and record on RiO by end of Quarter 3 to enable more effective information to be provided against KPI's	Deputy Director of Operations	31st December 2016
Forensic inpatient/secure wards				
FRN1	We found that there was not enough nursing staff to ensure that important nursing tasks were completed. • Meaningful activity targets were not being met.	**Meaningful Activity:** The current process of reporting will be reviewed: A task and finish activity will raise awareness across the service about the importance of meaningful, recovery based activity and how to record this effectively. 100% activity levels will be achieved. To be	Deputy Director of Operations	31st March 2017

Ref	Issue identified	Action	Lead	Completion date
	• There was a high level of bank and agency staff used who were unfamiliar with the wards. • Data provided by the trust showed that the wards were regularly breaching their own targets on minimum staffing levels. • Patients we spoke to told us there was not enough staff and too many agency workers. • There was no long term plan to resolve the staffing problems. This meant that patient activities and leave entitlement were often cancelled due to the lack of staff. This was a breach of regulation 18 (1)	linked to the Forensic Induction Programme. **Safer Staffing:** This is the long term plan that the service has been working to: • There is a Trust Group for Safer Staffing which the Forensic Services attend. • There is regular monitoring of safer staffing levels. • There are Workforce Meetings for the Forensic Services held 2/52. • A Business Case is being developed to address deficits in the Women's Service and improve the establishment to meet need. • Sickness / absence management is robust. • There is an ongoing programme of over recruitment to offset ongoing fluctuations in establishment. • The Forensic Service is currently managing through a process of workforce re-design with emergent band 2 opportunities and band 4 developments. • Bank shifts are being paid at an enhanced level between the months of June and September to attract regular staff and reduce agency use. • The long term plan is the have a sustainable workforce establishment which does not require agency use to achieve normal business. • Acuity will continue to be managed on a needs basis. • Maximising resources through efficient utilisation of experience and skills across the service. • There are national targets for the reduction of agency use. All the above work will contribute to the reduction in the agency use. A reduction in agency use will ensure that access to patient records is available for the majority of staff in order to provide safe patient care. Electronic Clinical Record (RiO) training is being implemented for regular agency staff, to ensure they can more effectively meet patient need, than relying on supported access through regular staff. • A therapy services review is underway and this will help to maximise use of resources. • A management and administration review is also underway to support the process. • Improving communication and engagement with staff to ensure they		

Ref	Issue identified	Action	Lead	Completion date
		are updated effectively of plans and how issues are being addressed		
FRN2	We found that medicines were not being stored in a safe way. • The temperature recorded in the clinic room regularly exceeded the maximum level. • There was no climate regulation in the clinic room. This meant that medicines were not being stored at the correct temperature to maintain their stability and effectiveness. This was a breach of regulation 12 (2) (g)	This issue was specific in one of the 12 clinic rooms in relation to temperature recordings. This particular clinic is on a 6 bedded pre-discharge area and only contains the medicines for one service user as all others are self-medicating. All clinics are recording temperatures which are safe for the storage of medicines. (Risk Management of Medicines stored in Clinical Areas. Temperature Control Edition 1 2015. NHS Pharmaceutical Quality Assurance Committee 2015). It is recognised higher temperatures for one week consistently may reduce the expiry date by a two weeks. However all medicines are cycled quickly and tend to be used well in advance of the expiry date, therefore this is not a risk. We are continuing to maintain and look at ways of improving our existing standards around storage of medications. We are looking at the following additional options in order to achieve this: • The use of a smaller fridge = reduced heat radiation. • Air conditioning installation. • Improved ventilation. • Alternative storage arrangements for the medication.	Deputy Director of Operations	31st August 2016
FRN3	We found that patients with learning disability or autism did not have positive behaviour support (PBS) plans or equivalent. • Care records showed that very few patients had PBS plans or equivalent. • The trust had not implemented PBS plans or equivalent until recently. • Staff showed a lack of knowledge and understanding of PBS plans or equivalent. This meant that patients with learning disability and autism were not receiving the correct care and treatment as recommended by the Mental Health Act Code of Practice.	• A briefing paper is being developed for staff, outlining what Positive Behaviour Support Plans are and their benefits to service users. • All plans will be clearly labelled as PBS plans.	Deputy Director of Operations	31st October 2016

Ref	Issue identified	Action	Lead	Completion date
	This was a breach of regulation 9			
FRN4	We found that there were no effective systems in place for the trust to maintain oversight in relation to staff training and staff supervision. • The trust did not collate figures on Mental Health Act, Mental Capacity Act and immediate life support training at a governance level. • The trust did not record data regarding staff supervision rates at a governance level. This meant that the trust was not assured that staff were adequately trained or supervised. This was a breach of regulation 17 (2) (a)	• The Trust has made MHA, MCA and Life Support Training Mandatory for all staff. This will enable staff to inform patients of their rights and record this in patient notes at regular intervals as set out in the MHA Code of Practice, and also support appropriate recording as per the Code of Practice, for people in long-term segregation. This will support that consent and capacity to consent should be assessed and recorded in patient notes in accordance with the MHA Code of Practice. • Achievement of training for the service will monitored in Forensic BDU monthly meetings and action implemented to ensure this is consistently achieved. • The BDU will comply with the Trusts initiatives to centrally store supervision figures. A database was developed in 2016 (January-March) and is currently under pilot. This is a system that will enable supervisees, supervisors and managers to monitor and manage how supervision is accessed and captured, or where this is not happening across individuals and teams. • The database will facilitate an audit of supervision to be planned and completed against the clear standard stipulated in the policy, including ensuring that where impromptu and a more informal style is accessed, this is supported by structured approaches with supervisors the supervisee holds ma contract with.	Deputy Director of Operations	30th November 2016
Wards for older people with mental health problems				
OIRN1	On The Poplars, Ward 19 and Chantry Unit the ward layout did not allow staff to observe all parts of the ward. This was not mitigated by the use of mirrors on Chantry Unit or Ward 19. The use of observations did not include staff being present in those areas on a routine basis and on the day of our inspection staff were not present in those areas. Risk	**Wakefield (The Poplars and The Chantry Unit)** 1. The ward managers at the Poplars unit and the Chantry Unit have undertaken an assessment to look at the use of the observation mirrors within the unit. This has resulted in additional mirrors being used for observation purposes. The actions that have been agreed will be completed by no later than 31/7/16 2. The Chantry Unit will be moving to new premises from 5/8/16. Contingencies will be put in place (described below) immediately and will continue after the move, an assessment will be carried out on	Deputy Director of Operations	31st August 2016

Ref	Issue identified	Action	Lead	Completion date
	assessments of patients did not refer to the blind spots within the wards when considering the risks to and from that patient. This meant that the ward was not doing all that was practicably possible to reduce the risk of harm to patient s and staff. This was a breach of regulation 12(2)(b)	7/7/16 of the new Chantry premises with the Estates Planning Manager to enable an appropriate level of observation mirrors to be implemented ready for the move of premises. 3. Additional risk assessment information has been added to the existing assessment. The environmental risk assessment record is now to include checking of all areas of the ward including blind spots as part of the 60 minute environmental observations record. 4. Specific environmental risk assessments are to be completed of all areas of wards to include blind spots. 5. An environmental safety care plan has been developed. 6. Changes have been made to the observation policy so that staff have clear guidance about the changes to the observation processes. **Kirklees (Ward 19)** 1. Estates are to undertake a review of ligature safe options for providing clear lines of sight. 2. Ward risk assessments will be undertaken to include consideration and mitigation of environmental factors impacting on service user risk. 3. Improve line of sight by installing mirrors in required areas.		
OIRN2	On Ward 19 the bedrooms door handles were a ligature risk. Although this was identified on the annual ligature risk assessment to be managed locally there were no bedrooms without these door handles. This meant that if patients were a high risk of self-harm they would need to be nursed on close observations which was not the least restrictive option. Furthermore this meant that patients who had no previously identified risk of self-harm were not routinely risk assessed for the ligature risk inside their bedroom leaving them with easy access to ligature points.	We have reduced the ligature risk by replacing bedroom door handles. Trust wide review has been completed and a preferred product agreed.	Deputy Director of Operations	31st December 2016

Ref	Issue identified	Action	Lead	Completion date
	This was a breach of regulation 15(1)(C)			
Long stay/rehabilitation mental health wards for working age adults				
LSRN1	We found that at Enfield Down the clinical team did not undertake regular reviews of patient risk assessments following incidents or when there was a change in presentation. They did not undertake physical health monitoring including electrocardiograms for patients prescribed high dose antipsychotic medication. This is a breach of Reg 12(2)(a)(g)	• Individual risk assessments will be undertaken as part of the care planning approach, regular care reviews, MDT meetings and discussed with staff within their individual supervision sessions. • Risk assessments will be developed in a person centred way to meet the patient's individual needs as required. • Risk assessments will be updated as individual's circumstance change. • Senior staff nurses will undertake a weekly medicine management review so that physical monitoring takes place and appropriate actions can be taken as needed to address any concerns within a timely manner. • A member of staff is to receive specialised training in relation to electrocardiograms.	Deputy Director of Operations	Completed
LSRN2	We found that at Enfield Down did not undertake regular MDT reviews to ensure timely and appropriate treatment plans. This is a breach of regulation 9 (1)(a)(b)	• The Community Service Manager has nominated an identified Care coordinator for all in-patients at Enfield Down. This person will attend all MDT meetings and be responsible for co-ordinating all patients' CPA reviews • Confirm the availability of medical staff to attend the MDT meetings or make alternative arrangements if there are difficulties with this to ensure there is medical input into the meetings.	Deputy Director of Operations	Completed
LSRN3	We found that the long stay / rehabilitation service did not have sufficient governance structures in place ensure effective monitoring of the service. The service currently lacked governance lead post and had failed to identify failings in the service.	Leadership of clinical services have been reviewed within the band 6 and band 7 roles and responsibilities. Bands 6 and 7 have taken on individual responsibilities for the 7 pillars of governance and the day to day responsibility for a defined group of service users. We have appointed a full-time Practice Governance Coach who has now commenced in post.	Deputy Director of Operations	Completed

Ref	Issue identified	Action	Lead	Completion date
	This is a breach of regulation 17(1)(2)(b)			
LSRN4	We found that the long stay / rehabilitation service did not ensure staff were adequately trained in the MHA and MCA This is a breach of regulation18 (2)(a)	• The trust has now implemented MHA/MCA as mandatory training. Team managers will received monthly notifications about any outstanding training for staff. The team managers will then ensure staff are booked onto training where this is needed or ask staff to undertake e-learning where applicable. • Ensure all staff retain their individual responsibilities for maintaining up to knowledge and expertise through such avenues as team meetings and supervision processes. • Managers will monitor compliance with the MHA/MCA through daily observations, incidents, service user feedback, audits etc.	Deputy Director of Operations	31st March 2017
LSRN5	We found that at Enfield Down, staff did not ensure that T2 (consent to treatment) forms were completed accurately. This was a breach of regulation 11 (1)	We have developed a written process and guidance for staff to follow to ensure T2 forms are completed accurately. This guidance will be on display in prominent places so the information is easy to access. Remind staff to prompt medical staff to check for accuracy when completing forms so that information is clear and easy to understand.	Deputy Director of Operations	Completed
MUST Dos				
OCMH MUST2	The trust must ensure there is access to crisis services for older people.	**Calderdale & Kirklees BDU** - Kirklees OPS have a team call Kirklees Outreach team who provide an intensive home based treatment model between the hours of 8am & 8pm, 7 days a week. Outside of these hours an all age crisis response is provided by the AWA IHBTT. Calderdale OPS CMHT have dedicated staff who provide an intensive home based treatment model up to 8pm during the week and up to 5pm at weekends. Outside of the hours and all age crisis response is provided by the AWA IHBTT.	Deputy Director of Operations	Completed

Draft v0.2

South West Yorkshire Partnership NHS
NHS Foundation Trust

CQC inspection quality summit

14 July 2016

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Ian Black - chair

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Our mission and values

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

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

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Our approach

- We welcomed the inspection and the independent view
- It's an opportunity to continue improving our services for local people
- We've communicated widely about it, including discussions at our public Board meetings
- Our action plans are being co-produced with our partners
- Our Members' Council will help shape our action plans

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Rob Webster - chief executive

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Our inspection

The CQC looked at a significant amount of written information - reports, meeting minutes, statistics, action plans, policies and strategies

They spoke to people who use our services, their carers and the general public, our Members' Council and partner organisations

They received 676 comments directly

- 76 inspectors
- 5 days
- 100% of our inpatient services
- 32% of our services in the community

With **all of us** in mind.

Our inspection

Our rating is made up of 14 separate reports:

- There is one report for each type of service
- 350+ pages in total across the 14 reports
- There is also a summary report

It reflects how complex we are:

- Over 230 individual services
- Making nearly 1 million contacts each year
- Across our four geographic districts

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

The headlines

Without exception, all of our services were found to be caring

The report highlights how staff treat people with kindness, care and compassion

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

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

Across these 14 reports, more than 70% of the individual ratings are 'Good' (green)

Overall there are eight 'Good' ratings across all of our community, mental health and learning disability services

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

The headlines

‘Outstanding’ areas of care:

- Effectiveness of our end of life services
- Caring nature of our community services for children, young people and families

And:

- No scores of ‘Inadequate’
- No immediate compliance actions
- No return visits from the CQC

With **all of us** in mind.

Areas that require improvement

Areas that require improvement include:

- Access issues in CAMHS and psychological therapies
- Elements of staffing
- Elements of internal governance
- One of our clinical information systems (RiO), following recent upgrade

These are all areas where we are getting better and already have plans to improve

We know that there are challenges, for example with staffing in some places, and this is reflected in the report

These areas were also reflected in our recent staff listening events

South West Yorkshire Partnership NHS
NHS Foundation Trust

Tim Breedon - director of nursing and professions, clinical governance and safety

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Working together to support improvement

Key areas for action, developed collaboratively:

- Safer staffing – keeping and recruiting new staff
- Clinical supervision recording and reporting
- CAMHS access to treatment
- Mandatory training - ILS / MHA & MCA all now mandated and will be reported to our Board

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Working together to support improvement cont.

- Review of our internal inspection programme - aligned to CQC based risk model
- Improving the integration of physical and mental health
- Improving clinical information - clinical record keeping, data quality, care planning, risk assessments

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Next steps

- Displaying our ratings by tomorrow
- Members' Council on 22 July
- Action plan to be approved and monitored by our Board
- Submitting action plan to CQC by 9 August

With **all of us** in mind.

Next steps cont.

- Continuing staff engagement around quality improvement
- Keeping doing the ‘Good’ and ‘Outstanding’ things
- Improving things that are in need of improvement
- Embracing the learning in line with our values

With **all of us** in mind.

Trust Board – 19 July 2016
Agenda item 9.2

Title:	**Finance Report – Month 3 2016/17**
Paper prepared by:	Director of Finance
Purpose:	To inform the Board of the financial position of the Trust as at month 3 2016/17 To raise any specific financial risks and issues with the Board and enable a discussion to take place regarding any actions that need to be taken to address these risks and issues
Mission/values/objectives:	Improve our use of resources
Any background papers/ previously considered by:	Not applicable
Executive summary:	• In-month surplus of £0.5 million and year-to-date surplus of £1.1 million. Cumulative position is marginally ahead of plan • Internal full year forecast surplus pre mitigation is £0.8 million. This is significantly below plan due to under-achievement of cost savings, out-of-area bed usage and agency staff costs. • Financial risk rating of 4. • Cash balance of £24.6 million, which is £4.6 million below plan largely due to timing of creditor payments and amount of income accruals • Cost improvement programme achievement of £2.1 million year-to-date, which is £0.7 million below plan. Full year CIP risk of £2.3 million with focus being applied to how this can be achieved or where replacement schemes can be identified. • Agency staff expenditure is above NHS Improvement target. Main issues relate to medical and nursing staff cover. Detailed analysis being undertaken to determine what actions can realistically be taken to reduce. • Capital expenditure currently behind plan, but forecast remains in line with full year plan
Recommendation:	**Trust Board is asked to REVIEW the finance report and discuss any specific issues arising from it**
Private session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 3 (2016/2017)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0 Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast	Narrative
1	NHS Improvement Risk Rating	4	4	The Trust has planned for and delivered a risk rating of 4 in June 2016. It is currently forecast that a rating of 4 will be maintained throughout the year.
2	Surplus	£1.1m	£0.8m	The year to date position shows a surplus of £1.1m; this is marginally ahead of plan. Full year forecast currently shows £1.1m under plan. This position needs to be validated. Main issues being CIP underachievement, agency costs and out of area bed usage. Mitigations to be fully assessed.
3	Agency Cap	£2.6m	tbc	NHS Trusts have been set maximum agency spend caps for 2016 / 2017 by NHS Improvement. Expenditure in month 3 is higher than previous months and Qtr 1 trajectory would see the ceiling exceeded by £3m - £4m. Main issues being medical and nursing staff.
4	Cash	£24.6m	£19.5m	The cash position is lower than planned at June 2016 mainly due to timing of creditor payments. Based upon the forecast surplus position the projected year end cash position is also less than plan.
5	Capital	£2.1m	£12.3m	Capital expenditure is under plan as at June 2016. An element of this relates to successful VAT recovery. The forecast remains in line with plan.
6	Delivery of CIP	£2.1m	£7.7m	Year to date CIP delivery is £0.7m behind plan. Overall the forecast position includes £2.3m of red rated schemes, against which actions must be taken or replacements identified to ensure delivery.
7	Better Payment	97%		This performance is based upon a combined NHS / Non NHS value.

