NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board (business and risk)
Tuesday 31 January 2017 at 9.30
Training room 1, Learning and Development Centre, Fieldhead, Wakefield

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 20 December 2016** (attached)

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

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

6. **Strategies for approval**
   - 6.1 Update to the risk management strategy (attached)

7. **Performance reports**
   - 7.1 Integrated performance report month 9 2016/17 including finance (attached)
   - 7.2 Customer services report Q3 2016/17 (attached)

8. **Governance items**
   - 8.1 Update to Trust Constitution (including Standing Orders) and Scheme of Delegation (attached)
   - 8.2 Update to the Treasury Management Policy (attached)
   - 8.3 Update to the Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) (attached)
   - 8.4 Update to the Customer Services Policy: management of complaints, concerns, comments and compliments (attached)
   - 8.5 Internal meeting governance framework (attached)

8.6 Guidance for the use of off-pay payroll (attached)

8.7 Receipt of minutes of partnership boards (attached)

9. Assurance framework and risk register (attached)

10. Board self-certification and assessment of operational, clinical and quality risks (attached)

11. Assurance from Trust Board committees

- Audit Committee 24 January 2017 (attached)
- Equality and Inclusion Forum 30 January 2017 (verbal item)

12. Trust Board work programme 2017 (attached)

13. Date of next meeting

The next meeting of Trust Board will be held on Tuesday 28 March 2017 Boardroom, Kendray, Barnsley.

Minutes of Trust Board meeting held on 20 December 2016

Present:	Ian Black	Chair
	Julie Fox	Deputy chair
	Laurence Campbell	Non-executive director
	Charlotte Dyson	Non-executive director
	Rachel Court	Non-executive director
	Chris Jones	Non-executive director
	Jonathan Jones	Non-executive director
	Rob Webster	Chief executive
	Dr Adrian Berry	Medical director / deputy chief executive
	Tim Breedon	Director of nursing and quality
	Mark Brooks	Director of finance and resources
Apologies:	Alan Davis	Director of HR, OD and estates
In attendance:	Dawn Stephenson	Director of Corporate Development (Company Secretary)
	Kate Henry	Director of marketing, communications and engagement
	James Drury	Interim Director of Strategic Planning
	Carol Harris	District Director – Forensic and Specialist Services
	Sean Rayner	District Director – Barnsley and Wakefield
	Karen Taylor	District Director – Calderdale and Kirklees
	Emma Jones	Integrated Governance Manager (author)
Guests:	Nasim Hasnie	Publicly Elected Governor (Kirklees), Members' Council
	Jeremy Smith	Publicly Elected Governor (Kirklees), Members' Council
	Mike Doyle	Deputy Director of Nursing
	Kiran Bali	The Insight Programme

TB/16/85 Welcome, introduction and apologies (agenda item 1)

The Chair Ian Black (IB) welcomed everyone to the meeting, in particular the observers. Apologies were noted as above.

TB/16/86 Declaration of interests (agenda item 2)

There were no declarations over and above those made in March 2016 or subsequently.

TB/16/87 Minutes and matters arising from previous Trust Board meeting held on 25 October 2016 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 25 October 2016 as a true and accurate record of the meeting.

TB/16/88 Chair and Chief Executive's remarks (agenda item 4)

IB reported that it was Jonathan Jones' (JJ) last meeting as a Non-Executive Director of the Trust. JJ served two full terms and at the request of the Board served an additional period. IB thanked JJ for his diligence and focus on estates, contracts and finance. IB advised that the Nominations Committee agreed to not replace JJ at this stage and aim to recruit in summer 2017. Due to this there will be the following changes to membership of Committees: Julie Fox (JF) would be a member on the Audit Committee, Charlotte Dyson (CD) would be a member on the Remuneration & Terms of Service Committee, and IB

would be a member on the Mental Health Act Committee. The committee memberships would be reviewed in summer 2017.

IB reported that the Barnsley integrated community equipment service were recently featured on BBC TV's The One Show. The team were also shortlisted for an Excellence award for 'improving the use of resources'. The service demonstrates how the Trust is interested in sustainability and how much the staff enjoyed their jobs.

Rob Webster (RW) provided an update to his written report:

- By way of introduction RW highlighted themes from service visits in the last fortnight that reflect the breadth and nature of our services, their impact on people's lives and the fundamental importance of supporting our staff:
  - Visit to the Care Navigation/Telehealth Service in Barnsley which supports patients with a long term condition through the deployment of four innovative care pathways; Care Navigation, Health Coaching, Telehealth Vital Sign Monitoring and Post Crisis Support. The aim of the service is to empower patients to better self-manage through positive behaviour change.
  - Visit to the health integration team who support the healthcare needs of refugees and the homeless. The team have worked closely with local GPs to help address the significant increase in TB cases and with third sector partners to help support vulnerable refugees.
  - Guest speaker at the Kirklees Mental Health Carers Forum on 12 December 2016 included feedback regarding staff that was mostly positive. It highlighted that carers also believe staff work in a system that is "broken" and that we don't always get our communications right when changes happen. The forum provided a real opportunity to work with carers to help shape the system.
  - Visit to see the impact of the fire on our estate, where a huge amount of credit should go to Trust staff for the management of the fire at Trinity 2 in Wakefield and its aftermath.
- There continues to be significant and sustained requests from the NHS and the broader public sector to tackle issues in social care funding, with the most recent speculation suggests that councils may be given greater powers to raise funds for social care through an increase in the "precept". This "precept" gives them an option for a 2% council tax levy to be applied.
- CQC have published findings of their review into the way NHS organisations review and investigate the deaths of patients in England. The report, entitled *Learning, candour and accountability*, includes a series of recommendations. They include the creation of a new standardised national framework for identifying potentially avoidable deaths and guidance on reviewing and learning from the care provided to people who die, particularly those with a learning disability or mental health problem. There will be several actions for Trusts to implement from April 2017.

It was RESOLVED to AGREE that the Director of Quality & Nursing acts as the Executive lead and the Chair of the Clinical Governance and Clinical Safety Committee as the Non-Executive Director lead in relation to any actions from the CQC Learning, candour and accountability report.

- The focus of STPs will shift from planning to engagement and implementation. This includes a suggestion that they should be seen as "implementation partnerships" with changes to governance that reflect this. The details of Transformation Funding arrangements have emerged with access to these funds through a bidding process, linked to STPs. In West Yorkshire, we are looking to coordinate the bids through the STP.

- Locally there have been some significant changes in leadership at the Barnsley Hospital NHS Trust and Wakefield Metropolitan District Council.
- The Brief monthly communication to all Trust staff has been included as an appendices and sets out current contextual issues, delivery updates, risks and priorities.

TB/16/89 Update on Health & Wellbeing Strategies (agenda item 5)

Karen Taylor (KT) introduced the paper which highlighted the status of Health & Wellbeing Strategies across Barnsley, Calderdale, Kirklees and Wakefield.

Laurence Campbell (LC) asked how the Health & Wellbeing Strategies align with the Sustainability and Transformation Plans (STP) and Accountable Care Organisations (ACO). RW confirmed that the West Yorkshire STP was built on the six local Health & Wellbeing Strategies, including those in front of the Board, and it would be expected to include any ACO arrangements. The South Yorkshire STP was similar in approach.