Red	Variance from plan greater than 15%
Amber	Variance from plan ranging from 5% to 15%
Green	In line, or greater than plan

1.1 NHS Improvement Risk Rating

The Trust currently completes a detailed return demonstrating current and future financial performance to NHS Improvement on a monthly basis. This is summarised, as per the Risk Assessment Framework, into a Financial Risk Rating and scored on a range of 0 to 4 (with 4 being the best rating possible.)

As highlighted below current performance is either in line with or better than plan for all metrics. The forecast also illustrate that the Trust will achieve a rating of 4 for the remainder of the year. Successful achievement of this rating is dependant upon delivery of the overall financial plan and therefore mitigation of current risks identified.

				Actual Performance		Plan - Month 3	
	Financial Criteria	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Continuity of Services	Balance Sheet Sustainability	25%	Capital Service Capacity	4.7	4	4.1	4
	Liquidity	25%	Liquidity (Days)	17.8	4	15.4	4
Financial Efficiency	Underlying Performance	25%	I & E Margin	2.0%	4	1.8%	4
	Variance from Plan	25%	Variance in I & E Margin as a % of income	0.8%	4	-0.4%	3
Weighted Average - Financial Sustainability Risk Rating					4		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

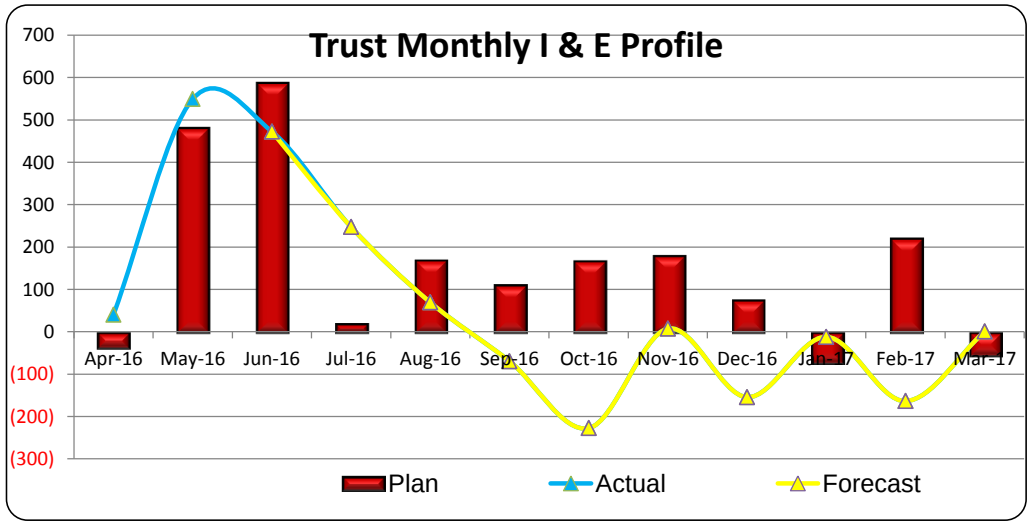
I & E Variance - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

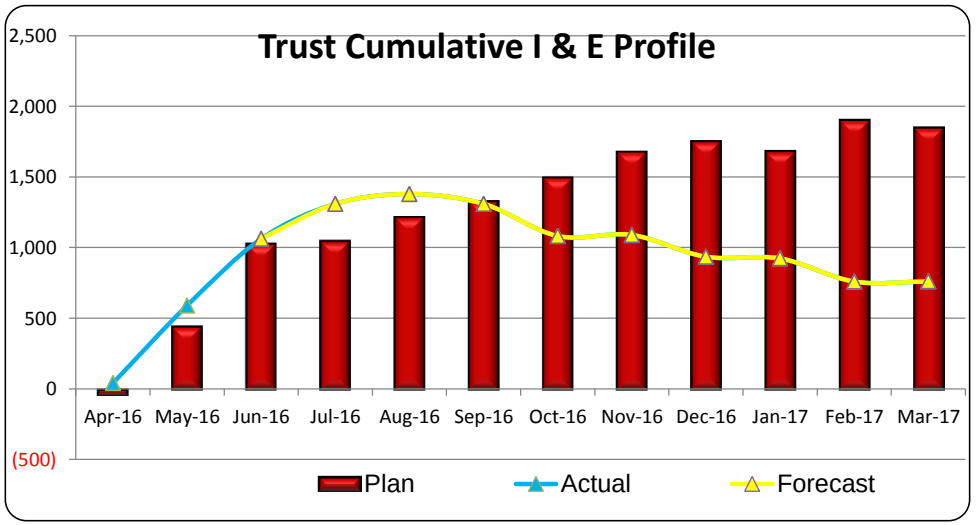
Risk Rating 4 - No evident Concerns

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

2.0 Income & Expenditure Position 2016 / 2017

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**
				18,268	18,240	(28)	Clinical Revenue	54,025	54,076	50	210,661	210,711	50
				18,268	**18,240**	**(28)**	**Total Clinical Revenue**	**54,025**	**54,076**	**50**	**210,661**	**210,711**	**50**
				969	1,160	191	Other Operating Revenue	3,610	3,609	(1)	13,475	13,645	171
				19,237	**19,400**	**163**	**Total Revenue**	**57,636**	**57,685**	**49**	**224,136**	**224,356**	**221**
4,483	4,234	(249)	5.6%	(14,741)	(14,633)	108	Pay Costs	(44,425)	(43,652)	773	(171,459)	(172,048)	(589)
				(3,543)	(3,891)	(348)	Non Pay Costs	(10,988)	(11,151)	(163)	(42,675)	(44,418)	(1,743)
				777	663	(114)	Provisions	1,471	1,372	(98)	1,419	2,382	964
4,483	**4,234**	**(249)**	**5.6%**	**(17,507)**	**(17,862)**	**(355)**	**Total Operating Expenses**	**(53,942)**	**(53,431)**	**512**	**(212,716)**	**(214,084)**	**(1,368)**
4,483	**4,234**	**(249)**	**5.6%**	**1,730**	**1,538**	**(192)**	**EBITDA**	**3,693**	**4,254**	**561**	**11,420**	**10,272**	**(1,148)**
				(894)	(813)	81	Depreciation	(1,912)	(2,440)	(528)	(6,565)	(6,507)	58
				(257)	(257)	0	PDC Paid	(770)	(770)	0	(3,080)	(3,080)	0
				6	4	(2)	Interest Received	19	18	(1)	75	74	(1)
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,483	**4,234**	**(249)**	**5.6%**	**586**	**472**	**(113)**	**Surplus / (Deficit)**	**1,030**	**1,062**	**32**	**1,850**	**760**	**(1,090)**





Income & Expenditure Position 2016 / 2017

Month 3

For the year to date the Trust has delivered a surplus position of £1.1m, this is marginally ahead of plan. In month financial performance was a surplus approaching £0.5m, which was £0.1m below plan.

The main components of the June variance are:

£33k	CIP under acheivement (please see CIP section)
£37k	Income reserves and the fixed cost impact of decomissioned services
£14k	Increase in the Trust bad debt provision.

Month 3 has also seen an increase in expenditure within the BDUs, particularly in Forensics, Barnsley and Support Services.

Pay remains underspent in month but the saving has reduced from an average of c. £330k over months 1 and 2 to £104k in month 3. Agency remains a significant financial pressure for the Trust, accounting for £87k of the increase. Detailed work is being carried out on all agency spend to fully understand where and why it is required. From that it will be assessed what actions can realistically be taken to reduce. Medical staff cover is a notable reason for agency spend.

Non pay expenditure has exceeded budget in month 3 which follows the trends of previous months. Key pressures remain such as costs associated with providing suitable Out of Area placements but month 3 also saw a noted increase in expenditure against mobile phone charges (£115k) and disabled living aids (£25k). Reasons for this are being analysed.

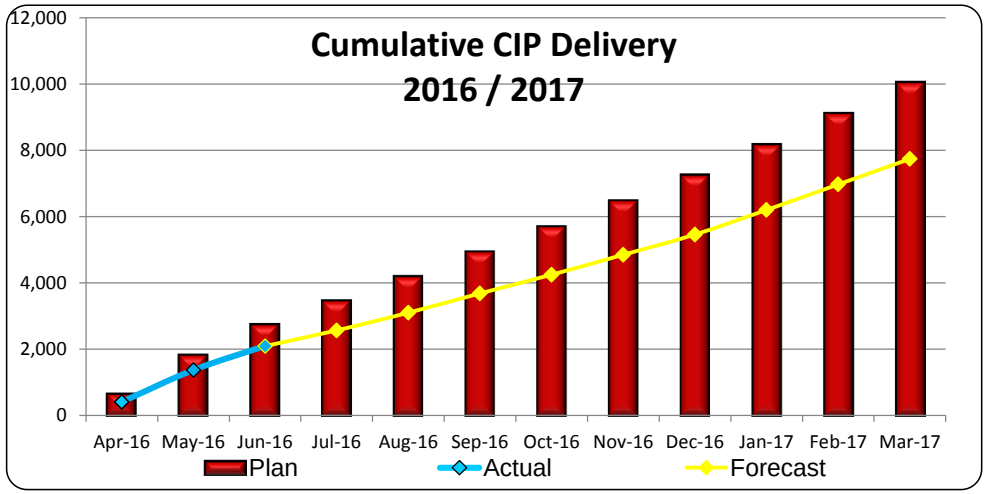
Forecast

The forecast outturn position for 2016 / 2017 is a surplus position of £0.8m which is £1.1m behind plan. This is based on individual BDU forecasts, with agency staffing, out of area bids and CIP shortfalls the most notable reasons for this forecast.

Month 3 has also seen a full review of provisions. The position reflected here assumes CIP's rated as red will deliver no financial saving in year. It is recommended at this stage the Trust does not change its forecast to NHSI but instead focuses attention and support on mitigating the financial risks and pressures.

2.1 Cost Improvement Programme 2016 / 2017

	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	661	662	662	665	679	695	717	723	728	863	891	891	1,986	8,837
Target - Non Recurrent	9	509	259	49	49	49	49	49	49	49	49	49	778	1,223
Target - Monitor Submission	670	1,172	922	715	729	744	766	772	777	912	940	940	2,764	10,059
Target - Cumulative	670	1,842	2,764	3,479	4,207	4,952	5,718	6,490	7,267	8,179	9,119	10,059	2,764	10,059
Delivery as planned	358	1,259	1,866	2,265	2,728	3,264	3,802	4,378	4,962	5,678	6,421	7,165	1,866	7,165
Mitigations - Recurrent	0	6	9	12	15	18	21	24	27	30	34	37	9	37
Mitigations - Non Recurrent	48	102	215	286	353	397	420	444	467	491	514	538	215	538
Total Delivery	**405**	**1,367**	**2,090**	**2,563**	**3,097**	**3,679**	**4,244**	**4,846**	**5,457**	**6,199**	**6,969**	**7,739**	**2,090**	**7,739**
Shortfall / Unidentified	265	475	674	916	1,111	1,273	1,474	1,644	1,810	1,980	2,150	2,320	674	2,320



The Trust identified a CIP programme for 2016 / 2017 which totals £10.1m. This was subject to an external review.

Work continues on delivery of CIP schemes. Forecast values for delivery as planned has increased by £1m in month to £7.2m (71%). Overall £7.7m (77%) has been rated as green / amber and forecast to deliver in year.

As at month 3 delivery is £0.7m lower than plan, with shortfalls particularly notable on trust-wide schemes.

Whilst progress continues to ensure that amber schemes are translated into green the main focus remains on red rated schemes. The full breakdown of these schemes, and associated actions, are presented on page 8.

2.1 Cost Improvement Programme 2016 / 2017 - Red Rated Scheme Summary

The detail of the CIP proposals which are currently rated as red and leading to financial risk is highlighted on a scheme by scheme basis below.

Progress continues to be made on a number of these schemes and this progress is reflected within the forecast position.

		Year to Date			Forecast			
Scheme Description	Lead Director	Target £k	Achieved £k	Shortfall £k	Target £k	Achieved £k	Shortfall £k	Notes / Milestones
Management & Admin Review	Alan Davis	295	0	295	1,181	541	640	Work continues to identify recurrent savings from this scheme. This is currently forecast to deliver recurrently from January 2017 and is marked as amber. Discussions have been held with BDU and Corporate teams to ensure no
Reduction of Out of Area Budgets	Karen Taylor	125	0	125	500	0	500	No saving in 16/17 currently forecast. Spend is currently increasing due to gender specific requirements.
Non Healthcare SLAs	Mark Brooks	203	0	203	837	474	363	Some schemes identified, but not yet in line with plan.
Learning & Development	Alan Davis	25	0	25	100	0	100	Unspecific target.
Psychology Review	Tim Breedon	55	0	55	220	0	220	No saving in 16/17 currently projected
Medical Staffing - Kirklees & Calderdale	Karen Taylor / Dr Berry	48	12	36	192	83	109	Partly achieved / mitigated
Barnsley BDU - 5% budget reduction	Sean Rayner	45	129	(84)	779	609	170	BDU continue to progress schemes as opportunities arise.
CAMHs	Carol Harris	30	0	30	160	0	160	
Consultancy Costs	Mark Brooks	15	10	6	60	55	6	Largely on plan
Procurement Costs	Mark Brooks	5	0	5	22	0	22	Potential for non recurrent mitigation being reviewed.
Terms & On Call	Dr Berry / BDU Directors	0	0	0	80	49	31	3 outline schemes to be confirmed with BDUs - £90k FYE
Total		**847**	**150**	**696**	**4,131**	**1,811**	**2,320**	

3.0 Balance Sheet 2016 / 2017

	2015 / 2016 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	114,134	115,047	114,045	1
Current Assets				
Inventories & Work in Progress	190	190	190	
NHS Trade Receivables (Debtors)	2,623	2,373	726	2
Other Receivables (Debtors)	7,541	7,217	10,025	3
Cash and Cash Equivalents	27,107	28,987	24,554	4
Total Current Assets	**37,461**	**38,767**	**35,495**	
Current Liabilities				
Trade Payables (Creditors)	(6,430)	(6,630)	(3,473)	5
Other Payables (Creditors)	(3,481)	(4,251)	(4,172)	5
Capital Payables (Creditors)	(785)	(785)	(932)	
Accruals	(8,576)	(10,826)	(8,689)	6
Deferred Income	(789)	(789)	(741)	
Total Current Liabilities	**(20,060)**	**(23,280)**	**(18,008)**	
Net Current Assets/Liabilities	**17,401**	**15,487**	**17,488**	
Total Assets less Current Liabilities	**131,535**	**130,534**	**131,532**	
Provisions for Liabilities	(10,017)	(8,327)	(8,952)	
Total Net Assets/(Liabilities)	**121,518**	**122,208**	**122,580**	
Taxpayers' Equity				
Public Dividend Capital	43,492	43,492	43,492	
Revaluation Reserve	19,446	19,446	19,446	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	53,361	54,050	54,423	7
Total Taxpayers' Equity	**121,518**	**122,208**	**122,580**	

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

1. The capital programme is currently behind profile but this is forecast to move back in line with plan over the next couple of months.

2. NHS Debtors remain very low and any issues continue to be proactively chased. £188k, covering a number of debtors, is older than 90 days and focus remains on collection.

3. Other debtors are higher than plan but 81% is less than 30 days old. It is therefore expected that the majority of these will resolved during July 2016. The timing of payments from Local Authorities for block contracts continues to be the main delay.

4. 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 13.

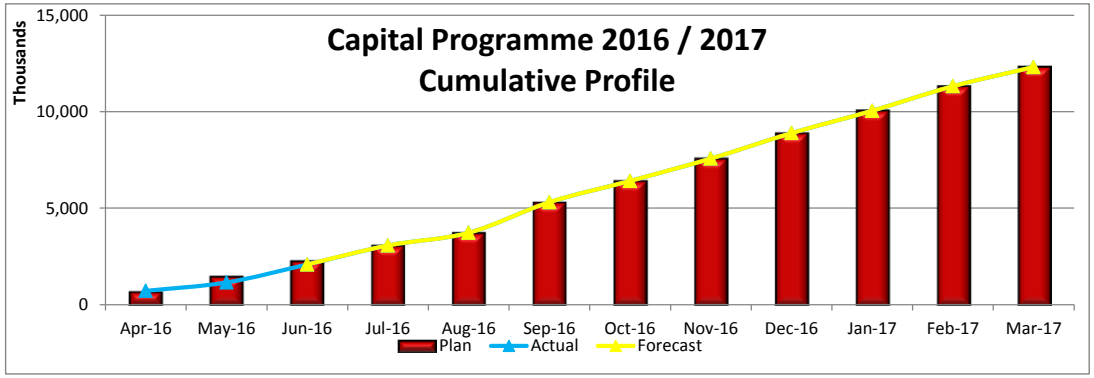
5. Creditors remain lower than plan due to timing of some payments.