Following a question about the different status of SWYPFT on each of the Health and Wellbeing Boards (HWBB), RW advised that when HWBBs were originally created they were seen as commissioner boards between CCGs and Local Authorities. Following a national intervention, there was a requirement to engage providers. This is left to local discretion and we have a mixed status as a result.

Sean Rayner (SR) highlighted that the draft Health & Wellbeing Strategy for Barnsley had been provided for ratification by partner boards. Three priorities in the strategy were in line with the Trust's strategic direction: reducing the incidence of smoking; improving early help for those suffering from mental ill health; and joining up services for supporting older people (focusing on dementia and falls). The Strategy has been written so that it was easy to understand and the Health & Wellbeing Board would develop a detailed action plan which would also come to partner boards for ratification.

The Trust Board discussed the good alignment between the strategy and the discussions about the future of the trust. The Board agreed that it should support the strategy, reflecting that the Trust should have an expectation that the Health & Wellbeing Strategies are reflected in the commissioning intentions about service scope and the joining up of services. It was agreed that the Chair should write to commissioners.

Action: Ian Black

It was RESOLVED to ACCEPT the attached Health and Wellbeing Strategies for Calderdale, Kirklees and Wakefield for information only and REQUEST that any updates come to the Trust Board for approval. It was AGREED that the Board should accommodate feedback from Health & Wellbeing Boards into its governance structure.

It was RESOLVED to APPROVE the revised Barnsley Health and Wellbeing Strategy (2016-20).

TB/16/90 Strategy refresh (agenda item 6)

James Drury (JD) presented the paper on the draft Strategy refresh for the Trust Board to note the progress to date and the intended process for completion. The Strategy refresh document brings together the learning gained from the recent engagement and insight exercises with stakeholders. This has included discussion sessions, online surveys, social media, and workshops with Members Council, Trust Board, and the Extended Executive Management Team. The Trust's service model is to provide integrated care to people in their community, all services are focused on principles of recovery and co-production, working with the strengths of each person and those of their carers and wider community.

The Trust's strategic goals are:

- Improve people's health and wellbeing.
- Improve the quality and experience of all that we do.
- Improve our use of resources.

The Trust's strategic choices have been identified as:

- We will take a place-based approach to the delivery of care. Except where a service based approach over a wider area is more appropriate e.g. forensic mental health.
- We will continue to be a combined provider of care with expertise in prevention, physical healthcare, learning disabilities and mental health.
- We will act as a system integrator, and in some places we may host accountable care partnerships. We will do this alongside our service delivery activities.
- We will become an exemplar of co-production, valuing both the service user and clinical perspectives.

In order to make a marked difference in delivery of the Trust's mission and strategy, the Trust has set the following ambition for the next five years: "**Become the leading operator of accountable care systems in West and South Yorkshire, by co-producing with people a holistic and recovery focused approach to improving health outcomes for everyone**".

The Trust Board discussed the refreshed strategy, confirming it reflected the discussions in recent Board sessions and the feedback from stakeholder events. The Board felt that there was a need to better explain the strategy across the organisation and suggested a simplified public facing version. This would be supported by the branding and communication work in development.

Action: James Drury / Kate Henry

It was RESOLVED to NOTE the progress made with the strategy refresh and the process and timescale for completion.

TB/16/91 Performance reports month 8 2016/17 (agenda item 7)

Integrated performance report month 8 2016/17 including finance (agenda item 7.1)

Mark Brooks (MB) presented the paper and highlighted that despite a range of pressures the Trust was green on the majority of NHS Improvement indicators.

The revised format, following involvement by Non-Executive Directors was agreed as the right way forward. The chair also noted how well the revised format of reporting to Governors was received at their November meeting.

Tim Breedon (TB) outlined the key quality headlines:

- NHS Safety Thermometer - Medicines Omissions is an indicator within the CQUINs for the west and has been identified as at risk of achievement.
- Whilst agency spend reduced by £0.1m in the month it remains well above both ceiling and forecast. Further work is under way to understand and control the use of agency staff.
- Safer staffing fill rates by BDU were at 113% in October 2016, which was a good position. TB informed the Board that this was sometimes achieved through a dilution of registered to non-registered staff, which was used to maintain safe staffing levels. This is now routinely reported to the Board, where a trigger point of 80% [check] of registered staffing is met. Three wards fell below the threshold for registered nurses, but overall were over 100% and had been scrutinised by quality team.
- This is part of the revised risk scan approach conducted on a monthly basis on CQC themes which helps inform conversations at Trust Board in addition to a weekly risk scan received by the Executive Management Team.
- A national review by the CQC has found that the NHS is missing opportunities to learn from patient deaths and that too many families are not being included or listened to when an investigation happens. The report will be considered by the Trust Board in 2017.
- The CQC have re-visited our core services that required improvement or have a regulatory breach. The inspectors have revisited the teams within the community mental health services for older people, long stay rehabilitation and recovery, inpatient wards for older people, Forensic services, LD community services and CAMHS. We await feedback from the CQC as to the findings of the visits. No immediate concerns have been raised.
- The first year of the Trust's sign up to safety plan has recently been reviewed and a number of positive outcomes identified around the reduction in harm. A report will be presented to the Clinical Governance & Clinical Safety Committee.

The Board sought assurance of monitoring of the increase in incidents. TB advised that a quarterly incident report is received by the Clinical Governance & Clinical Safety (CG&CS) Committee which focuses on the categories, locations, numbers and any themes and trends. A learning report identifies key themes and actions. The Executive Management Team also received a weekly risk scan. TB confirmed that there were no other items for escalation to the Board at this point.

The Board discussed how the scrutiny of clinical risks, in line with the risk tolerance, would be supported by the CG&CS subcommittee. This was in line with the work presented by Deloitte to the Board as part of our internal audit.

MB outlined the key NHS Improvement (NHSI) headlines:

- Majority of NHSI metrics show the Trust meeting targets.
- New metrics were introduced as part of the Single Oversight Framework which includes the recording of data around employment, school attendance and accommodation. This data has not been recorded previously and an action plan would need to be agreed on how it was addressed.
- Below target on one of the IAPT metrics in Barnsley and Kirklees with work commencing with GPs to understand why referrals were not progressing into recovery.

JD outlined the key transformation headlines:

- A number of transformation projects were nearing completion.

- Acute and community care mental health transformation was currently implementing the 'core and enhanced' community pathways which have been devised through this project. This is due to be completed in Q4 of 2016/2017.
- Barnsley community nursing transformation was currently mobilising workforce changes required to move the service to a six neighbourhood model and supporting new ways of working. Implementation commenced 1 October 2016. Rebranding of the service to 'Neighbourhood Nursing Service' has taken place and communications held with primary care practices.
- Specialist adult learning disability services transformation has moved to a benefits realisation phase. A project closure report is being prepared for submission to EMT in January 2017 which will focus on benefits identification, measurement, timetabling and tracking and on post implementation quality impact assessment.