6. Overall accruals are lower than planned.

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

3.1 Capital Programme 2016 / 2017

	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	2,050	308	242	(65)	2,050	0	
IM&T	1,210	218	74	(144)	1,210	0	3
Total Minor Capital & IM &T	**3,260**	**526**	**316**	**(209)**	**3,260**	**0**	
Major Capital Schemes							
Pontefract Hub	1,795	1,005	1,045	40	1,795	0	4
Wakefield Hub	735	375	375	0	735	0	4
Fieldhead Non Secure	4,725	83	254	171	4,725	0	5
Fieldhead Development	1,300	0	6	6	1,300	0	
Other	498	293	212	(82)	498	0	
Total Major Schemes	**9,053**	**1,756**	**1,892**	**136**	**9,053**	**0**	
VAT Refunds	0	0	(129)	(129)	0	0	2
TOTALS	**12,313**	**2,282**	**2,079**	**(203)**	**12,313**	**0**	



Capital Expenditure 2016 / 2017

1. The Trust Capital Programme for 2016 / 2017 is £12.3m and schemes are guided by the Trust Estates Strategy.

2. The year to date position is £0.2m behind plan (9%). Of this £129k relates to successful VAT recovery agreed with HMRC. This is reflected to ensure full transparency of costs associated with the Trust Capital Programme.

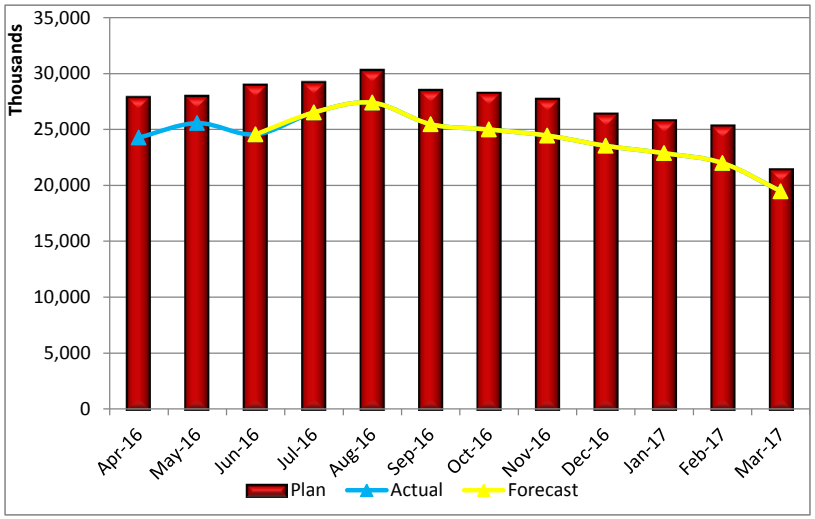
3. IM & T expenditure is currently behind plan but all schemes are forecast to deliver in full in year.

4. Both hub projects are in line with plan from a financial and milestone perspective. Performance is regularly monitored through the Project Board and risks continue to be mitigated in a proactive manner.

5. A guaranteed maximum price (GMP) for the Fieldhead non secure scheme has been agreed with the Trust P21+ partner. The impact of this upon the 2016 / 2017 actual expenditure is currently being calculated.

Due to the timing of this Board Report the forecast capital expenditure for 2016 / 2017 is still being assessed. Overall it is forecast that the full value of the scheme will be spent.

3.2 Cash Flow & Cash Flow Forecast 2016 / 2017



	Plan	Actual	Variance
	£k	£k	£k
Opening Balance	27,107	27,107	
Closing Balance	28,987	24,554	(4,433)

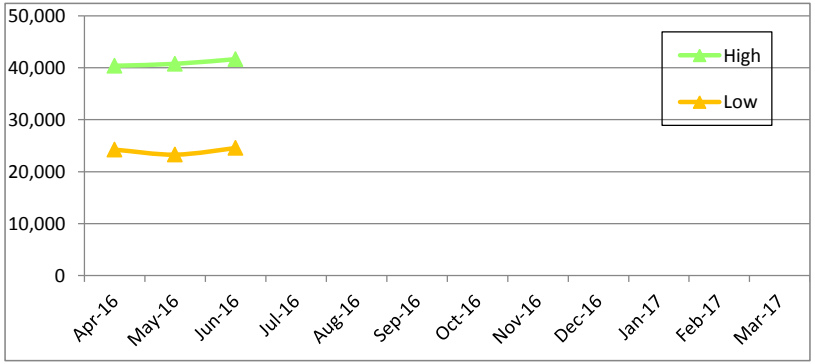
The cash position provides a key element of the Continuity of Service and Financial Efficiency Risk Rating. As such this is monitored and reviewed on a daily basis.

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

Overall the cash position is £24.6m which is £4.4m lower than planned. The main reasons are higher than planned levels of accrued income and lower than planned creditors. Actions are being taken to reduce income accruals.

A detailed reconciliation of working capital compared to plan is presented at page 12.

During April 2016 the Trust have again invested with the National Loan Fund (NLF). This secures a higher rate than the main Government Banking Service. (0.43% compared to 0.25%) This returns to the Trust 22nd July 2016 and a proposal for re-investment is in place.



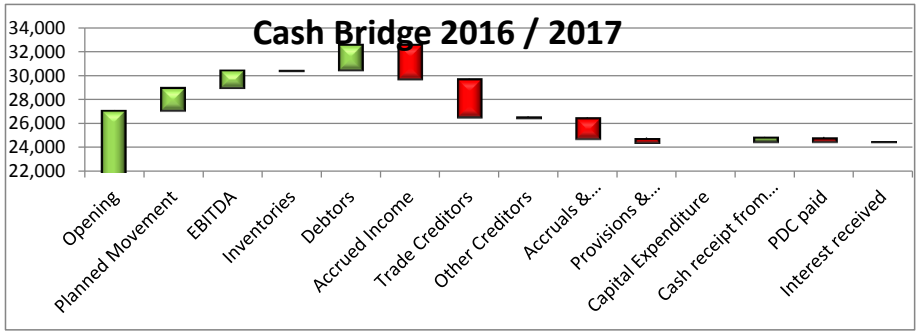
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£41.7m
The lowest balance is:	£24.6m

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

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**27,107**	**27,107**		
Surplus (Exc. non-cash items & revaluation)	2,809	4,281	1,472	1
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	1,025	3,150	2,125	2
Accrued Income	0	(2,846)	(2,846)	3
Trade Payables (Creditors)	200	(2,957)	(3,157)	4
Other Payables (Creditors)	0	(78)	(78)	
Accruals & Deferred income	1,750	66	(1,684)	5
Provisions & Liabilities	(1,940)	(2,255)	(315)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(2,282)	(1,932)	350	
Cash receipts from asset sales	299	0	(299)	
PDC Dividends paid	0	0	0	
Interest (paid)/ received	19	18	(1)	
Closing Balances	**28,987**	**24,554**	**(4,433)**	



The Plan value reflects the April 2016 submission to Monitor.

Factors which increase the cash positon against plan:

1. The overall surplus position at month 3 is broadly in line with plan. However the non cash element, specifically higher than profiled depreciation charges, is favourable from a cash perspective.

2. Debtors (invoices raised) are lower than planned. This is partially due to invoices which have not yet been raised and this is being addressed in month 4. (see note 3)

Factors which decrease the cash position against plan:

3. As a significant pressure this has been identified separately within this reconciliation in month 3. Accrued income is higher than planned and this has been targeted for significant reduction in month 4 with all Quarter 1 invoices raised.

4. The Trust cash plan had assumed that as a consequence of the upgrade of the financial ledger system there would be a delay in making payments to suppliers and as such Creditors would increase. However the team have been proactively resolving issues resulting in a reduction in creditors.

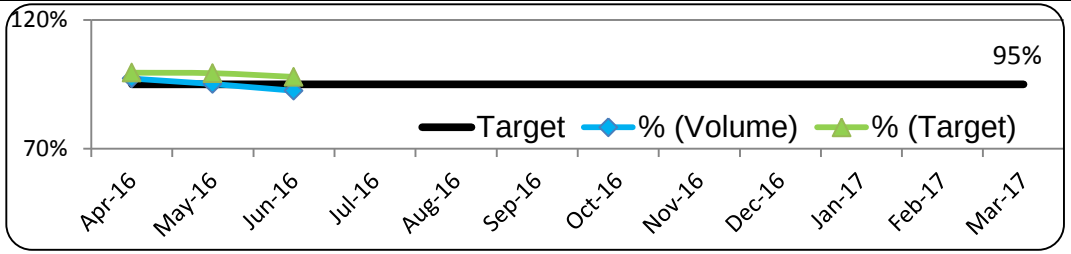
5. Overall accruals, and assumptions around expenditure commitments remain lower than planned.

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

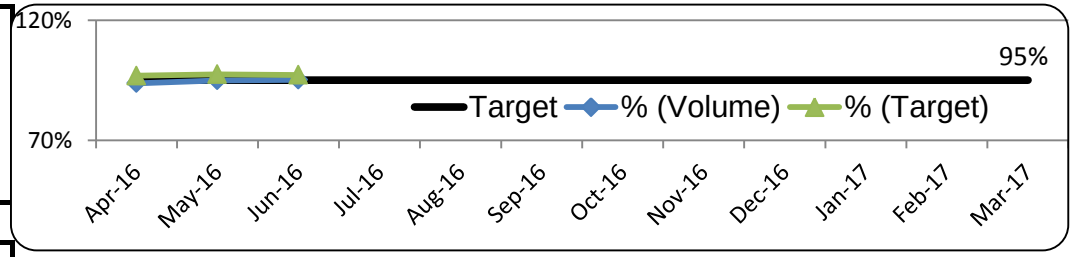
4.0 Better Payment Practice Code

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 delivery of the 95% target and identify solutions to problems and bottlenecks in the process. Overall year to date progress remains positive.

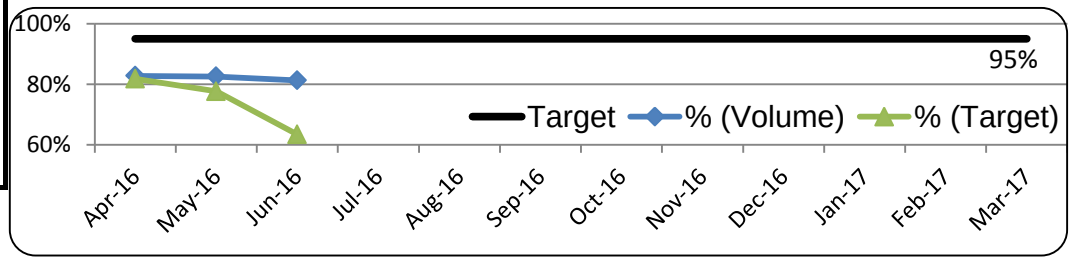
NHS	Number %	Value %
Year to May 2016	95%	99%
Year to June 2016	92%	98%



Non NHS	Number %	Value %
Year to May 2016	95%	98%
Year to June 2016	95%	97%



Local Suppliers (10 days)	Number %	Value %
Year to May 2016	83%	78%
Year to June 2016	81%	63%



4.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £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 or information which is personally sensitive.

At the current time NHS Improvement 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 (£)
01/06/2016	Insurance Costs	Trustwide	Zurich Insurance Company	8158457	1,015,049
27/05/2016	Property Lease	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	8157745	208,398
15/06/2016	Property Lease	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	8158242	208,398
31/05/2016	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2202869	137,112
03/06/2016	Lease Rents	Kirklees	Bradbury Investments Ltd	2203010	118,518
03/06/2016	Lease Rents	Kirklees	Bradbury Investments Ltd	2203074	116,071
20/05/2016	Drugs FP10's	Trustwide	NHSBSA Prescription Pricing Division	2202337	48,395
03/06/2016	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership NHS FT	2202988	41,949
11/05/2016	Electricity	Trustwide	British Gas Trading Limited	2201701	35,109
15/06/2016	CNST contributions	Trustwide	NHS Litigation Authority	8158093	33,986
03/06/2016	Lease Rents	Kirklees	Bradbury Investments Ltd	2203075	28,584
03/06/2016	Lease Rents	Kirklees	Bradbury Investments Ltd	2203016	25,158

4.2 Glossary

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

* Non-Recurrent - an 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. For 2016 / 2017 the Trust were set a control total surplus.

* 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 part of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency or reduce expenditure.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. 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.

Trust Board 19 July
Agenda item 9.3

Title:	**Customer Services Report – Quarter 1 2016/17**
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 the summary Friends and Family Test results and number of requests received by the Trust under the Freedom of Information Act.
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. The Trust is committed to responding openly and transparently to all requests for information under FOI.
Any background papers/ previously considered by:	Trust Board reviews the Customer Services Policy on an annual basis; the last review was in January 2016. Most recent policy updates reflects CQC essential standards 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. Trust Board reviews a KPI on the percentage of complaints with staff attitude as an issue. Performance is consistently 'green' in line with or better than target, with a forecast of '4' that this position can be maintained. Work is also underway to improve the number of complaints closed within 40 days. 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. This report links to item 5 on this agenda – Freedom to Speak Up Guardians – supporting an open and transparent culture where people feel able to raise issues. The CQC in its inspection report indicated that service users knew how to make a complaint and that staff were able to describe how complaints were dealt with, including the duty of candour (CQC Quality Report pg. 12). The CQC observed evidence of lessons learned from Board to ward in almost all services (pg.14). It found that complaints were handled appropriately and people were supported with compassion, there was full investigation, excellent record keeping and mechanisms to share learning (pg. 52/53).
Executive summary:	**Customer Services Report – Q1 2016/17** This report provides information on feedback received, the themes indicated, lessons learned and action taken in response to feedback. This report supplements information supplied weekly to BDUs. In Q1, there were 75 formal complaints, 72 compliments, 245 issues were responded to and 88 requests to access information under the Freedom of Information Act. Most complaints contain a number of issues; the most

	frequently raised issues were staff behaviours, communication, access to treatment, Trust administration, care and waiting times. This report is shared with The Members' Council, 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, and in BDU governance meetings.
Recommendation:	**Trust Board is asked to REVIEW and NOTE the feedback received through Customer Services in Q1 of financial year 2016/17.**
Private session:	Not applicable

South West Yorkshire Partnership
NHS Foundation Trust

Customer Services Report - Quarter 1 2016/2017

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. Trust processes emphasise the importance of using insight from service user experience to influence and improve services.

The service operates as a single gateway for raising issues and enquiries, including requests under the Freedom of Information Act. Urgent issues or potential risks identified through Customer Services processes are highlighted to the relevant BDU and the nursing or medical director as appropriate.

This 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 85 general enquiries in Qtr. 1, 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 276 telephone enquiries from staff, offering support and advice in resolving concerns at local level (a significant increase in staff contact on the previous quarter, reported at 170)

Feedback received

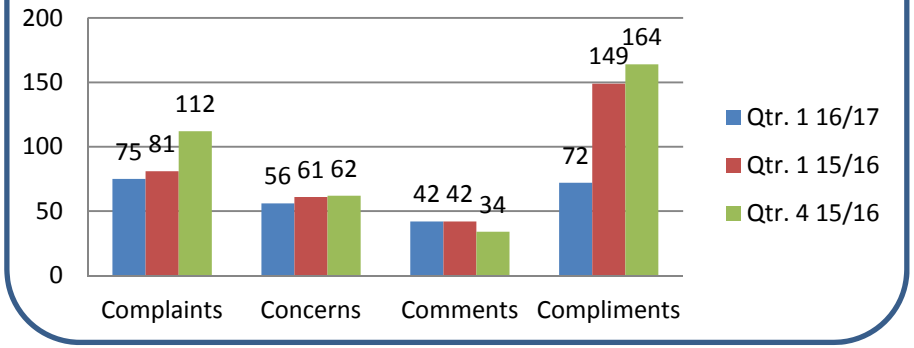
In Qtr. 1. The Customer Services Team responded to 245 issues (372 in Qtr. 4); 75 formal complaints were received (112 in Qtr. 4) and 72 compliments (164 in Qtr. 4).

Values and behaviours (staff) was identified as the most frequently raised negative issue (27). This was followed by communications (23), access to treatment or drugs (22), Trust admin/Policies/Procedures (22) , Patient care (12), and waiting times (12) Most complaints contained a number of themes.

In Qtr. 1 Ashdale Ward , The Dales, received 8 separate items of feedback from service users, career and families. These were regarding admission, and discharge procedures, staff values including attitude, patient care, staff numbers and facilities.

In Qtr. 1, 70% of people using mental health services across the Trust said they would recommend them, 99% would recommend community health services in Barnsley.

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 feedback is posted.

During Qtr. 1, 2 individuals added positive comments on NHS Choices about their experience of Trust services, which was acknowledged, and shared with the appropriate teams.

PHSO (Ombudsman)

In Qtr. 1, 2 complainants asked the Parliamentary and Health Service Ombudsman to review their complaints following contact with the Trust, and 1 complaint was re-opened with the PHSO following an appeal against their original decision. 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 3 cases. 1 was closed with no further action required. 2 cases: 1(Calderdale & Kirklees CAMHS) and 1 (Calderdale and Kirklees BDU) were partially upheld. Recommendations to the Trust included the preparation of action plans to reflect proposed improvements to services, and an appropriate apology to the complainant. The Trust currently has 3 further 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)

5 complaints were raised during the quarter regarding detention under the Mental Health Act. 3 were raised by service users and 2 raised by the parents of service users, one of which 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.