MB outlined the key finance headlines:

- The NHS Improvement financial risk rating remains capped at level 3 due to the agency metric rating of 4. Given the in-month deficit position ratings associated with underlying financial performance (and performance against plan) have deteriorated from 1 to 2.
- November 2016 financial performance is a normalised deficit position of £566k compared to planned surplus of £181k, cumulative surplus of £964k is £718k below plan. The main factors being continued and increased cost pressures on Out of Area beds and CQUIN income. Action is being taken to reduce expenditure and whilst forecast remains in line with plan there is a real risk this will not be achieved.
- Agency expenditure in November 2016 is £0.7m which represents a £0.1m reduction compared to October. Spend has reduced across nursing and non-clinical staff but has increased for medical staff. Year to date this position is 85% over the NHSI cap.
- The Trust cash position is £1.5m less than plan at month 8 due to the level of accrued income and higher creditor payments.
- Capital expenditure is behind plan at October by £1m excluding VAT reclaims.

The Board discussed the approach to managing finances for this year. The Board supported the significant action in place to reduce expenditure and contain costs. The Board agreed that further Non-Executive Director involvement in Executive Management Team meetings would strengthen the degree of constructive challenge and assurance.

MB outlined the key workforce headlines:

- There is a risk around IG training compliance with almost 2,000 staff due to complete mandatory training by end of January 2017. This is a consequence of the cycle of training and could be exacerbated by the national changes to e-learning packages. TB explained that the Trust deadline of end of January was intended to help deliver compliance by the statutory deadline of 31 March.

Action: Mark Brooks / Alan Davis

- Reporting against Mental Health Act/Mental Capacity Act training compliance would be available from January 2017.

It was RESOLVED to NOTE the Integrated Performance Report, strengthen the Non-Executive Director involvement in the appropriate Executive Management Team meetings and continue with the current format through until March 2017 before further review.

TB/16/92 Governance matters (agenda item 9)

Approval of the Operational Plan 2016/17 and 2017/18 (agenda item 9.4)

JD introduced the paper which summarised the process undertaken in developing the operational plan and enable the approval of that plan for submission to NHS Improvement on 23 December 2016.

MB reminded the Trust Board of a few key points in considering the plan:

- That the control total had been reduced from £1.4m to £1m (pre any STF funding).
- The income included in the plan was based on what was currently known, which was subject to contract negotiations.
- All of the national guidance and assumptions had been taken into account including the 0.1% increase based on the latest advice from commissioners.
- There was a risk of a of £1.5m for 2016/17 which may have an impact on our ability to meet the control total as well as a further degree of risk around out of area beds.
- Since the paper was written, a further potential saving of £500-800k has been identified in 2017/18.

A Non-Executive Director sought clarification on the impact of not agreeing the control total. MB confirmed that possible implications if the control total is not accepted would be an impact on the Trust's risk rating, no access to external finances, withholding of the £1.4 million STF-funding, and further scrutiny by NHS Improvement (NHSI). This would also mean the Trust would not be operating at a surplus, which would put pressure on cash availability and the ability to invest in our services and meet capital investment needs.

Non-Executive Director members of the Trust Board would be invited to the Executive Management Team meetings where the operational plan is discussed for further understanding of the detail behind the cost improvement programme.

It was RESOLVED to APROVE the public facing summary in principle and the Board REQUESTED an Easy Read version be available.

It was RESOLVED UNANIMOUSLY to CONFIRM the *conditional* acceptance of the control totals pre Sustainability and Transformation Funds of £1.02m for 2017/18 and 2018/19 based on the assumptions identified in the plan.

It was RESOLVED to APPROVE the submission of the operating plan subject to changes agreed at the private session of the Trust Board.

It was RESOLVED to DELEGATE the approval of the final document to the Trust Chair and Chief Executive for final submission in line with the timescales outlined.

TB/16/93 Exception reporting (agenda item 8)

TB/16/93a 2015 Community Mental Health survey (agenda item 8.1)

Dawn Stephenson (DS) introduced the paper on the annual survey conducted by the CQC of people over 18 in the service between February and March 2016. The response rate for the Trust was 32% which was above national average of 29%. The Executive Management Team have agreed three themes for focus, looking at best practice internally and externally, which may be incorporated into the Integrated Performance Report for monitoring:

- Service users being involved in decisions about their own care.
- Service users being provided with information around peer support.

- Service users being provided with information around finding support for financial advice or benefit.

The Board debated the results of the survey and agreed the focus suggested by the Executive.

It was RESOLVED to NOTE the content of the report.

TB/16/94 Governance matters (continued, agenda item 9)

TB/16/94a Compliance with NHS Constitution (agenda item 9.1)

DS introduced the paper which provides assurance to Trust Board that the Trust meets the rights and pledges set out in the NHS Constitution in relation to patients and staff, and that it is mindful of the commitments in the NHS Constitution in delivering, planning and developing its services.

It was RESOLVED to APPROVE the paper which demonstrates how the Trust is meeting the requirements of the Constitution.

TB/16/94b CQC well-led review update (agenda item 9.2)

TB introduced the paper which describes the Trusts understanding of the well-led review revisit process and the work required to ensure that the Trust can explain how we have responded positively to our CQC report, in a manner consistent with our desire to improve and aim to be outstanding. The Trusts approach is also consistent with our strategic objective to improve the quality and experience of all that we do. A briefing session for the Trust Board would be scheduled when the inspection plan was received from the CQC.

It was RESOLVED to NOTE the update.

TB/16/94c Agency staff self-certification (agenda item 9.3)

Dr Adrian Berry (Abe) introduced the paper on the NHS Improvement agency self-certification checklist submitted on 30 November 2016. The Board discussed the self-certification process at previous meetings and this paper clarified the submitted paperwork.

The Board discussed how the self-certification process allowed for the description of current control measures in place and further proposed actions. This will ensure that there was a robust operational grip on agency usage together with a strategic plan for more effective resource utilisation. The process also ensured that there was clear executive level accountability for reducing specific areas of agency spend. Specific challenge was given to plans that were outlined with regard to governance and accountability, the timely use of data, adopting robust process for approving and reducing agency use and working within the wider health economy.

The Board sought a continued focus on reporting this issue.

It was RESOLVED to NOTE the submission of the self-certification which was completed in accordance with the required timescale.

TB/16/94d Trust Board work programme 2017 (agenda item 9.5)

IB highlighted that it was important for the Trust Board to have a work programme in place which identifies key Board considerations and actions required in a year. The work programme ensures allocation to relevant meetings and allows for both management and the Board to be aware of the planned approach. The work programme links to the

organisational risk register and assurance framework, addressing principal risks to the delivery of the Trust's strategic objectives.

The Trust Board discussed further items that could be incorporated into the work programme including progress on IM&T, regular review of mortality, a forward look on performance and monitoring, and reporting from external Committees. It was important to ensure the correct sequencing of timing of items from Committees through to the Board.

Action: Dawn Stephenson

It was RESOLVED to AGREE the work programme for 2017.

TB/16/94e Membership of Wakefield Multi-Speciality Community Provider Committee in Common (agenda item 9.6)

DS introduced the paper which describes the plan to establish a Multispecialty Community Provider (MCP) to serve the population of Wakefield Metropolitan District. It was requested that the Board agree that the Trust be a member of the Wakefield New Models of Care Partnership Board, established as a ''Committee in Common'' (CiC), as the first stage of the governance arrangements for the new MCP organisation which aligns with the ambition of the Trust's strategy.