CQC / ICO

During Quarter 1 the Trust received 5 requests for information from the CQC – 2 relating to acute mental health services , 2 forensic services and 1 older people's services. Issues are subject to investigation and response.

The Information Commissioner is currently reviewing a breach reported by the Trust regarding sensitive information being sent to incorrect addresses.

Joint Working

National guidance emphasises the importance of organisations working together 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.

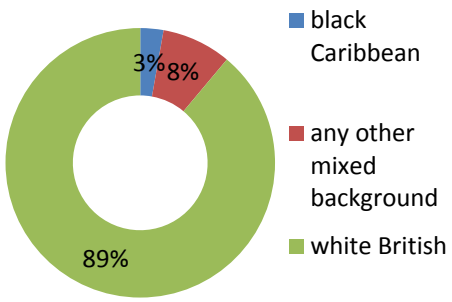
The Customer Services function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information. Healthwatch are provided with copies of quarterly reports and request additional information from the Trust on occasion.

Healthwatch Calderdale attended a recent art therapy engagement event. Healthwatch Barnsley have recently reviewed CAMHS services and are liaising with the service regarding recommendations.

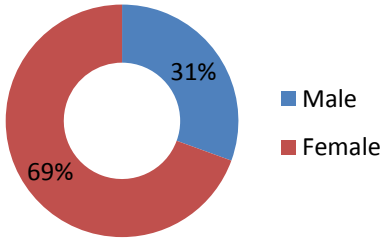
Issues spanning more than one organisation Qtr. 1	Complaint	Concern	Comment
Care Quality Commission	5	0	1
Member of Parliament	4	5	1
Mid Yorkshire Hospital NHS Trust	0	1	0
NHS Calderdale CCG	2	0	0
Other Local Authority	0	0	1

Equality and Inclusion – Formal Complaints - Protected Characteristics Data

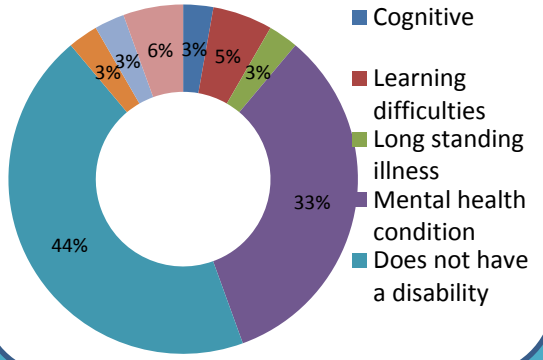
Ethnicity



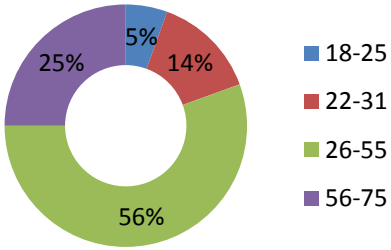
Gender



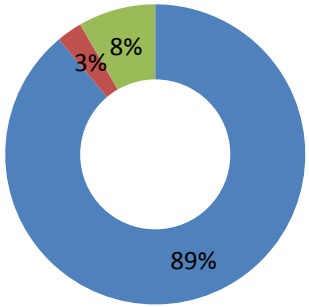
Disability



Age



Sexual Orientation



Equality data is captured, where possible, at the time a formal complaint is made, or as soon as telephone contact is made following receipt of any written concerns raised. Additional information is now shared with the complainant explaining why collection of this data is important to the Trust and that it is essential to ensure equality of access to Trust services. [It is important to note that the person making a complaint may not be the person receiving services].

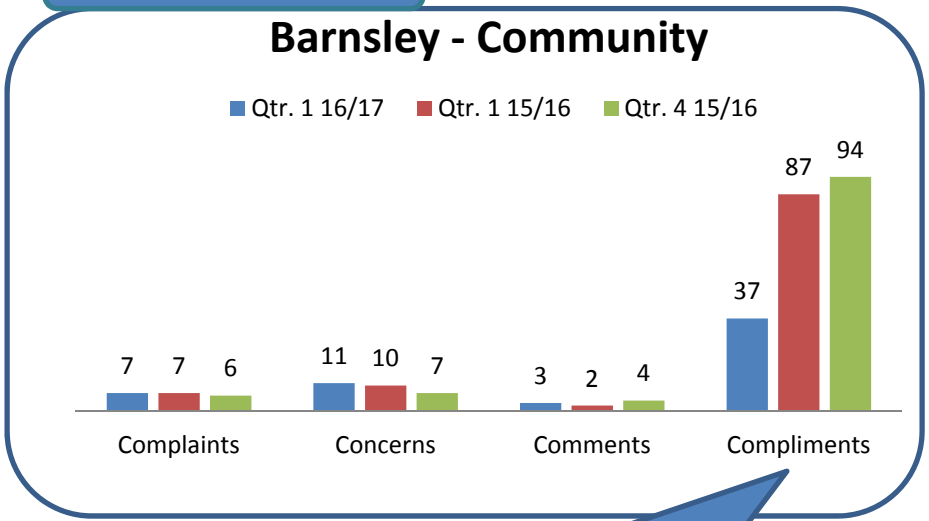
During quarter 1 – 36 people offered equality data – a 48% response rate.

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 – General Community Services

Number of issues



Actions Taken

- Further training provided to staff ensuring that aseptic and hand washing techniques are adhered to. On-going training is being provided to staff regarding the importance of clear and frequent communication with service users and carers
- Additional supervision has been identified and implemented to assist service users when equipment is required e.g. wheelchair or adaptations.
- Staff have been reminded of the importance of remaining professional at all times.
- The importance of accurate record keeping has been reiterated to all staff.

The team working with the service user went above and beyond the call of duty and was fundamental in providing an integrated approach to promoting and maintaining a high level of care, compassion and continuity. - **Palliative care team - Barnsley**

Complaints closed <25 days **40%**

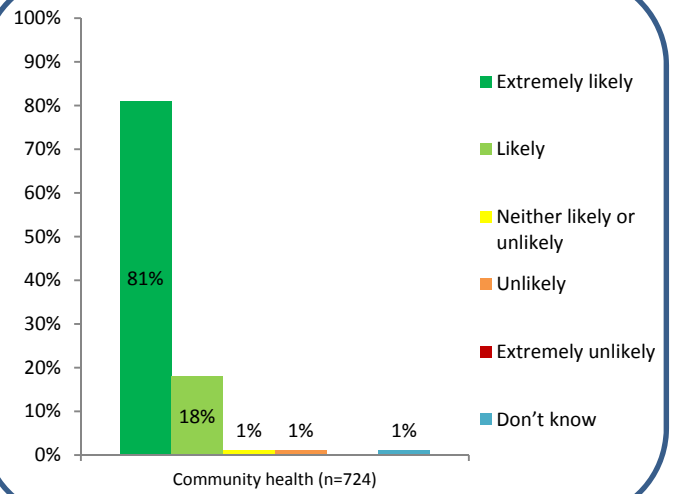
Complaints closed 26 – 40 days **40%**

Complaints closed >40 days **20%**

60% of complaints were allocated to a lead investigator within 5 days. No complaints were reopened.

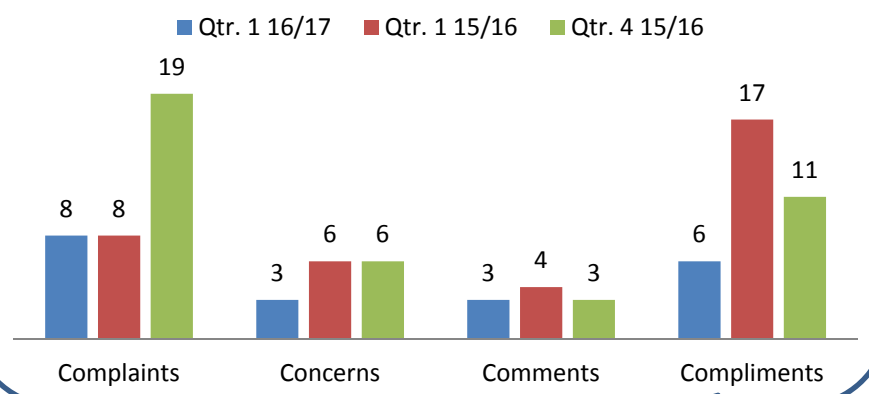
There has been a decrease in the number of complaints closed within the 25 day timeframe since last quarter. Weekly reporting to BDUs, which is shared with district directors, deputies and 'Trios', identifies areas of concerns which require action, and identify any lessons learned to inform governance processes.

Friends and Family Test



Barnsley – Mental Health Services

Number of issues



Actions Taken

- Discharge medication processes have been reviewed in line with a review of the medication policy. Staff have been reminded of the importance of clear communication with service users, and carers regarding changes to medication.
- The importance of clear communication with carers/relatives has been reiterated during team brief and staff supervision.
- The importance of ensuring information regarding MH Act is clearly communicated with service users has been reinforced
- Training on confidentiality regarding access to records.

I would like to say how good your team is. I was unwell for the past two and a half years including the time I was admitted to hospital. They all need a gold medal. – **Early Intervention Service**

Complaints closed <25 days 29%

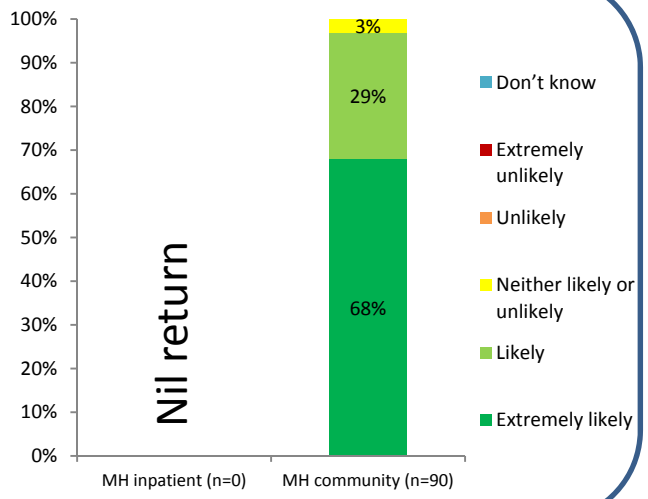
Complaints closed 26 – 40 days 14%

Complaints closed >40 days 57%

40% of complaints were allocated to a lead investigator within 5 days. No complaints were reopened.

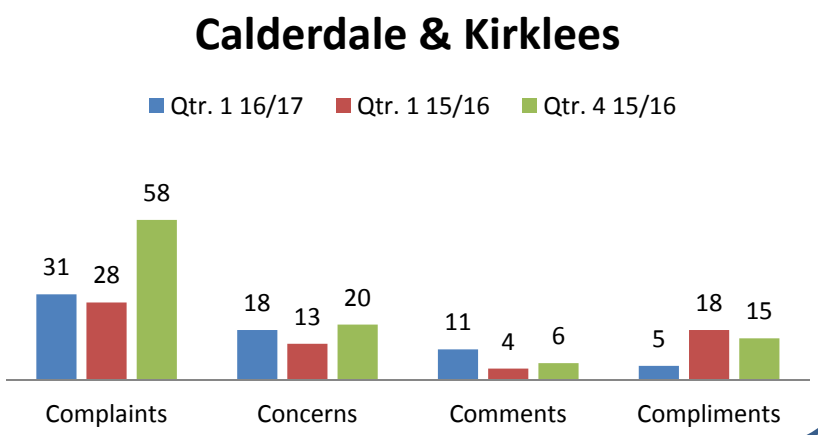
There has been an improvement in the number of complaints closed within the 25 day timeframe since last quarter. Weekly reporting to BDUs, which is shared with district directors, deputies and 'Trios', identifies areas of concerns which require action, and identify any lessons learned to inform governance processes.

Friends and Family Test



Calderdale & Kirklees Business Delivery Unit

Number of issues



Actions Taken

- Apology provided for lack of consistency in consultant medical input. Meeting offered to discuss care and treatment.
- Assurances provided that engagement has been undertaken regarding service reviews in Calderdale, and there is on-going engagement re art therapy.
- Feedback provided to the domestic team regarding cleanliness
- Letters updated with correct contact details, and answer machines now contain up to date information for the service.
- Service is currently undergoing a period of review. Service users care will be reviewed by therapist and necessary plan will be put in place.
- Staff will be reminded of the importance of passing messages on promptly. Also factors surrounding the complaint will be discussed with the staff member in appraisal as opportunity for learning and reflection.
- Staff will be reminded to send out a contact letter to individuals, when there is no response to messages left, following telephone contact.
- Changes to teams will provide increased consistency of care.

Thank you for all your help and support whilst I was in hospital. - **Elmdale Inpatient Services Ward**

Complaints closed <25 days
13%

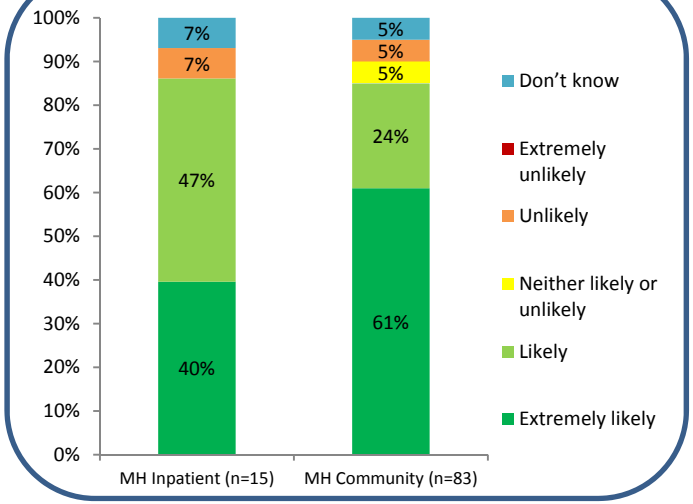
Complaints closed 26 – 40 days
22%

Complaints closed >40 days
63%

50% of complaints were allocated a lead investigator within 5 days. 8 complaints were reopened – 3 inpatients, 3 psy. therapies and 2 comm. – complainants not happy with first response.

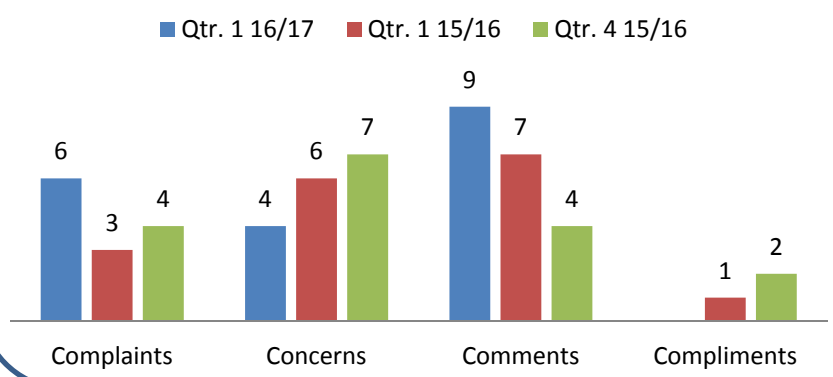
There has been a decrease in the in the number of complaints closed within the 25 day timeframe since last quarter. This is due to the complexity of the complaints that have been received. Weekly reporting to BDUs which is shared with district directors, deputies and 'Trios' identifies areas of concerns which require action, and identifies any lessons learned to inform governance processes.

Friends and Family Test



Forensics Business Delivery Unit

Number of issues



Actions Taken

- Documentation is subject to review and update
- There is a rolling programme of recruitment, to address staff shortages and improve staffing levels.

Complaints closed <25 days 60%

Complaints closed 26 – 40 days 0%

Complaints closed >40 days 40%

20% of complaints were allocated to a lead investigator within 5 days. No complaints were reopened.

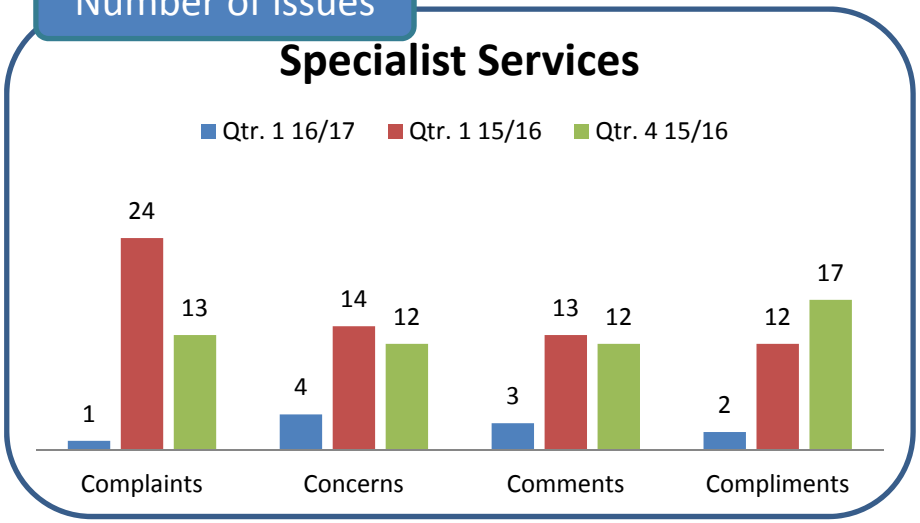
There has been an improvement on the number of complaints closed within the 25 day timeframe since last quarter. Weekly reporting to BDUs which is shared with district directors, deputies and 'Trios' identifies areas of concerns which require action, and any lessons learned to inform governance processes.