It was RESOLVED to SUPPORT the Trust being a member of the Wakefield New Models of Care Partnership Board and the creation of a Multi-Speciality Community Provider, serving the population of Wakefield CCG.

It was RESOLVED to AGREE that the Chief Executive works with partner organisations in the development of the details regarding the Committee in Common, and that the Chief Executive provides timely updates to the Board, including ratification of any final form of the Committee.

TB/16/95 Assurance from Trust Board Committees (agenda item 10)

The Trust Board discussed how further assurance could be provided rather than an outline of matters discussed and agreed that risks should be identified with assurance on the actions being taken.

TB/16/95a Remuneration and Terms of Service Committee 4 November 2016

RC reported that the Committee discussed the final metrics in the Directors Performance related pay scheme and the results of the staff wellbeing and engagement survey and action plan.

TB/16/95b Clinical Governance and Clinical Safety Committee 8 November 2016

JF reported that the Committee received an update on Child and Adolescent Mental Health Services (CAMHS) through an in-depth report with a single point of access (SPA) in place. Concern was raised around waiting times. The CQC action plan was discussed along with the NICE InPhase assurance and QI monitoring system to assist with NICE compliance and the Quality Impact Assessment (QIA) of the cost improvement programme.

TB/16/95c Estates Forum 15 November 2016

JJ reported that the Forum discussed hospital sites in Barnsley. The current estate continues to be evaluated to ensure areas are fit for purpose and if services were located onto one site what would happen with the vacant sites.

TB/16/95d Mental Health Act Committee 15 November 2016
CJ reported a risk around the compliance with the Mental Health Act Code of Practice and requested that it be an area of focus by the Executive Management Team. Another risk identified was around ability to analyse data by ethnicity.

TB/16/95e Nominations Committee 13 December 2016
IB reported as advised under the Chair and Chief Executive's remarks the Nominations Committee agreed to not replace JJ at this stage and look to recruit in summer 2017

TB/16/96 Use of Trust seal (agenda item 11)

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

TB/16/97 Date of next meeting (agenda item 12)

The next meeting of Trust Board will be held on Tuesday 31 January 2017 at Fieldhead, Wakefield.

Signed …… Date ……

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 31 January 2017
Agenda item 4

Title:	Chief Executive's Report
Paper prepared by:	**Chief Executive**
Purpose:	To provide the strategic context for the Board conversation
Mission/values:	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers/ previously considered by:	This paper references several of the papers in the public and private parts of the meeting and also external papers and links.
Executive summary:	➢ *The Brief* for all staff on 5 January 2017 has been shared with Board members. This sets out current contextual issues, delivery updates, risks and priorities ➢ Since publication of *The Brief* we have seen: o The NHS continues to be a major political issue, with winter pressures affecting all services. o The Prime Minister made a major speech outlining the fundamentals of a UK position on Brexit. o National NHS bodies continue to promote collaboration across organisations to deliver the five year forward view. o The Care Quality Commission (CQC) is consulting on how it regulates quality within a more joined up system and NHS Improvement and the CQC are jointly consulting on leadership and use of resources in NHS Trusts. o NHS England launched its *AHPs into action* report which showcases the role which AHPs play in delivering improvement in care. o Niall Dickson has been appointed at the CEO of NHS Confederation and will start in February. o In West Yorkshire, we are working towards a new approach to overseeing the delivery of the Sustainability and Transformation Plan (STP), including more collaborative commissioning functions at West Yorkshire level, local place based planning, and more collaboration between providers. o Bids were submitted by our local STPs for transformation funding in January. o Yorkshire Smokefree has been nominated for a HSJ Value award; and the women's pathway team in Forensics nominated for the Yorkshire and Humber Innovation, Improvement and Impact Awards. o The Board papers show that the organisation is managing significant stress and pressure on its finances and elements of operational delivery. o The CQC are currently reinspecting elements of the Trust, including a well led review that covers the period of this Board meeting. ➢ The issues raised within this paper are largely contextual. They are adequately reflected in the assurance framework and risk register, with

	due consideration of the risk appetite, particularly on safety and finance.
Recommendation:	**Trust Board is asked to NOTE the context within which we operate and remain focused on the things we can control and influence, remaining true to our mission and our new strategy.**
Private session:	Not Applicable

South West Yorkshire Partnership NHS Foundation Trust

Chief Executive's Report

Trust Board 31 January 2017

Purpose

1. This report sets the context for the board meeting. It ensures a consistent understanding of the issues we face from frontline delivery right through to the Board. This report should be **read in conjunction with The Brief for January** which is cascaded to all staff and is attached at **Annex 1.** This report builds on the content of the brief updating for specific developments of note.

National Context

2. **The NHS continues to be a major political issue.** With winter pressures affecting all services, there has been a growing clamour of national bodies, Royal Colleges and representative groups behind reports of an "NHS Crisis". This has fuelled demands for Government to recognise that the funding available to the system is inadequate. This is exemplified by a reported split between NHS England and Number 10 on NHS funding and Simon Steven's appearance before MPs debating NHS sustainability.

3. Despite the noise there has been **no suggestion of any additional funding** for the NHS and a shift to the **local government raising its own funding** for social care. Some Councils have started moving on this issue, with significant rises in council tax being reported in some boroughs.

4. The other major political issue in play is **Brexit and we need to keep in view its potential impact on the NHS.** The Prime Minister made a major speech outlining the fundamentals of a UK position on Brexit Prime Minister sets out UK government Brexit approach. The NHS Confederation produces useful briefings on the potential consequences for the NHS on workforce, research, grants and regulations here Brexit and the NHS.

5. Against this backdrop of political noise and service pressure, the **national NHS bodies continue to promote collaboration across organisations** to deliver the five year forward view. There has been a strong signal that signing contracts and agreeing plans before Christmas will allow for a focus on the Sustainability and Transformation Plan from the end of January. To kick start this, a two day retreat has been arranged for the 44 STP leads with the national CEOs at the end of January to discuss next steps. Unfortunately this clashes with the Board and I will not be attending.

6. The **Care Quality Commission** (CQC) has opened its consultation on how it **regulates quality** within a more joined up system CQC next phase regulation. With NHS Improvement, the CQC is jointly consulting on **leadership and use of resources** in NHS Trusts Draft framework: use of resources and well-led assessments. These are critically important developments for the system and reflect a welcome approach by the national bodies to develop in a changing landscape. We will be responding as a Trust as well as feeding in to the feedback from representative groups like the NHS Confederation.

7. **NHS England launched its *AHPs into action* report** which showcases the role which AHPs play in delivering improvement in care. I spoke at the launch event alongside Sir Bruce Keogh, Roy Lilley and Suzanne Raistrick. The report was crowd-sourced and is very practical, making it both authentic and useful. I have asked the Executive to see how we can apply it within the Trust. The Chief Professional Officers from NHS England and other national bodies also expressed a desire to come and visit us.

8. **Niall Dickson has been appointed at the CEO of NHS Confederation and will start in February.** We are members of the Confederation and its Mental Health Network, as well as NHS Providers. These organisations need to have distinctive complimentary roles – with the Confederation lobbying on behalf of the NHS as a whole and NHS Provider representing "secondary care providers" only. The organisations are looking to work in ways that reduce duplication and increase impact. What is clear is that we must have a functioning system and a system voice for the NHS is very welcome.