Friends and Family Test

No FFT collection in Quarter 1 for Forensic Services. Multiple CQUIN surveys, audits and patient reported outcome measures collected in Q1. FFT survey to be conducted Q2 and Q4

Specialist Services Business Delivery Unit (excluding CAMHS)

Number of issues



Actions Taken

- Future home visit to be carried out by 2 members of staff - to ensure that staff receive an increased level of supervision. All future communication to be confirmed in writing.
- The service is currently continuing to progress additional support regarding creative approaches used in recovery.
- The service will ensure that staff establish preferred communication methods to engage with individuals.

Text message received by staff member from service user's mother, thanking her for staying with her son until a hospital bed could be found and he was safely on his way. - **Calderdale Community Learning Disability Team**

Complaints closed <25 days 25%

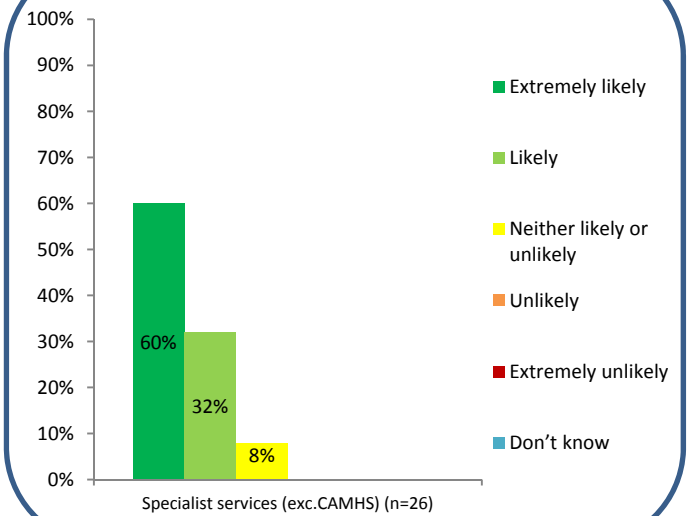
Complaints closed 26 – 40 days 0%

Complaints closed >40 days 75%

All complaints took longer than 5 days to allocate to a lead investigator. 1 complaint was reopened.

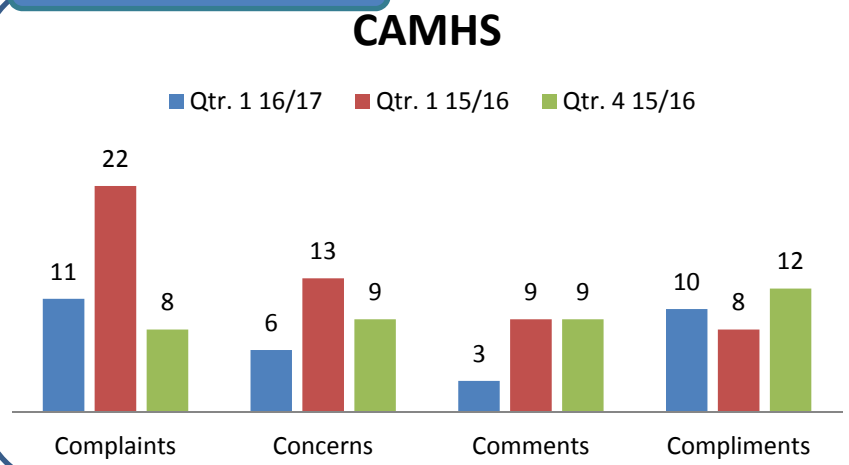
There has been a decrease in the number of complaints closed within the 25 day timeframe since last quarter. Weekly reporting to BDUs, which is shared with district directors, deputies and 'Trios', identifies areas of concerns which require action, and identify any lessons learned to inform governance processes.

Friends and Family Test



Child and Adolescent Mental Health Services

Number of issues



Actions Taken

- Staff have been reminded of the importance of best practice and clear documentation when completing healthcare records
- Staff have been reminded of the importance of ensuring service user and carers understand information. Staff to ensure that the opinion is always sought from the child as well as parent/ carer and that this is documented clearly.

Your support has been amazing, we could not have got to where we are without it. Knowing you were always there to help us has been a comfort to us. You listened to us and took on board our concerns. - **Mulberry House CAMHS Team, CNDH**

Complaints closed <25 days
0%

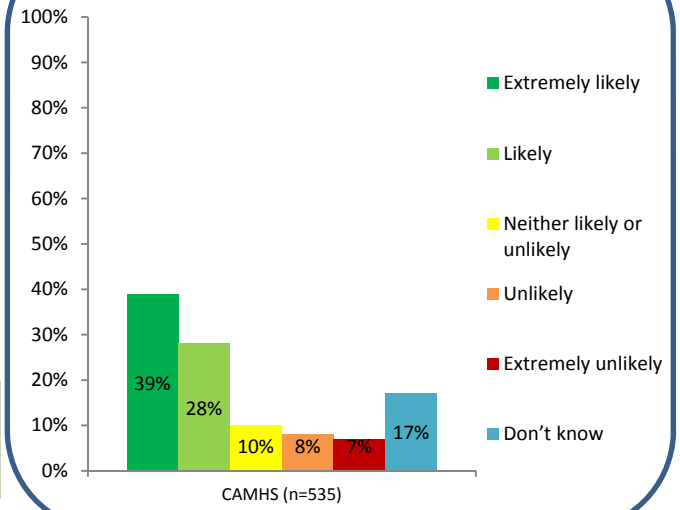
Complaints closed 26 – 40 days
50%

Complaints closed >40 days
50%

33% of complaints were allocated to a lead investigator within 5 days. 1 complaint reopened.

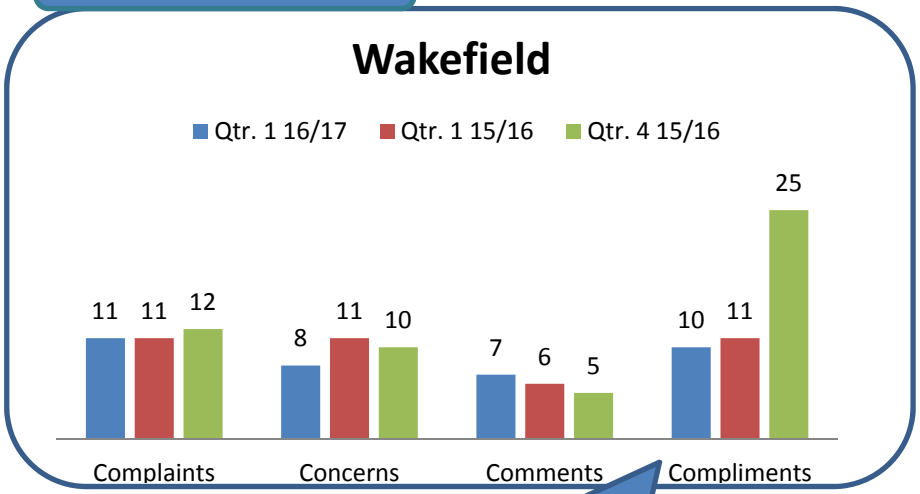
There has were no complaints closed within 25 days – a decrease on the last quarter. Weekly reporting to BDUs which is shared with district directors, deputies and 'Trios' identifies areas of concerns which require action, and any lessons learned to inform governance processes.

Friends and Family Test



Wakefield Business Delivery Unit

Number of issues



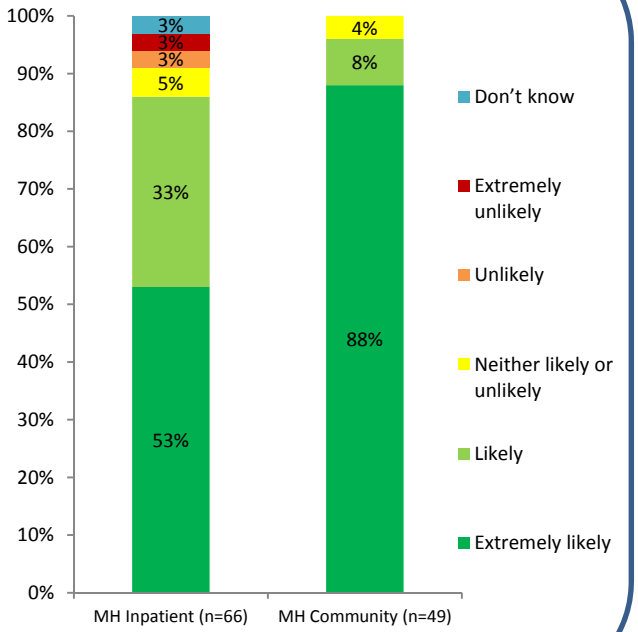
I would like to say it was a great privilege to meet and feel honoured to have been given therapy from such a marvellous and talented consultant. May I say a big thank you for your time, your help has been a life changing experience. - **APTS Castleford and SPT Horbury**

Actions Taken

- Staff have been reminded to discuss with carers and services users additional support that might be available upon discharge

I received a compassionate and consistent level of support and a very high standard of care from psychological therapies in Ossett. From the reception staff to the therapists they have been fantastic. Accessing therapy can take months but I have been seen and treated quickly. I am now a recovery college volunteer.

Friends and Family Test



Complaints closed <25 days 50%

Complaints closed 26 – 40 days 30%

Complaints closed >40 days 20%

66% of complaints were allocated to lead investigators within 5 days. 1 complaint was reopened.

There has been a improvement in the number of complaints closed within the 25 day timeframe since last quarter. Weekly reporting to BDUs, which is shared with district directors, deputies and 'Trios' identifies areas of concerns which require action, and any lessons learned to inform governance processes.

Freedom of Information requests

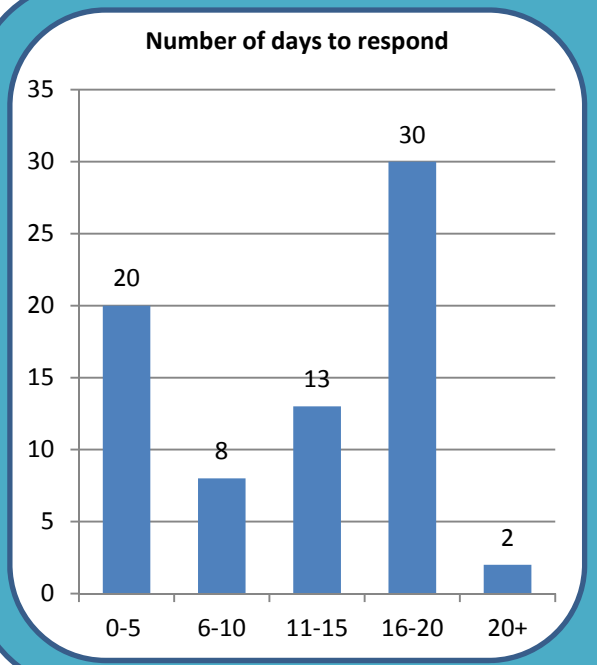
88 requests to access information under the Freedom of Information Act were processed in Qtr. 1, an increase on the previous quarter when 77 requests were processed. Most requests were detailed and complex in nature and required significant time to collate an appropriate response working with services and quality academy functions.

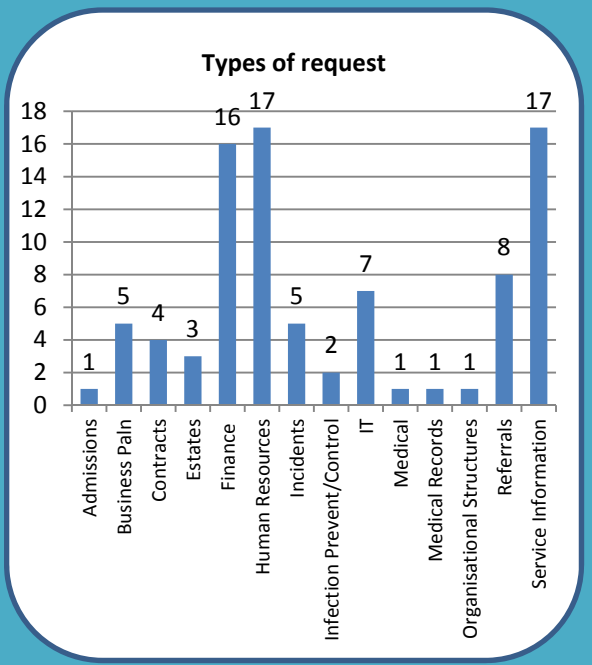
The Customer Services Team works with information owners in the Trust to respond to requests as promptly as possible, but within the 20 working day requirement. Timescales were re-negotiated for the 2 requests which exceeded 20 days.

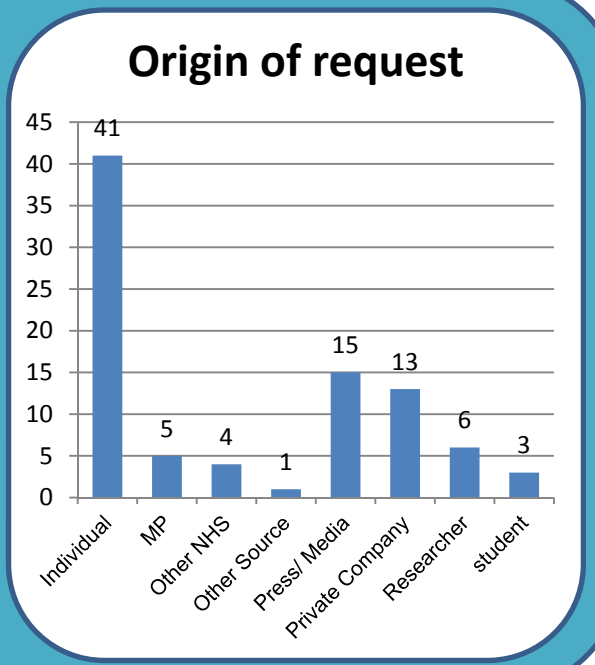
During Qtr. 1, 4 exemptions were applied:

- 2 x Exemption 43, Commercial Interests
- 1 x Exemption 21, Information reasonably accessible to the applicant by other means
- 1 x Exemption 36 prejudice to effective conduct of public affairs

There was 1 request for review following information provided. Reviews / appeals are reviewed by the Deputy Director of Corporate Development.







Trust Board 19 July 2016
Agenda item 10

Title:	**Equality and Inclusion summary report – review of activity 2015/16 and next steps for 2016/17.**
Paper prepared by:	Director of Corporate Development
Purpose:	To review the Equality and Inclusion activity in 2015/16, as reported to the Equality and Inclusion Forum, and the differences the Trust has made to the lives of service users/carers and staff through the implementation of its Equality First Strategy. To note areas of focus in 2016/17.
Mission/values:	Valuing diversity in the communities we serve and in our staff is fundamental to our value of person first and in the centre
Any background papers/ previously considered by:	Equality First Strategy
Executive summary:	This report evidences ways in which the Trust values inclusivity in services and supports staff to deliver services that meet individual need. It highlights work to ensure an approach that is about culture not compliance, promoting an agenda of inclusivity and respect and valuing the diversity of the communities we serve and of the staff we employ. A public facing summary will be produced. The report summarises work reported to the Equality Forum, established in May 2015. The Forum's primary purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion into everything it does through promoting the value of inclusivity and treating people with respect and dignity. The Forum focusses on driving a values-based approach to equality and inclusion through the organisation rather than a traditional compliance-based approach. The forum agreed four key priorities: 1. To revise training to equip staff and managers to be effective champions of diversity, instilling confidence to challenge behaviours inappropriate to living our values, to communicate with people from different backgrounds and to ensure those responsible for recording equality monitoring information feel comfortable asking the necessary questions. 2. To improve the representation of Asian people in the workforce to better reflect the communities we serve and to increase the number of people from a BME background at managerial grades 8 and 9, where they are currently under represented. 3. To undertake targeted community engagement, using technology to bring voices and stories to Trust Board to give us insight which will improve the accessibility of services to people from different backgrounds and improve the experience of service users from Black and Asian backgrounds (the latter measured by the friends and family service user question "how likely are you to recommend this service to friends or family"). 4. Increasing the percentage of service users in employment through a new pilot project in the Barnsley BDU working in partnership with the Local Authority and local employers These priorities form the strategic approach which complement on-going

	activity and support delivery of the four goals previously agreed by the Board to meet the EDS2 framework: • Better health outcomes • Improved patient access and experience • A representative and supported workforce • Inclusive leadership.
Recommendation:	**Trust Board is asked to note the progress made during 2015/16 and the continued work in 2016/17**
Private session:	Not applicable

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Equality and Inclusion Summary report 2015/16 and forward plan for 2016/17

Director of Corporate Development

July 2016

With **all of us** in mind.

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Equality and Inclusion Summary Report – July 2016

Introduction

This report offers a summary of activity to demonstrate the Trust's commitment to equality, diversity and inclusion. Working with service users, carers and staff the Trust aims to provide services which:

- Promote recovery
- Challenge stigma
- Enable social inclusion
- Promote an inclusive and fair working environment for staff.