Local and Trust context

9. The latest **Leadership Day** for the **West Yorkshire and Harrogate STP** has taken place, as well as the equivalent meetings in **South Yorkshire**. In West Yorkshire, we are working towards a new approach to overseeing the delivery of the STP. This includes more collaborative commissioning functions at West Yorkshire level, local place based planning, and more collaboration between providers. The consequences of moving to such arrangements are being worked through and planned via a smaller steering group that I chair. The arrangements mean:

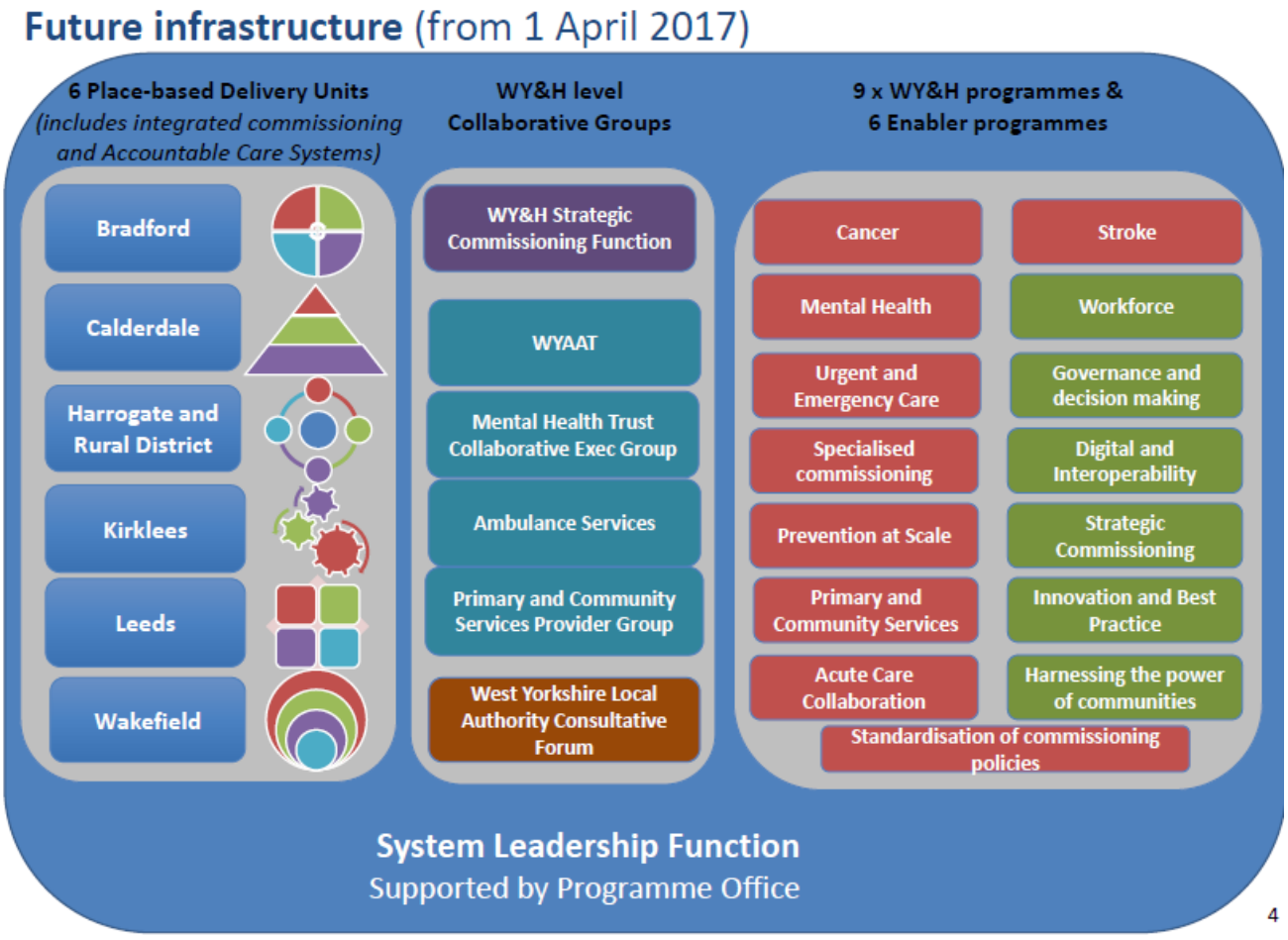
    9.1. **6 Place based delivery systems** aligned to local authorities like Kirklees, Wakefield and Calderdale.
    9.2. **West Yorkshire and Harrogate level collaboration** on commissioning through a joint committee; providers working in groups on a sectoral basis; and an interface with local government on this footprint
    9.3. Shared delivery programmes on issues like cancer, mental health and urgent care

9.4. A system leadership and programme office function to oversee the STP, bringing in resources from NHS England and NHS Improvement too. This would host my role.

10. The draft arrangements are set out in the diagram below. Discussions continue about staffing these arrangements from existing resources that are recycled into programmes.

11. **Similar arrangements are also developing in South Yorkshire**. Neither arrangements affect the governance of the Trust nor its statutory duties at this stage. A separate briefing will be provided as part of the Strategy Board in February.

Figure: Draft Schematic of West Yorkshire and Harrogate System



12. Elements of this model are **already playing out in our local systems,** building on ACO developments, our vanguards and pioneers. This is already demonstrating benefits, and it was a privilege for us to be part of a visit to the Wakefield Care Home Vanguard where a team across the system presented to global improvement expert Professor Don Berwick. Professor Berwick was reportedly "blown away" by the power of the work, including a presentation by Shaorn Carter on the impact "Portrait of a Life" has on the interactions between people with dementia and staff.

13. There is also strain in the system. STPs rely on transformation and **bids were submitted by our local STPs for transformation funding in January.** The bids are covered more fully in the contracts, bids and tenders paper in the private part of the meeting.

14. Our local STPs must also demonstrate that they are delivering a number of things collectively – **financial control totals**, financial backing for the **GP and Mental Health Five Year Forward Views**. These issues are clearly intertwined and the Board papers reflect this. What is clear is that CCGs have not yet been able to demonstrate that they are able to invest the resources required for the GP and Mental Health Five Year Forward Views. Our contracts stipulate that they will and that they will work with us to demonstrate where the money has been invested – recognising that we are not necessarily going to be their provider pf choice for all investments. As things stand, the levels of real investment in prevention, primary, community, Learning Disability and Mental Health Services fall below what is set out in the STP. We will continue to work constructively with both STPs and our commissioners to resolve this.

15. The STPs provide hope for the future – and they will be very difficult to deliver. In the last few weeks I have spoken at national and regional conferences with my Trust and STP hats on for NHS England, National Voices, the Leadership Academy, Health Education England and NHS Digital. I have covered topics on **leadership development, workforce issues, engagement and coproduction, technology and the positive impact AHPs may have.** These are all issues where we have a serious ambition and a degree of consensus. Delivery is not yet secured in terms of governance, leadership and finances across the STPs and the current service pressures may mean capacity is rightly focused there and not transforming care.