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

Delivery against this agenda is regularly monitored by the Trust's Equality and Inclusion Forum. The Forum was established in May 2015 to support a values based approach to equality and inclusion, rather than a traditional compliance based approach. It is chaired by Ian Black, Trust Chair.

Meeting legislation, national standards, guidelines and the Public Sector Equality Duty* help us evidence good practice. However the focus is on this being the right thing to do, ensuing equality and diversity considerations are an intrinsic part of improving service user and carer experience, and the workplace culture, especially for those people who have additional needs with a protected characteristic. These are listed below:

- Age
- Disability
- Gender reassignment
- Marriage and Civil Partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Carers (this characteristic is Trust specific – in line with our values).

* The Public Sector Equality Duty is a law set out in Section 149 of the Equality Act 2010. It states that public authorities must think about how they can make sure that everyone has the same chance to use their services. The law says authorities must:

- Remove or minimise discrimination
- Take steps to meet the needs of people in different groups
- Encourage people from different groups to take part in public life
- Make sure people from different groups can participate
- Tackle prejudice and promote understanding

The Equality and Inclusion Forum

The Equality and Inclusion Forum is made up of Non-Executive and Executive directors, staff responsible for leading on this agenda and staff side representation. The Forum monitors activity to deliver four key priorities. These priorities are set out below with examples of work in each area:

Priority area – staff training: A revised training offer which equips staff and managers to be effective champions of diversity. To give people confidence to challenge behaviours inappropriate to living our values, to communicate with people from different backgrounds and to ensure those responsible for recording equality monitoring information feel comfortable asking the necessary questions.

Actions underway:

- The Equality and Diversity training offer has been revised. Staff can now access e-learning or face to face training, the latter offering a mix of information sharing and case studies to test practical application of theory. Staff can also access additional support to explore equality and diversity in more depth and help with specific service issues. The revised offer is subject to on-going evaluation. Trust Board participated in training in April 2016 and feedback to the trainers was positive.
- A 'quick guide' to Equality Impact Assessments (EIAs) has been developed and shared with services to support teams to think about the likely impact of their work on different communities or groups, and see life through their 'lens'. The aim of the guide is to support teams to anticipate the consequences of service decisions and changes and ensure negative consequences are eliminated or minimised and opportunities for promoting equality are maximised. Training on how to complete EIAs is also offered and a key objective for the Partnerships Team equality development workers is to work collaboratively with Business Delivery Unit colleagues to refresh EIAs for all services.
- A campaign to raise awareness amongst staff of the protected characteristics was undertaken in 2015 /16, focussing on a characteristic each month and sharing information via the intranet. The campaign achieved over 1300 page views.
- The Partnerships Team is working with colleagues across the Trust to introduce a 'Human Library' – staff happy to share their experience of a protected characteristic to support understanding of what it feels like to be in that position at work. Pilot sessions are planned for the Summer to support understanding and learning.
- Work to embed the Accessible Information Standard continues, with systems in place to ensure staff ask people about their information needs, record this, share as appropriate and act to ensure needs are met. Drop in sessions for staff are taking place over the coming weeks to provide additional information and address any concerns and a bank of frequently used material is being prepared in easy read format. On-going monitoring of compliance with the Standard will be undertaken.

Priority area – a representative workforce. To improve representation of Asian people in the workforce to better reflect the communities we serve and to increase

the number of people from a BME background at managerial grades 8 and 9, where they are currently under represented.

Actions underway:

- The Equality Workforce Monitoring Report 2015 was subject to review and discussion at the Equality and Inclusion Forum in June 2016. The report covers a range of information about staff, mapped to protected characteristics, and a range of indicators including starters, leavers, promotions, pay bandings and update of training. The report is available on the Trust's website at http://www.southwestyorkshire.nhs.uk/wp-content/uploads/2012/07/Equality-workforce-monitoring-annual-report-2015.pdf
- The report concludes that the workforce is broadly representative of the communities it serves, with the exception of South Asian, particularly in Kirklees. Targeted recruitment is being explored to address this, including through an apprenticeship scheme for young people. BDUs also consider workforce diversity issues as part of the annual planning process.
- A Black and Minority Ethnic (BAME) Staff Network has been set up to empower and support BAME Staff to achieve their potential and maximise their contribution in delivering the Trust's Mission, Values and Strategic Objectives. The purpose of the Network is to:
    - Help shape and influence policies and procedures within the Trust to ensure that the BAME equality perspective is proactively considered.
    - To provide a support function which includes, through the development of networks and face to face meetings, a safe environment for BAME staff to openly and confidentially discuss issues
    - To share concerns so that they can be escalated or signposted to existing Trust procedures and be addressed in a "safe" and confidential manner.
    - Develop understanding of the workings of the Trust and discuss issues affecting BAME staff with key decision makers including the Executive Management Team Champion (Director of Human Resources and Workforce Development).
    - Assist the Trust in meeting its statutory obligations regarding its Public Sector Equality Duty under the Equality Act 2010 and its commitment to the Equality Delivery System, the Workforce Race Equality Standard and the Equality and Inclusion agenda, including assisting in reviewing existing policies and procedures when called upon.
    - Consider the potential opportunities and career progression within the Trust, by identifying training needs and other such provision, as well as challenges of working at, or with different levels within the organisation.
    - Work with other equality networks to support them and staff within their networks.
    - Promote and support an understanding in the Trust of the needs of BAME individuals within local communities.

Priority area - targeted community engagement. To improve the accessibility of services to people from different backgrounds and improve the experience of service users from Black and Asian backgrounds (the latter measured by the friends and family service user question "how likely are you to recommend this service to friends or family").

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Actions underway:

- The Trust is conducting a Mental Health Act Admissions audit to explore the needs of the BME (South Asian) working aged adult population in North Kirklees. This is to support understanding of the barriers that result in delayed engagement with mental health services and people coming into services in crisis.
  The audit involves tracking the clinical pathway for BME service users, working with GPs to promote timely referral and prevent delays in referral and subsequent diagnosis, and working with service users and carer groups to raise awareness of and increase engagement with mental health services.
- Alongside this work, the Trust has supported understanding of the needs of Muslims during Ramadam by making information available on the website and running 'Fasting and Medication' sessions for staff.
- Equality data is requested when people complete the Friends and Family Test. The aim is to increase the percentage of people who would recommend the Trust's services to family and friends, with a target set of 95% for March 2017. A comparison of data collected over the past two years is shown below:

	2014/ 15	2015 / 16
Ethnic group	% of people who would recommend Trust services	% of people who would recommend Trust services
White	96	97
Asian	89	94
Mixed	100	75
Black	76	88

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  Friends and Family results are reported on a quarterly basis to Trust Board through the Customer Services report.

Prioity area – supporting service users into employment. To increase the percentage of service users in employment through a pilot project in Barnsley Business Delivery Unit, working in partnership with the Local Authority and local employers.

Actions underway:

- There is a key performance indicator on the Trust's performance management framework of a 10% target of supporting service users on CPA into employment. Performance has plateaued at around 7%. Recent discussions at EMT and Board have focused on assessing the Trust's contribution to local targets and standards in relation to employment and impact on overall health and wellbeing. Work will be undertaken to inform a review of the target and alternative ways of measuring the Trust's contribution to supporting all service users, not just those on CPA, into employment (which may include volunteering as a stepping stone).
- The Trust is working with Barnsley Metropolitan Borough Council (Economic Regeneration and Employment and Skills) to understand what employment support opportunities are available across Barnsley

- Links have been made with Department for Work and Pensions (DWP) Employment Advisors to explore employment support and training opportunities
- The Trust has been successful as part of a bid led by Northern College on a project entitled ‘Great Lives, Great Learning’ which provides opportunities for people to get back into education/learning
- Connections with local Businesses are being made to offer advice/information regarding employee mental health in exchange for work placements opportunities.
- A visit to Merseycare is planned to see the Individual Placement Support (IPS) model in practice (an evidence based tool for helping people into employment).
- A volunteer pathway has been implemented in the BDU to link to The Exchange (Barnsley Recovery College) and to Trustwide volunteering opportunities.
- A collection of stories and experiences are being collected to evidence the impact of the Recovery College on people accessing employment, volunteering and training.
- The Trust has also worked with Mencap and has identified volunteer opportunities in catering services for 2 people with a learning disability.
- The Trust currently has over 170 volunteers who undertake a variety of roles helping to improve the experience of people who use services. Many people volunteer in addition to paid work, wanting to utilise their skills and knowledge in a different way, some just want to be involved and take part. Some people however volunteer to build their confidence and increase skills to equip them to work. Over the last year 8 people who volunteered with the Trust moved on to paid employment in roles such as sales advisor, trainer, sessional tutor and HR advisor.

EDS2

The Equality Delivery System was designed by the Department of Health, and reviewed by NHS England, to help NHS organisations measure their equality performance, and understand how driving equality improvements can strengthen accountability to service users and the public. EDS2 includes 18 outcomes grouped into four goals:

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

The Trust Board agreed a focus on Race for Equality assessment in 2015/16.

The local health economy in Calderdale, Kirklees and Wakefield agreed to form a partnership to assess local performance against the 2 public facing goals (1 & 2). This co-ordinated approach involving CCGs and provider organisations was carried out through events held in each locality in November and December 2015. Each organisation shared examples of current work, showcasing projects or services which demonstrated progress against the goals.

The Trust held an event in April 2016 in Barnsley to update local people on progress against the goals and assess performance.

99 people, excluding staff, attended the events across the Trust footprint.

In 2015-16 we focused on one outcome from each goal and then measured the progress we had made with stakeholders. We agreed that we were at a “developing stage” for all the outcomes.

The Trust asked staff their view on progress regarding Goal 3 by means of a confidential survey which asked 3 questions:

1) Do you feel the Trust has a fair recruitment and selection process?
Response - Yes 72.31% No 27.69%
2) Do you feel that the Trust has a workforce that reflects the diversity of the communities we serve?
Response - Yes 52.31% No 47.69%
3) Do you feel that all Trust staff have equal access to career opportunities and skill development in the workplace?
Response - Yes 46.15% No 53.85%

The Trust asked staff their view on progress regarding Goal 4 by means of a confidential survey which asked 3 questions:

1) Did you know that the Trust has an Equality Forum, led by the Trust’s Chair which champions Equality, Diversity and Inclusion issues?
Response - Yes 50.79% No 49.21%
2) Do you think the Trust's Mission and Values help to embed Equality, Diversity and Inclusion in the culture of the organisation?
Response - Yes 80.95% No 19.05%
3) Do Board members and senior leaders model the values of the organisation in promoting Equality, Diversity and Inclusion?
Response - Yes 55.56% No 44.44%

Action plans are in place to respond to the survey results.

The table at the end of this report offer examples of work undertaken to meet the goals, feedback received from stakeholders and staff, agreed grading and further work to be done.

Next steps

The Forum has agreed to maintain a focus in the coming year on the priority areas already identified:

- Equipping staff to be effective champions of diversity
- Striving to have a workforce which is representative of the communities we serve
- Targeted community engagement to support positive community engagement and promote understanding of and access to services
- Supporting service users into employment, through partnership working with

education and business and through creating a range of volunteering opportunities in services to enhance skills and confidence
- Continue to make progress against EDS2 goals, evidencing good practice and the impact for service users and carers.

Action plans are being developed to take work forward, which will be agreed by the Forum and subject to on-going monitoring.

Work is also continuing to support the strategic placement of the Equality, Diversity and Inclusion agenda focusing on culture not compliance and ‘the way we do things around here’.

EDS2 outcomes

Goal / Outcome	Examples of work to achieve outcome	Stakeholder feedback	Additional evidence	Grading
Better Health Outcomes Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.	• Improved data collection through electronic patient record systems, monitored through data completeness reports. • We've set up a forensic learning disabilities network to help us work together with service users and carers • Learning disability and mental health services staff have set up a working group to explore ways of joint working • The Mental Health Access Team in Barnsley have revised their service to better accommodate the needs of people with a learning disability • Making Safeguarding Personal - involving individuals and carers in work relating to protecting people from abuse and neglect • Mental health services at Kendray hospital and community mental health teams have an allocated police officer to assist with safeguarding in order to give a seamless and supportive service for vulnerable people. • We've listened to 1,000 opinions at 14 public events from service users, carers and public about the future design of	• Communication was a constant theme, including the need to make information available in a variety of formats • Options for self-referral need to be explained • People don't want to wait until they are in crisis • Need good signposting • People want feedback and to understand how their input has been used – 'You said, we did, this means'	• Work is progressing to ensure that we have the mechanisms in place to capture the equality information on SystemOne. • A work stream has been set up for Service Users and Carers to influence, be involved, and listened to as we develop our "Hub" facilities to make our services seamless. • On-going monitoring of equality data of attendance at our public events so the "voices of difference" can be heard or work undertaken systematically if this doesn't occur. • Trust-wide process in place to support compliance with the accessible Information Standard.	Developing

	our services			
Improved patient access and experience Patients are informed and supported to be as involved as they wish to be in decisions about their care.	• We're continuing to focus on CPA policy and embedding the principles of "No decisions about me, without me", ensuring people feel informed and supported and involved in their care • Calderdale Memory Service was recognised by the Royal College of Psychiatrists for the care they provide to people with memory problems and dementia and their families • Our Friends and Family Test enables people to share their views about our services using a short postcard or by completing a longer questionnaire. This has been acknowledged as good practice within the Yorkshire and the Humber NHS Equality & Diversity Leads network. • More than 60 service users came to Medicines for You events where pharmacists explained the use of medication • Calderdale services are working in partnership with the Women's Activity Centre on a mental health awareness training project and a diabetes self-care programme • Service user and carer involvement in clinical services is being mapped across the Trust • Staff have undertaken training with the British Legion to raise awareness of the 'veteran' culture –	• Good partnership working with third sector through Creative Minds and Consultation events. • Creative opportunities welcomed and more needed. • Deaf people with mental health issues need more support • More staff training required to support culture change • New Care Plan documents capture how involved service users feel in decision making. • More planning required in advance of discharge. • Ensure people understand the information they receive and it is in the best format for them. • Listen to the individual, family and carer more at meetings and record/write down all sessions. • FFT is a good measure and needs to be used for all clients.	• Process introduced to gather equality data on short and long forms for Friends and Family Test. • The Deloitte, 'well led' review described engagement with service users and governors as particularly strong, for example the format of the Members Council was seen to enhance engagement. Service users and governors were found to perceive the Trust as open. • The Accessible Information Standard will work to ensure people needs are met.	Developing

	enabling them to make adjustments to services as needed. • Community mental health teams have improved their engagement with people who have forgotten or who choose not to wear hearing aids by offering them the use of portable headsets • Work to support and engage carers across the Trust is progressing with projects on many wards • The Trust was re-assessed against the Customer Service Excellence standard in June 2016, and is currently awaiting the outcome.			
A represented and supported workforce Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.	We've rolled out values-based recruitment, induction and appraisal across the organisation • We provide equal opportunities for career progression or promotion, according to the Workforce Race Equality Standard • We're members of Project Innov8, which seeks to increase workforce diversity • We monitor the Wellbeing survey results, which invites staff to share views about the issues affecting their wellbeing and plan action for things which need improvement • We've introduced a clinical training and development recruitment scheme across the Trust, for all healthcare support workers who do not hold a relevant health care qualification • a revised training offer is in place, using case studies to support	• NHS Jobs website seen to limit applicants – people may not know how to apply. • Secondments and acting up opportunities viewed as closed to competition – described as 'jobs for the boys', • Staff recognised a need to market the Trust • Disabled people seen as poorly represented • Low numbers of BME staff in high BME population areas. • Little opportunity for career progression at lower bands a cause for concern • Trust seen to value staff development.	• The Trust has a values based recruitment policy which supports and encourages a transparent, fair and inclusive recruitment and selection process. • The Trust publishes its Equality workforce monitoring annual report • There is planned engagement with local BME communities, particularly South Asian communities, to encourage applications, including through the apprenticeship scheme • A BME staff network is being set up with a launch planned for September 2016. • Uptake of equality and diversity mandatory training is monitored.	Developing

	'theory into practice'. • We delivered recruitment and selection training to service users, carers and our Members Council, in order to enhance 'lived experience' insight on interview panels			
Inclusive leadership Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisation.	• We are embedding a culture which values inclusive leadership and promotes organisational capability with a focus on diversity through our membership of the Innov8 charter • We're working to reflect the population profile on the Board and to encourage uptake of band 7 staff in a training scheme led by senior managers that creates opportunities for a diverse workforce	• Some staff awareness of Equality Forum • Trust must be seen to champion issue through the forum • Equality perceived as an add on - when it should be running through everything • Some staff adhere to values but many don't • Board members seen to model the values and promote them.	• Establishment of Equality and Inclusion Forum to champion as well as address culture change needs identified in service areas. • A shadow Board programme is underway in pilot form, with the principles of Inclusive Leadership running through the core. • The Trust Board undertook the revised Values based Equality, Diversity and Inclusion training module in April 2016. • The Deloitte review found that "Board Members bring a diverse range of experience, and skills requirements of the Board have been considered as part of recent appointments. The Board is cognisant of the need to increase its focus on longer term succession planning." • values are visible and utilised in recruitment and appraisals.	Developing

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 19 July 2016
Agenda item 11

Title:	**Assurance framework and organisational risk register Q1 2016/17**
Paper prepared by:	Director of Corporate Development
Purpose:	For 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 2016/17** The Board assurance framework provides the Trust Board with a simple but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's strategic objectives. In respect of the assurance framework for 2016/17, 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 the 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 assurance framework will be used by the Chief Executive to support his quarterly review meetings with Directors. This will ensure Directors are delivering against agreed objectives and action plans are in place to address any areas of risk identified. The assurance framework indicates an overall current assurance level of amber/green. The rational and the individual principle risk rag ratings, are set out in the attached report. The assurance framework for 2016/17 is based on the revised strategic objectives set by the Board and as such changes from Q4 cannot be mapped across in a meaning full manner. For future Boards a summary of the changes and rational from one quarter to another will be provided.