16. This should not detract from the **transformation that is happening, reflected in the Brief and the external awards and showcases of our work.** In the last few weeks we have seen **Yorkshire Smokefree** nominated for a HSJ Value award; and the **women's pathway team in Forensics** nominated for the Yorkshire and Humber Innovation, Improvement and Impact Awards. The Trust's safeguarding lead, Julie Warren-Sykes has been invited to present one of three keynote presentations at the International Association of Forensic Mental Health Services

Conference in Split, Croatia in June 2017, IAFMHS Keynote Speakers . Julie was selected by the conference scientific committee from a short list ahead of a number of very distinguished speakers with international reputations and she is joining Professor Michael Daffern from Australia and Professor Jeffrey Swanson from the USA as keynote speakers.

17. Change can also be difficult and we are working closely with **the new hubs** to manage new ways of working at Baghill House and the Wakefield Hub. These changes exemplify that changes to estate are less about the buildings and more about change and practice. It is good news therefore that our new **Director of Strategy, Salma Yasmeen** will be focusing on innovation and change as part of her work.

18. The Board papers also show that the organisation is **managing significant stress and pressure** on its finances and elements of operational delivery. Within this, we continue to apply a safety first, always principle. Progress is being made on areas of delivery and of particular note is the **achievement of our flu target.** This is a major turnaround – from 33% last year to over 75% this year. Through insight work, a delivery programme, leadership through the Board and BDUs and dedicated effort in every team, we have achieved one of the biggest improvements in the country. I would like to personally thank everyone involved for protection themselves, their colleagues, their families and the people we care for.

19. Work is underway with our Members' Council to refresh our **Membership Strategy**. The strategy is currently included within the Involving People Strategy which has now been superseded by the Communication, Engagement and Involvement Strategy approved the Trust Board October 2016. The Membership Strategy will sets out our ambition over the next three years to effectively communicate, engage and involve our membership, which includes staff and public members.

20. The process for this year's **Members' Council Election** is about to commence with nominations opening on 2 February 2017. This year there are 10 seats up for election, including 2 staff seats: Barnsley (2 seats), Calderdale (1 seat), Kirklees (2 seats), Wakefield (2 seats), Rest of South and West Yorkshire (1 seat), Staff (2 seats – Psychological therapies and staff in integrated teams). Governors are really important to our Trust. They contribute their views and ideas for our future plans and priorities and being a Governor is a great way to engage with the local community and learn more about health services. The process will be managed on our behalf by Electoral Reform Services (ERS) to ensure that the elections are managed impartially and fairly and that the process is independent and transparent.

Conclusion

21. **The CQC are currently reinspecting elements of the Trust**, including a well led review that covers the period of this Board meeting. As an organisation that aims to be outstanding, relevant for today and ready for tomorrow, I welcome the chance to test whether and how we are improving the quality and safety of our services. They arrive during a difficult period for the NHS, for local systems and in the heart of winter. There is no better time to test our resilience and the reality of service provision as we support people to fulfil their potential and live well in their communities.

22. The current context is one that is dominated by politics and pressure. As a Board, we must remain focused on the things we can control and influence, remaining true to our mission and our new strategy. This is something that the Board can enhance by setting the tone and the priorities for action for our Trust and in South West Yorkshire.

Rob Webster

CEO

South West Yorkshire Partnership NHS
NHS Foundation Trust

The Brief

5 January 2017

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.

What's happening externally?

National news
The Care Quality Commission (CQC) has published findings of their review into the way NHS organisations review and investigate the deaths of patients in England. The report, *Learning, candour and accountability,* includes a series of recommendations which were addressed in a speech by the Secretary of State for Health, Jeremy Hunt. Our clinical governance and clinical safety committee will be reviewing the recommendations in detail.

There's been lots of debate since the Autumn Statement about funding for social care. The Government has announced that local authorities will be able to increase council tax rates by 3% in 2017/18 and a further 3% the following year to help cover social care costs.

Winter pressures have been in the news over the New Year, with reports of bed pressures, lengthy waits in A&Es and to see a GP.

Local news
We've been working with our partner organisations to make sure that contracts for 2017/18 and 2018/19 have been agreed in principle. All NHS organisations were also required to submit a two-year operational plan to NHS Improvement by 23 Dec. Ours is now available on our website.

System pressures have been mounting in Barnsley over the Christmas and New Year period. Barnsley Hospital opened 52 additional escalation beds and our community and Mount Vernon services have been doing all they can to help. Thank you to all staff involved.

What's happening internally?

Safety and quality

- The first year of our 'sign up to safety' plan is showing good results. We're on track to reduce inpatient falls, pressure ulcers and prone restraint 30% by 2018
- We've had a coroner's report under regulation 28 to help us prevent future deaths – the key learning for us is around making sure we keep up-to-date records at all times
- In Dec we held mortality review training for 26 of our staff
- With Mental Health Act / Mental Capacity Act training now being mandatory, please make sure you've completed yours asap
- We're working with NHS organisations across the North, along with Mazars, to make

sure we're reviewing and learning from deaths.

The CQC have re-inspected our clinical areas with 'must-do' actions, and are carrying out a well-led review of the organisation from **30 Jan – 1 Feb**. We expect it will be a few months after this date before we get draft reports back for factual accuracy checking. We'll keep you updated as and when we know more.

Performance
We met all of our NHS Improvement performance targets in Nov. We also now report internally on additional measures that we think are important. For example, in Nov:

- **116%** safer staffing fill rate – against our target of 90%
- **96%** fill rate of registered nurses – against our target of 80%
- **1,147** incidents reported – including **4** serious incidents
- **22.9%** mental health safety thermometer medicine omissions
- **18%** of complaints with staff attitude as an issue – down from 22% in Oct
- **79** compliments received - please remember to log compliments with our customer services team.

We're also keeping a close eye on information governance (IG), following several recent breaches that we had to report to the Information Commissioner's Office. Our IG team have come up with three top tips to help each of us improve our practice:

1. Check, and check again before sending correspondence. Have you got the right person? And the right contact details?
2. Don't ever ignore a difference in patient records highlighted between The Spine and local systems. Always investigate and ensure details are up-to-date.
3. Remember you are personally responsible for getting things right. Failing to safeguard patient confidentiality can have serious consequences for you and the Trust.

Staffing

- Our IG training was at 85.9% in Nov against target of 95%, with lots due to expire by end of Jan
- Our sickness levels remain above target at 4.8%
- Appraisals were at 89.8% (band 6 and above) and 84.9% (band 5 and below) in Nov against our target for both of 95% - please make sure you've had yours
- Plans are underway to bring down our agency spend including focusing on recruitment and retention.
- Our Members' Council elections open for nominations on 2 Feb. There's two staff Governor seats available this year – one to represent psychological therapies and one to represent staff in integrated teams. Please keep an eye out for more details

We're so close – just 106 more jabs to go! (as at 5 January)
Progress towards our flu jab target has been phenomenal. Thank you so much to everybody who's helped us to reach our current level of 71%, providing our staff and the people we care for with essential protection.

There's no getting away from the fact that there's a CQUIN attached to the flu jab, meaning we need 75% of staff to have the jab if we're to protect £384k of frontline funding. We now have slightly longer to do this – until Tues 10 Jan. And we only need 106 more staff to have the jab, so we're amazingly close.

Managers, please record all jabs by 10 Jan. You can find out the facts about the jab and where to get it on the intranet.

Month 8 finances (Nov 2016)

We're in NHS Improvement's segment 3 due to our agency spend – there are four segments that NHS trusts are categorised by, with 1 being the best and 4 being the worst.

In Nov we had a deficit of £566k, mainly due to our spend on out of area beds. We have a year to date surplus of £64k, which is £700k less than we'd planned and excludes Sustainability and Transformation Funding. The rest of the year therefore remains very challenging.

We spent £700k on agency in Nov. While this has reduced from Oct, it is still much higher than planned. We've spent £6.7m on agency costs so far this year, against our cap of £5.1m for the full year.

Our cost improvement programmes (CIPs), which add up to £10m this year, are currently £0.4m behind plan. In addition, £0.8m of our CIPs are rated as red.

Four hotspots

We identified four areas that need careful attention in order to help us improve our position:

1. CQUIN achievement re flu jabs – we've made great progress and are close to reaching our 75% target in many areas, with less than a week to go. Hitting our target will mean we don't lose £384k.
2. Agency spend – we're making progress and have new processes in place. Dr Adrian Berry, our medical director and deputy chief executive, is now our executive lead for this. Spend was slightly down in Nov compared to Oct, however it's challenging and we have more to do.
3. Out of area placements – a project group is now up and running, led by district director for Barnsley and Wakefield Sean Rayner. We're looking at opening additional bed capacity and/or block buying interim capacity from another NHS provider. This is very challenging and will be a key focus over the coming months.
4. Discretionary spend - all directors have identified discretionary spend that can be saved in their areas – e.g. non-pay budgets and holding some non-clinical vacancies. There are still opportunities for further savings in this area that need to be explored.

Change

As ever, there's lots of change happening across the trust. This includes areas where we're undertaking transformation programmes to live our values and improve and be outstanding. It also includes commissioning decisions around contracts, bids and tenders:

- Kirklees Council have informed us that the Kirklees Smokefree contract will end on 31 Mar – this affects 11 of our staff
- Our community nursing team in Barnsley are moving to a six-neighbourhood model and are now called the neighbourhood nursing service
- As part of our acute and community transformation programme, we're now implementing 'core and enhanced' community pathways
- We're developing an older people's mental health transformation business case
- We're one of four healthcare providers to be awarded the £10m-a-year Kirklees healthy child contract - we'll continue to provide CAMHS in Kirklees as part of a wider contract to deliver 0-19 services, led by Locala
- Our existing Calderdale CAMHS contract will be rolled over when it runs out in April. Calderdale CCG has decided to end its procurement process and will be working closely with us to come to an agreement around the best way to deliver the service
- We've won £100k from NHS England to look at psychologically informed environments at Wetherby Young Offenders Institution
- We're receiving £17k extra funding from Yorkshire and Humber Clinical Networks for

perinatal mental health training in advance of our new community service from Apr
- We successfully bid to NHS England to become the 'alliance coordinator' across South Yorkshire for liaison and diversion services – this will be funding for one post

Infrastructure
Our estates developments at Fieldhead are progressing well – the new non-secure wards are now have steel frames in place, and refurbishment of blocks 8 and 9 will mean staff can move across from Castleford, Normanton and District Hospital soon.

We're also developing a new estates strategy to cover the next five years (2017-22). This will include disposal of sites we no longer need and plans to make best use of our buildings.

Thanks to all who have attended a workshop to identify requirements of our future mental health clinical system, with our current contract for RiO expiring in Mar 2018. We're producing a specification in Jan, and should have a recommendation ready by March.

If you haven't shared your views yet, you still have time – complete our online survey asap.

Innovation
Thanks to everyone who is involved in discussions on i-hub, our online platform for sharing ideas. We'll be progressing quickly with next steps following the bureaucracy busting and finance matters challenges to act on your suggestions.

There are many innovations already underway across the trust, including a checklist for autism friendly environments. The checklist has now been endorsed by NICE, and if you haven't seen it yet, it's well worth a look whatever service you work in.

Finally, if you are keen to either share the work that you and your team do, or would like to learn more about the work of others, get involved in our new shadowing programme. There's been lots of interest already, and it's easy to take part. Find out more on the intranet.

Dates for your diary

• Tues 17 Jan	Contributing to child protection conferences and core groups – 3-hour briefing, Wakefield
• Weds 18 Jan	Patient safety learning event, Fieldhead
• Sat 21 Jan	Dementia friendly Lindley community event
• Tues 31 Jan	Trust Board meeting held in public, Fieldhead
• Tues 28 Mar	Trust Board meeting held in public, Kendray

Take home messages

1. Keep your focus on quality and delivering our CQC action plan – safety first always
2. We all need to work together to reduce our agency, out of area and non-pay spend
3. Remember the top tips for good information governance – it's our responsibility to each get it right
4. Have a final push on flu jabs before deadline on Tues 10 Jan – we're nearly there
5. Share your views on our future mental health clinical system – complete the online survey
6. Make sure you've done your Mental Health Act / Mental Capacity Act training
7. Members Council elections are coming up – your chance to get involved and have a say

We have a bright future

To deliver it, we need:

- System leadership
- Values based leadership
- Leadership from every seat in the organisation

Keep talking and get involved

Thank you for your support during these challenging and changing times

Give feedback on The Brief to your line manager and/or the Communications team - you can also share your views via an online survey

The next issue of The Brief will start on 2 February 2017

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 January 2017
Agenda item 5

Title:	**Strategic Overview of Business and Associated Risks**
Paper prepared by:	Deputy Director of Strategic Planning
Purpose:	Trust Board is asked to note the contents of the report
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 (Political, Economic, Social, Technological, Legal/ Regulatory and Environmental) and SWOT (Strengths, weaknesses, Opportunities and Threats) analyses which were considered by the Trust Board meeting which took place in October 2016. The Trust Board receives Quarterly updates on strategic business and risks. This paper links with the Trust Risk Register, and also connects to the Trust Strategy Refresh. The Strategy Refresh was reported to Trust Board in December 2016. The SWOT and PESTLE reflects the latest Trust strategy
Executive summary:	• To support the above strategy re-fresh exercise the Trust's SWOT and PESTLE analyses have been revised to reflect the implementation throughout 2016 of initiatives to deliver our organisational objectives; and to reflect the changing external environment. This paper summarises these analyses. • The **PESTLE** analysis has been revised to reflect changes to the regulatory and policy context in which the Trust operates, and the local context with regard to place based plans and sustainability and transformation plans. Other significant issues highlighted include • Gap between ideal of FYFV funding shift (prevention, primary care, mental health etc) and reality of 2017 – 2019 contracts • Increased impact on jobs, services and income related to public health prevention services. Pace of change increased significantly, linked to continued austerity in local authorities • Increased impact of market forces on vulnerabilities in NHS markets for staff and flexible bed capacity. Experienced through agency usage and costs (mitigated by agency cap), and independent sector bed-day prices. • Increased pace of movement towards new organisational forms and partnership vehicles suitable for place based solutions (e.g. ACO, MCP), and for service line specific collaboration (e.g. mental health). • Gap emerging between regulatory and legal frameworks and the intended future structures for integrated place based care provision