	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. As part of the development of the revised Board assurance framework, a comprehensive review of the risk was undertaken by the EMT led by the Director of Corporate Development to ensure the risks on the risk register reflected the Trust's current position and were aligned with the Trust's revised strategic objectives. The risk register now contains the following risks. - No. 275 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. - No. 695 Trust sustainability declaration. - No. 772 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. - No. 812 commissioning risks – local commissioning intentions and impact of national developments. - No. 850 impact of RiO 7 upgrade on clinical services. - No. 852 increase in information governance incidents. - No. TBC staffing levels in Wakefield acute services. - No. TBC long waiting lists to access child and adolescent mental health services. A number of new risks have been identified in relation to the following and these will be included in the next iteration of the organisational risk register. - The risk of Trust systems being target of cyber-crime. - The availability of cash to support the Trust's capital programme. - The risk that the Trust IT systems do not meet the Trust' requirements. - The risk of loss of contracts and the impact on the Trust's sustainability.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the controls and assurances against corporate objectives for Q1 2016/17;** ➢ **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

South West Yorkshire Partnership NHS
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:
Strategic objectives and Priorities as set out in our Annual Plan, underpinned by our values and linked to wider health economy and regulatory requirements.

Strategic 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, mitigated in accordance with Trust risk appetite statement.

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

With **all of us** in mind.

Assurance Framework 2016/17 Quarter 1

KEY: BDU= Business Delivery Unit Directors, CEO=Chief Executive Officer, DCD=Director of Corporate Development, DFPI=Director of Finance Performance and Information, DHII=Director of Health Intelligence and Improvement, DHR=Director of Human Resources, DMECD= Director of Marketing, Engagement and Commercial Development, DNCGS=Director of Nursing Clinical Governance and safety, IDSP=Interim Director of Strategic Planning, MD=Medical Director. AC=Audit Committee, EF-Estates Forum, EMT=Executive Management Team, CGCS=Clinical Governance & Clinical Safety Committee, MHA=Mental Health Act Committee, R&TSC=Remuneration and Terms of Service Committee.. Note 1=Policy Lead as applicable to policy type ORR=Organisational Risk Register

Principle Strategic Objective:	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
1. Improve the health of the people we serve and reduce health inequalities	As noted below	EF, EMT, CGCS, MHA,	A/G			

	Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment	Rag Rating
1.1	Differences in commissioned services and local strategic priorities across our districts leading to service inequalities across the Trusts footprint	A/G
1.2	Trust plans for service transformation are not aligned to multiplicity of stakeholder requirements leading to inability to create a person centred delivery system.	A/G
1.3	Failure to deliver the estates strategy and capital programme leading to health & safety and compliance issues, poor service user and staff experience	G
1.4	Differences in the services provided due to local strategic priorities and internal variation in practice may result in inequitable service offers across the whole Trust	A/G

	Controls – systems and processes (what are we currently doing about the Strategic Risks?)	Director lead
C.1	Senior representation on local partnership boards, building relationships, ensuring transparency of agenda's and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction (1.1, 1.2)	CEO
C.2	Annual Business planning guidance in place standardising process and ensuring consistency of approach across the Trust, standardised process in place for producing businesses cases with full benefits realisation (1.1, 1.2)	IDSP
C.3	Formal contract negotiation meetings with clinical commissioning and specialist commissioners underpinned by legal agreements to support strategic review of services (1.1)	IDSP
C.4	Development of joint Quality Innovation Productivity Prevention (QIPP) plans and Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with QIPP plans and CQUIN targets in place. (1.1)	BDU
C.5	Trust performance management system in place with KPIs covering national and local priorities reviewed by EMT and Trust Board (1.1, 1.2)	DFPI
C.6	Cross-BDU performance meetings established to identify performance issues and learn from good practices in other areas (1.1, 1.4)	BDU
C.7	Director leads in place for revised service offer through transformation programme, work streams and resources in place, overseen by project boards and EMT (1.1, 1.3).	BDU
C.8	Project Boards for transformation work streams established, with appropriate membership skills and competencies, PIDs, Project Plans, project governance, risk registers for key projects in place (1.2, 1.3, 1.4)	BDU IDSP
C.9	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (1.2)	DHR
C.10	Further round of Middle ground 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 (1.2)	DHR
C.11	Partnership Boards established with staff side organisations to facilitate necessary change (1.2, 1.3)	DHR
C.12	Estates Forum in place with defined Terms of Reference chaired by a NED, supported by 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 (1.3)	DHR
C.13	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon (1.2, 1.4)	DCD
C.14	Communications and Engagement Strategies and approaches in place for service users/carers, staff and stakeholders/partners , engagement events gaining insight and feedback, including identification of themes and reporting on how feedback been used (1.2)	DHR DCD DMECD
C.15	Policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval (1.1)	Note 1
C.16	Governors engagement and involvement on Member Council and on working groups, holding NEDs to account (1.2, 1.4)	DCD

		Report Title/**Date**
A.1	Annual plan and budget and five-year strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by Monitor (IDSP)	
A.2	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan DCD)	
A.3	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 (DCD)	
A.4	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks (BDU)	
A.5	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems (CEO)	
A.6	Business cases for expansion/change of services approved by EMT and/or Trust Board subject to delegated limits ensuring **alignment with strategic direction a**nd investment framework (BDU)	
A.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 (DFPI)	
A.8	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested (DFPI)	
A.9	Independent PLACE audits undertaken and results and actions to be taken reported to EMT, Members' Council and Trust Board (DHR)	
A.10	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events (DHR DCD DMECD)	
A.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 (DNCGS)	
A.12	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives (CEO)	
A.13	Service user survey results reported annually to Trust Board and action plans produced as applicable (DCD)	
A.14	CQC registration in place and assurance provided that Trust complies with its registration (DNCGS)	
A.15	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board (DNCGS)	
A.16	Strategic overview and analysis of partnerships in line with Trust vision and objectives through EMT (CRM system) (DMECD)	
A.17	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 (DCD)	
A.18	Staff wellbeing survey results reported to Trust Board and/or Remuneration and Terms of Service Committee and action plans produced as applicable (DHR)	

Gaps in control and what do we need to do to address these and by when	Date
- ORR 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 ORR	Oct.2016
- ORR no. 695 – Trust sustainability declaration, being mitigated through action plans as set out in the ORR	Quarter 4
- ORR no. 812 – commissioning intentions, being mitigated through action plans as set out in the ORR	Quarter 3

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.	Dec.2016

Rationale for current assurance level
- Independent well-led review assessed the Trust as Green in two areas and amber/green in eight areas with action plan in place to move towards green.
- Governance rating green and financial rating of 4 in line with Monitor's Risk Assessment Framework.
- Contracts agreed with commissioners and clarification of approach to Barnsley 0-19 services.
- Clear strategic approach identified for 2016/17 and operational plan submitted to Monitor following Trust Board approval.
- Contracts agreed with commissioners and clarification of approach to Barnsley 0-19 services.
- In the main, positive Friends and Family Test feedback from service users and staff.
- Strong and robust partnership working with local partners, such as Locala to deliver the Care Close to Home 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).
- Trust involved in local Vanguards and STP's.
- Chair and Chief Executive have key roles in Mental Health Network (NHS Confederation) and NHS Providers.
- Involved in development of Accountable Care Organisation in Barnsley.

Principle Delivery Objective: 2. Improve the quality and experience of the care we provide	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	As noted below	EMT, R&TSC, IM&T Forum, CGCS	A/G			

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
2.1	Lack of suitable and robust, performance and clinical information systems leading to lack of timely high quality management and clinical information to enable improved decision-making	A
2,2	Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience	A/G
2.3	Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation	A/G
2.4	Failure to create and communicate a coherent articulation of Trust Mission, Vision and Values leading to inability for staff to identify with and deliver against Trust Strategic objectives	G

Controls – systems and processes (what are we currently doing about the Strategic Risks?)		Director Lead
C.1	IM&T strategy in place and assured through IM&T forum supporting delivery of strategic objectives, agile working, estates strategy, underpinned by IM&T Forum, with defined terms of reference, chaired by a NED (2.1)	DFPI
C.2	Development of data warehouse and business intelligence tool supporting improved decision making (2.1)	DFPI
C.3	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (2.2)	DHR
C.4	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme (2.2)	DHR
C.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 (2.2)	DHR
C.6	Trust Board sets the Trust vision and corporate objectives as the strategic framework within which the Trust works (2.4)	CEO
C.7	Performance management system in place with KPIs covering national and local priorities reviewed by EMT and Trust Board (2.1, 2.2, 2.3)	DFPI
C.8	Executive Management Team ensures alignment of developing strategies with Trust vision and strategic objectives (2.4)	IDSP
C.9	Weekly serious incident summaries to EMT supported by quarterly and annual reports to EMT, Clinical Governance and Clinical Safety Committee and Trust Board (2.3)	DNCGS
C.10	Leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services (2.2, 2.3)	BDU
C.11	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 (2.4)	CEO
C.12	Risk assessment and action plan for delivery of CQUIN indicators in place (2.1)	IDSP
C.13	Risk assessment and action plan for data quality assurance in place (2.1)	DFPI
C.14	Values-based appraisal process in place and monitored through KPI's (2.2, 2.4)	DHR
C.15	Values-based Trust Welcome Event in place covering mission, vision, values, key policies and procedures (2.2, 2.4)	DHR
C.16	Mandatory training standards set and monitored for each staff group (2.2)	DHR
C.17	Staff Engagement Strategy approved by Board and action plan in place (2.2)	DHR
C.18	Medical Leadership Programme in place with external facilitation (2.2)	MD
C.19	OD Framework and plan re support objectives "the how" in place with underpinning delivery plan (2.2)	DHR
C.20	Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training (2.3)	DCD

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Report title/Date
A.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 (DCD)	
A.2	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems (CEO)	
A.3	Monthly review and monitoring of performance reports through EMT deviations identified and remedial plans requested (DFPI)	
A.4	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives (CE)	
A.5	CQC registration in place and assurance provided that Trust complies with its registration (DN)	
A.6	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans (DN)	
A.7	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken (DCD)	
A.8	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place (DCD)	
A.9	Assurance reports to Clinical Governance and Clinical Safety Committee covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place (DN)	
A.10	Monthly/Quarterly quality/integrated performance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken (DFPI)	
A.11	Annual report to Trust Board to risk assess changes in compliance requirements and achievement of performance targets, in year updates as applicable (DPFI)	
A.12	Nursing and Medical staff revalidation in place evidenced through report to Trust Board	
A.13	Data quality improvement plan monitored through EMT deviations identified and remedial plans requested (DFPI)	
A.14	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 (DN)	
A.15	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 (DHR).	
A.16	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board (DN)	
A.17	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 (DFPI)	
A.18	Monitoring of organisational development plan through EMT, deviations identified and remedial plans requested (DHR)	
A.19	Health Watch undertake unannounced visits to services providing external assurance on standards and quality of care (BDU)	
A.20	Independent CQC reports to Mental Health Act Committee provided assurance on compliance with Mental Health Act (DN)	
A.21	External accreditation against IIP supported by internal assessors, ensuring consistency of approach in the support of staff development and links with organisational objectives (DHR)	

Gaps in control and what do we need to do to address these and by when	Date
- ORR 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 ORR	October.2016
- ORR no. 850 – RiO upgrade implementation, being mitigated through action plans as set out in the ORR	August 2016
- ORR no. 852 – information governance incidents, being mitigated through action plans as set out in the ORR	July 2016
- ORR no. TBC - risk that current difficulties in maintaining adequate levels of registered nursing staff in working age adults acute services in Wakefield could lead to unsafe staffing levels being mitigated through action plans as set out in the ORR	August 2016
- ORR no. TBC - risk that the Trust's information systems could be the target of cybercrime leading to theft of personal data levels being mitigated through action plans as set out in the ORR	TBC
- ORR no. TBC - risk that the Trust IT systems do not meet staff needs or appropriate clinical standards leading to potential issues with patient safety and low staff morale being mitigated through action plans as set out in the organisational risk register.	TBC
- ORR no. TBC - long waiting lists to access CAMHS treatment and ASD diagnosis and treatment leading to a delay in young people starting treatment, potentially causing further deterioration in their mental health and a breakdown of their support networks being mitigated through action plans as set out in the ORR .	TBC TBC
- MH Act audits identified issues with recording around capacity and consent, being addressed through BDU action plans working with MH Act officers,	Quarter 3
- Internal audit report – patient property partial assurance with improvement requirements being addressed through BDUs.	TBC
- Mandatory training standards not being delivered in all areas, routine reports to teams identifying individuals out of compliance.	Quarter 4

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.	January 2017
- Further updates to CG&CS and Audit Committees on capture of clinical information and impact on data quality	October 2016
- Mandatory training standards not being delivered in all areas, routine reports to teams identifying individuals out of compliance.	Quarter 4
- Appraisal targets not being met in Q1 2016/17, routine reporting to EMT and R&TSC	October 2016

Rationale for current assurance level
- CQC inspection outcome of requires improvement. Services are safe, some areas for improvement, Trust has capacity to implement changes. Trust commended for caring approach of staff within services.
- Clear strategic approach identified for 2016/17 and operational plan submitted to Monitor following Trust Board approval.
- Contracts agreed with commissioners and clarification of approach to Barnsley 0-19 services.
- Successful delivery of plans for 2015/16.
- Well-led review undertaken by independent reviewer demonstrated through stakeholder engagement that the Trust's mission and values were clearly embedded through the organisation.
- Staff 'living the values' as evidenced through values into excellence awards.
- In the main, positive Friends and Family Test feedback from service users and staff.
- Embedding of new Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery.
- Strong and robust partnership working with local partners, such as Locala to deliver the Care Close to Home contract and establishment of Programme Board.
- Internal Audit report on leadership development – significant assurance with minor improvement opportunities.; Information Governance Toolkit (phase 1) – partial assurance with improvements required; Information Governance Toolkit (phase 2) – significant assurance; payroll – significant assurance with minor improvement opportunities; job planning – partial assurance with improvements required;

Principle Delivery Objective: 3. Improve our use of resources.	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	.As noted	AC, EMT	A			

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
3.1	Failure to manage costs leading to unsustainable organisation and insufficient cash to deliver capital programme	A
3.2	Failure to develop required relationships or commissioner support to develop new services/expand existing services leading to contracts being lost, reduction in income	A
3.3	Failure to deliver efficiency Improvements/CIPs	A
3.4	Capacity and resources not prioritised leading to failure to meet strategic objectives.	A

Controls – systems and processes (what are we currently doing about the Strategic Risks?)		Director Lead
C.1	Independent "Well led" review of governance arrangements commissioned and action plan in place (3.1, 3.2)	DCD
C.2	Annual financial planning process CIP and QIA process (3.1, 3.3)	DFPI DHR
C.3	Financial control and financial reporting processes (3.1, 3.3)	DFPI
C.4	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 (3.4)	DFPI IDSP
C.5	EMT review of market assessment against a number of frameworks including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power (3.2)	IDSP
C.6	Weekly Operational Requirement Group chaired by Chief Executive providing overview of operational delivery, services/resources, identifying and mitigating pressures/risks (3.1, 3.3)	CEO
C.7	Standing Orders, Standing Financial Systems, scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities (3.1)	DFPI DCD
C.8	Performance management system in place with KPIs covering national and local priorities reviewed by EMT and Trust Board (3.1)	DFPI
C.9	Project Management office in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities (3.4)	IDSP
C.10	Standardised process in place for producing businesses cases with full benefits realisation (3.1)	DFPI
C.11	Innovation Framework in place, Innovation fund established to pump prime investment to deliver service change and innovation (3.4)	DHII
C.12	Service line reporting/ service line management approach (3.1)	DFPI
C.13	Finance managers aligned to BDU's acting as integral part of local management teams(3.1,)	DFPI BDU
C.14	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (3.4)	DHR
C.15	Contingency/reserves – budget for anticipated risks of slippage/ under-delivery (3.1)	DFPI
C.16	Development of joint Quality Innovation Productivity Prevention (QIPP) plans and Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with QIPP plans and CQUIN targets in place. (3.3)	IDSP
C.17	Annual Business planning guidance in place standardising process and ensuring consistency of approach across the Trust, standardised process in place for producing businesses cases with full benefits realisation (3.1)	IDSP
C.18	Formal contract negotiation meetings with clinical commissioning and specialist commissioners underpinned by legal agreements to support strategic review of services (3.2)	IDSP
C.19	Trust performance management system in place with KPIs covering national and local priorities reviewed by EMT and Trust Board (3.3)	DFPI
C.20	Regular formal contract review meetings with clinical commissioning and specialist commissioning groups (3.4)	

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Report Title/Date
A.1	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	
A.2	Monthly review and monitoring of performance reports through EMT deviations identified and remedial plans requested	
A.3	Monthly/Quarterly quality/integrated performance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	
A.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	
A.5	Quarterly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity	
A.6	Sustainability action plans monitored through Sustainability TAG, deviations identified and remedial plans requested.	
A.7	Annual Governance Statement reviewed and approved by Audit Committee and Trust Board and externally audited	
A.8	Market analysis reviewed through EMT, market assessment to Trust Board ensuring identification of opportunities and threats	
A.9	QIPP performance monitored through delivery EMT, deviations identified and remedial plans requested	
A.10	Remuneration and Terms of Service Committee receive HR Performance Reports, monitor compliance against plans and receive assurance from reports around staff development, workforce resilience	
A.11	Innovation fund allocation approved through EMT with guidance to ensure consistency of approach and alignment with strategic priorities and corporate objectives	
A.12	Benchmarking of services and action plans in place to address variation	
A.13	Annual plan and budget and five-year strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by Monitor (IDSP)	
A.14	Innovation fund allocation approved through EMT with guidance to ensure consistency of approach and alignment with strategic priorities and corporate objectives	
A.15	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 (BDU)	
A.16	Strategic overview and analysis of partnerships in line with Trust vision and objectives through EMT (CRM system) (DMECD)	
A.17	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place (DCD)	

Gaps in control and what do we need to do to address these and by when	Date
- ORR no. TBC - risk that the Trust may run out of cash given the high value capital programme committed to, leading to an inability to pay staff and suppliers without DH support.	TBC
- ORR no. TBC - risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	TBC

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	Quarter 3
- Completion of review of decision-making framework (Scheme of Delegation) to inform delegated authority at all levels (to Audit Committee)	October 2016
- Review of contingencies and reserves to meet potential shortfall in CIP	October 2016

Rationale for current assurance level
- Independent well-led review assessed the Trust as Green in two areas and amber/green in eight areas with action plan in place to move towards green by end of Q1 2016/17.
- Holding significant income steams with local authorities in the current climate will generate risk.
- Risk of potential STP driven change may impact on our service portfolio.
- Clear strategic approach identified for 2016/17 and operational plan submitted to Monitor following Trust Board approval.
- Contracts agreed with commissioners and clarification of approach to Barnsley 0-19 services.
- Building on successful delivery of plans for 2015/16
- Internal audit reports – management of service level agreements – partial assurance with improvements required; financial management and reporting – significant assurance with minor improvement opportunities; risk management and board assurance framework – significant assurance.
- CQC inspection outcome of requires improvement. Services are safe, some areas for improvement, Trust has capacity to implement changes. Trust commended for caring approach of staff within services.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Risk profile Trust Board 19 July 2016

Consequence (impact/severity)	Likelihood (frequency)				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Catastrophic (5)			< Local commissioning intentions (812) ! Availability of cash to support the Trust's capital programme	= Trust sustainability declaration made in five-year strategy plan (695) = Staffing pressures in Wakefield (TBA) > Increase in information governance incidents (852) ! Loss of contracts and impact on Trust sutainability	
Major (4)				< Reduction in local authority funding to commission services (772) ! Trust systems target of cyber-crime ! Trust IT systems do not meet the Trust's needs ! Access to child and adolescent mental health services	= Reduction in local authority funding to provide services (275) = Upgrade to RiO (850)
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.

ORGANISATIONAL LEVEL RISK REPORT

Trust Board 19 July 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	Risk Responsibility	BDU / Directorate	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/ Next milestone	Risk review date
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 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.	➢ 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 regarding delivery, such as delayed transfers of care and service users in settled accommodation.	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 planned activity in each service line is 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 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. ➢ Identification of leading indicators to highlight where local authority service change and or benefits changes lead to increased demand. To be led by Health Intelligence team ➢ Quarterly Strategic overview of business and associated risks to EMT and Trust Board		B&W BDU Dir. (SR) (on behalf of BDU Dirs.)	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	12 (4*3)	Amber/ High (8-12)	Yes	Strategic Overview of Business and Associated Risk to EMT and Board Q3.	Trust Board July 2016
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 achieve the	➢ Risk scenario modelled in five-year plan submitted to Monitor in June 2014, which identified a tiered strategy to achieve sustainability which assumes	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.		Dir. of Finance (MB)	Plan submitted to regulator May 2015 Updated operationa	Monthly review EMT Transformation Board review Quarterly updates to Board	8 (2*4)	Amber/ high (8-12)	Yes	Report to EMT and Trust Board re refresh of 5 year plan	Trust Board July 2016

			transitions identified in the five year plan as the Trust may become operationally, clinically and financially unsustainable in its current configuration.	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. ➢ Updated position submitted in 2016/17 operational plan submitted to NHS Improvement on 18 April 2016. Demonstrates recurrent financial surplus after achievement of challenging CIP.					➢ 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. ➢ Active engagement in Strategic Transformation Plan/Leadership of West Yorkshire STP. ➢ Development of pricing strategy to engage with commissioners in 2016/17 ➢ Enhanced management of CIP programme in 2016/17 including targeted admin review; effective management of interims ➢ Refreshed 5 year forward plan to EMT and Trust Board.			l plan submitted to Monitor April 2016						
772	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	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, and could also lead to quality issues as a consequence of lack of care home placements available.	➢ 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 safe transfer plan 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. ➢ Service Line strategy review work tested with Trust Board identified direction of travel for service lines which are challenged by local authority austerity and commissioning practices. Enables timely decision making (exit/ partner etc.) as opportunities arise. ➢ Link with STP and impact of wider system planning		Dir. of Finance (MB)	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	Report to EMT and Trust Board October 2016 re links to STP and wider system planning..	Trust Board July 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 by impact of local commissioning	➢ Develop a clear service strategy through the internal Transformation Programmes to engage commissioners and service users on the value of services	5 Catastrophic	3 Possible	15	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	Loss of income could be in the order of £1m	Dir. of Finance (MB)	Annual plan Contract development plans Including in Vanguard action	Monthly at EMT. Quarterly risk and business board.	8	Amber/ high (8-12)	Yes	Investment appraisal report to Trust Board Q3	Trust Board July 2016

			intentions from CCGs and local authorities including 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.	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.					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. ➢ Further alignment of Contracting and Business Development functions to support a proactive approach to retention of contract income and growth of new income streams ➢ Quarterly Investment Appraisal Report to EMT and Trust Board,	- £5m		plans						
850	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	The upgrade to RiO V7 has resulted in system functionality and operational issues in several areas which are impacting on the Trust's ability to effectively support clinical services operationally and in the production and submission of central returns and accurately record clinical coding information.	➢ Daily issue management ongoing ➢ IM&T co-ordinating with clinical services and P&I colleagues in reviewing /testing resolutions provided by system supplier Servelec Healthcare in respect of system usability and dataset submission reporting ➢ Issues identified and raised with the supplier and the proposed solution is currently being tested with the Trust. ➢ Update of national OCS files to RiO. ➢ New version of medicode available for install which includes the Diagnosis module. Not yet implemented by supplier due to system performance issues the lack of this module is impacting on the clinical coding accuracy ➢ Lack of access to RiO and information not always saving has resulted in a reduction in activity volumes and data quality. ➢ The Health & Social Care Information Centre have been informed and a request to put a health warning on our data has been sent. Commissioners are being updated during monthly routine	4 Major	5 Almost certain	20	Red/extreme /SUI risk (15-25)	➢ Issue management activities ongoing on a daily basis internally to review and monitor progress resolution and to manage effective communications ➢ Daily liaison ongoing with RiO system supplier regarding issue resolution and updates on progress ➢ Issue management resolution separated into technical (IT infrastructure) and functional (clinical system) ➢ All Technical issues resolved locally by Trust/Daisy with functional issues being addressed by RiO system supplier ➢ Internal Trust investigation to serious untoward incident completed ➢ External Audit of RiO V7 implementation commissioned, recommendations received and number already implemented or being planned. ➢ Programme of refresher training for staff and teams established together with additional specialist support to enable staff work through and address issues resolved – being conducted on a site by site basis in collaboration with PGCs. ➢ Weekly monitoring of RiO V7 issue resolution and progress ongoing at Trust Executive Management Team level and at ORG. ➢ Issue resolution testing has been formalised and issues are not closed until positive confirmation has been obtained from clinical services impacted ➢ Contract terms reviewed – this will be in conjunction with the supplier		Dir. of Finance (MB)	Taking stock of issues resolved and where changes in ways of working may be required by 31/07/2016.	Trust Board (Monthly), EMT (Weekly), ORG (weekly). within IM&T senior Management Team (daily) Weekly with BDU clinical representatives Trust wide communications issued twice a week		Yellow/ Moderate (4-6))	Yes	Report into IM&T Forum August/September 2016.	Trust Board July 2016

				meetings. ➢ Executive management meetings held with Servelec Executive Team to ensure focus and prioritisation of issues ➢ Support Contract under review														
852	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 policies 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	Dir. of Finance (MB)	ICO external monitoring of progress by external evidence/desk based reviews	Progress monitored through EMT and weekly risk scan	15	Green/low (1-3)	Yes	Trust signed an undertaking with the Information Commissioner 's Office in June 2015 due to continued breaches of Principle 7. Half year review by ICO repots good progress to date. ICO will undertake audit in 2016 of all Data Protection Practices w/c 28th November 2016) Report with recommendations into EMT 21st July 2016.	Trust Board July 2016
TBA	Corporate/ organisation level risk (corporate use only EMT)	Wakefield BDU	Risk those current difficulties in maintaining adequate levels of registered nursing staff in working age adults acute services in Wakefield could lead to unsafe staffing levels.	Detailed Action Plan in place, monitored weekly by the BDU Trios, twice-weekly by the Ward Managers and monthly by the Service Line Meeting Recruitment process in underway. Action plan New escalation plan agreed in March 2016, which includes use of additional hours, bank/agency staff, review of staff on secondment, review of leave, review of registered nurses in other services and other staff, re-deployment of community/non-ward clinical staff within ward,	5	4	20	Red/extreme /SUI risk (15-25)	➢ Recruitment process underway. ➢ Overtime payments agreed on a temporary basis to ensure continuity of care for Service users and reduce reliance on agencies. ➢ Business Continuity Plan in place		B&W BDU Dir. (SR)		Monitored daily at BDU level and weekly by EMT through risk scan process	6	Yellow / moderate (4 – 6)	Yes	Report into EMT August 2016.	Trust Board July 2016

				re-deployment of registered nursing staff. Weekly review to limit admissions on Trinity 2.															
TBA	Corporate/ organisation level risk (corporate use only EMT)	Calderdale and Kirklees	Long waiting lists to access CAMHS treatment and ASD diagnosis and treatment lead to a delay in young people starting treatment, potentially causing further deterioration in their mental health and a breakdown of their support networks. Beyond the initial assessment waiting time, data monitoring is not yet able to accurately identify waiting times in line with each pathway. The waiting lists and the lack of clarity of information impact negatively on the confidence of Commissioners and young people and their families in the service.	If a child / young person deteriorates whilst on the waiting list they receive an immediate emergency response. The implementation of a single point of access system has shown early indication of a reduction in referrals to the specialist CAMHS service, therefore releasing capacity. Extensive work, supported by the PMO, is underway to develop the care pathways and agree consistent recording and monitoring of activity and outcome data. The Trust is working closely with Commissioners to manage the situation within available resources for ASD. Commissioners have established an ASD Board and local commissioning plans are in place to start to address backlog for ASD. Future in Mind investments are in place to support the whole CAMHS system and therefore release demand on specialist CAMHS. Healthwatch Barnsley and Wakefield have carried out monitoring visits and are supporting local teams with the action plans.	4	4	16	Red/extreme /SUI risk (15-25)	➢ Work with the PMO is progressing to better understand demand and capacity so that resources can be best utilised. ➢ Work is ongoing to develop care pathways and will identify consistent recording of activity and outcome data. ➢ The team is working with commissioners to implement additional solutions for people waiting for ASD assessment and treatment. ➢ The team is contributing to the locality plans and reviewing the impact of the Future in Mind investments on demand for specialist CAMHS		Dir. of Specialist Services (CH)	October 2016	Performance reporting to EMT Assurance report to Clinical Governance Committee Individual district performance reports reviewed by BDU	6 (2-3)	Yellow/ Moderate (4-6)			Trust Board July 2016

Trust Board 19 July 2016
Agenda item 12

Title:	**Board self-certification and assessment of operational, clinical and quality risks (NHS Improvement Quarter 1 return 2016/17)**
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 NHS Improvement'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 NHS Improvement highlights issues previously reported to Trust Board through performance and compliance reports.
Executive summary:	Due to the timing of Trust Board in July 2016, full performance information is not available to complete the exception report usually presented to Trust Board prior to submission to NHS Improvement. Trust Board will be asked to delegate authority to the Chair and Chief Executive to approve the final version of the Trust's governance return, which includes exception reporting. The finance submission, which is due for submission on 22 July 2016, is summarised in the finance report (agenda item 9.2). <u>Quarter 1 assessment</u> Based on the evidence and assurance received by Trust Board through performance and compliance reports, the Trust is currently reporting a governance risk rating of **green** under Monitor's Risk Assessment Framework; however, as reported to Trust Board in June 2016, the Trust may fail the target for Improving Access to Psychological Therapies (IAPT). As this would be the third consecutive quarter the Trust has not achieved this target, it may trigger NHS Improvement intervention with the potential to impact on the Trust's green governance rating. An update will be provided to Trust Board as part of the performance report (item 9.1). The Trust is reporting a continuity of services/finance risk rating of **green** with a score of **4**. <u>Self-certification</u> NHS Improvement 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 NHS Improvement 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 (subject to the Trust's position in relation to IAPT). - And that Trust Board can confirm there are no matters arising in the quarter requiring an exception report to NHS Improvement, which have not already been reported. The Framework also uses an in-year quality governance metric. At the time of writing this paper, NHS Improvement had not issued the governance template for Q1; however, it is expected that the metric will be the same as that used since quarter 4 of 2013/14, which relates to 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 with the caution noted above in relation to the IAPT target. <u>Exception report</u> Trust Board is advised that the exception report will contain the following items and is asked to consider whether any further narrative should be included based on the discussions at this meeting. - Care Quality Commission inspection outcome and Quality Summit. - Lead Governor appointment (for decision at the Members' Council on 22 July 2016). - IAPT target and any further performance issues. - Changes to Trust Board in relation to Chief Executive and Director of Finance appointments. - Third party reports. - Independent investigation of the implementation of the Trust's clinical information system (RiO) upgrade. - Routine performance items. - Any changes to services, such as 0-19 services in Barnsley and intermediate care services.
Recommendation:	**Trust Board is asked to NOTE the above report and to DELEGATE AUTHORITY to the Chair and Chief Executive to APPROVE the submission and exception report to NHS Improvement, subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**
Private session:	Not applicable

Trust Board 19 July 2016
Agenda item 13 – assurance from Trust Board Committees

Audit Committee

Date	12 July 2016
Presented by	Laurence Campbell
Key items to raise at Trust Board	➢ Trust-wide review of non-pay expenditure – progress ➢ Training for Audit Committee and, potentially, other Committees and Trust Board ➢ Triangulation of risk, performance and governance ➢ Internal audits of clinical record keeping/data quality and agile working project, which both received partial assurance opinions. Related concern from the Committee regarding the level of partial assurance opinions received. ➢ Agreement by the Committee to sign-off or be advised of (dependent on the contract value) for non-audit work undertaken by external audit

Remuneration and Terms of Service Committee

Date	7 July 2016
Presented by	Ian Black
Key items to raise at Trust Board	The main focus for the Committee was the consideration and approval of the Directors' performance related pay scheme for 2016/17, the review of Directors' portfolios and the management administration review update.

Equality and Inclusion Forum

Date	21 June 2016
Presented by	Ian Black
Key items to raise at Trust Board	The Forum considered: ➢ progress towards the Accessible Information Standard; ➢ progress towards Equality Delivery System 2 and towards the Trust's equality objectives; ➢ further work undertaken to support mental health service users moving into employment, volunteering and training; ➢ equality workforce annual report 2015 benchmarking; and ➢ the revised training offer.

Information Management and Technology Forum

Date	28 June 2016
Presented by	Ian Black
Key items to raise at Trust Board	The Forum received the report commissioned by Deloitte into the RiO 7 implementation, identifying learning points for the Trust. The key themes and recommendations were: • IT Environment: WES updates not clearly and consistently communicated; • technical complexity and resource capacity not presented in sufficient detail or subject to sufficient scrutiny; • execution of the implementation and go-live lacked a sufficiently

	robust readiness framework; • project arrangements and issue management did not adequately bring together the senior leaders of the Trust and Servelec. A number of the recommendations have already been acted upon with the remainder being planned. The most important issue is to address the outstanding system performance issues and a deadline for the end of July was agreed with the Forum. In relation to re-procurement of the Trust's clinical information system, the Forum was of the view that it would not be possible to undertake a robust and full tender exercise by April 2017. Further discussions will take place with Servelec and with Bradford District Care NHS Foundation Trust, which is in a similar position.