	• The **SWOT** analysis has been revised to reflect the Trust's positioning in relation to the changed external environment. Overall this reflects improved clarity and capability in several of the areas prioritised in our 2016/17 objectives. • It also reflects the learning from our recent stakeholder engagement processes. This has enabled the SWOT to reflect a greater degree of clarity about the Trust's strengths in the context of the development of Accountable Care Systems • Further changes to the 'opportunities' and 'threats' sections of the SWOT aim to better reflect the specific situations currently impacting on the Trust. **Risk appetite** With respect to **risk appetite**, the content of this report does not request any decisions of Trust Board and as such does not alter the risk profile of the organisation. However it does reference the risks contained within the Trust Board risk register, and notes that these risks are managed within the stated risk appetite.
Recommendation:	**Trust Board is asked to NOTE the content of the report.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Strategic overview of business and risks

Trust Board Agenda Item 5 31 January 2017

James Drury – Deputy Director of Strategic Planning

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 (Political, Economic, Social, Technological, Legal/ Regulatory, and Environmental) analysis of external factors and a view of the Trust's strengths, opportunities, weaknesses and threats in response to those circumstances.

This report presents an updated PESTLE and SWOT analysis to reflect this ongoing review including consideration of the Trust's risk register.

2. Strategy Refresh

The Trust has recently undertaken an exercise to review and refresh our strategy to reflect the needs of the people we serve, and the changing external environment. In particular a shift towards further integration of health and care in the context of place-based plans, and new models of care, linked to regional STP developments.

Additionally the regulatory and national policy context in which NHS Foundation Trusts operate has been revised and clarified through a series of announcements and publications in the first half of 2016/17 including the 'Financial Reset', Single Oversight Framework, and the NHS Planning Guidance for 2017/8 – 2018/19. These aspects are reflected in the revisions to the SWOT (Strengths, Weaknesses, Opportunities and Threats) and PESTLE analyses at sections 3 and 4.

A process of listening and engaging with colleagues, service users and other stakeholders informed the strategy refresh and Trust Board received a draft Strategy Refresh document in December 2016.

3. PESTLE

The PESTLE analysis has been approached in the context of the Trust's refreshed strategy.The aspects of the PESTLE analysis which have changed since the October 2016 report are indicated in blue text for ease of identification.

3.1 Political

- Public debate regarding social care funding gap and resulting tensions between local and central government related to tax revenue raising powers. Resulting in heightened debate around 'health and care' and increasing openness to challenge assumptions regarding future form and function of the NHS
- Public debate regarding 'winter pressures' in urgent care and primary care starting to change expectations on targets, access and personal responsibility.
- Post-publication of STPs new alignments with local elected members and Health and Wellbeing Boards are starting to emerge. As these are developed there is potential for confusion and delay.

- 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 Heath & Wellbeing Boards and Overview and Scrutiny Committees etc
- 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.
- Government ministerial changes, which may have unknown impacts on public policy affecting the NHS, and wider social and economic drivers of health and wellbeing. However consistency in terms of SoS for Health.
- 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.
- Increased Treasury influence over the style and emphasis of DoH and NHSE communications, also impacting on regulatory regime.
- Political stance on NHS employment contracts, e.g. Junior Doctors, emphasises potential for continued discontent and disruption

3.2 Economic

- Gap between ideal of FYFV funding shift (prevention, primary care, mental health etc) and reality of 2017 – 2019 contracts emerging as a theme of debate
- Increased impact on jobs, services and income related to public health prevention services. Pace of change increased significantly, linked to continued austerity in local authorities
- Increased impact of market forces on vulnerabilities in NHS markets for staff and flexible bed capacity. Experienced through agency usage and costs (mitigated by agency cap), and independent sector bed-day prices.
- Impact of NHS financial control measures on both commissioners and providers – control totals, agency caps etc. Stronger financial interdependence across health systems through Sustainability and Transformation Plans, including STP-level control totals with consequential leverage on CQUIN.
- Impact of current employment market for clinical and IT staff, manifesting in buoyant agency market, driving cost growth for Trusts in excess of plans and 'cap'.

- 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. However there have been some opportunities to bid for transformation funding in mental health – bids successful in Perinatal mental health and IAPT, with outcomes awaited in relation to Liaison and further IAPT bids.

3.3 Socio-cultural

- High profile campaigns and celebrity endorsement, as well as local action all starting to impact on societal attitudes towards mental health, increasing recognition of widespread prevalence and relevance in the lives of all. Potentially increases likelihood of people seeking help, thereby increasing demand, but also potentially increases likelihood of people seeking help earlier increasing opportunities for effective early intervention.
- Migration trends into the UK show increasingly diverse countries of origin, increasing complexity in service provision, and enriching local communities. Future impact of Brexit on European migration trends not yet fully understood.
- 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

- Increased threat from cyber-crime impacting on NHS bodies – resulting in additional cost of defence and prevention, and heightened risk of disruption to service provision (mitigated by business continuity plans)
- 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

- Increased pace of movement towards new organisational forms and partnership vehicles suitable for place based solutions (e.g. ACO, MCP), and for service line specific collaboration (e.g. mental health). Gap emerging between regulatory and legal frameworks and the intended future structures for integrated place based care provision
- Changing landscape of regulation and approaches from regulators – NHSI's Single Oversight Framework and alignment with CQC. Diminished emphasis on previous markers of independence such as FT status and more focus on system-wide view of finance, 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.

- Some signals of changing commissioner alignment and relationships. In terms of commissioner to commissioner relationships, and also breaking down aspects of 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

- Local Economic Partnership areas developing plans linked to local authority housebuilding and development control policy. Likely to increase density of population in some areas and change the environment.
- 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
- Clarity of approach to management of partnerships and contractual relationships with other providers, and track record of integrated teams and multi-agency joint-delivery, is a strength in formation of accountable care systems
- Partnership track record and place based delivery structure underpinned by clear FT governance arrangements including plans to fully engage and mobilise an active public membership – all key for system leadership in emerging Accountable Care Organisations/ Systems
- Developing partnerships with neighbouring providers of mental health and learning disability services, aligned to achievement of STP aims
- Devolved BDU structures offer tried and tested approach to operating as a multi-'place based' provider – increasingly relevant in development of accountable care systems

- ‘Centres of excellence’ within services recognised internally and externally – e.g. Equipment Store recycling rates, Forensic CAMHS expertise shaping policy, leading implementation of suicide prevention strategy for West Yorks STP
- 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 end of life care services 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.
- Our stakeholder survey indicates partners consider the Trust to be well led with an important role to play in formation and delivery of local place based plans

4.2 Weaknesses

- Some elements of data quality undersell the true quality and contribution made by the Trust. Also examples of poor use of data that undermine stakeholder confidence and therefore impacts on reputation and sustainability.
- There are some services where access to help can be too slow and needs to improve. This will require changes within services and support by commissioners to achieve the right level of capacity.
- 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’
- Sometimes we act in silos, with particular need to address gaps between operations and corporate support, and between strong local identities.

- There is a gap between our brand and offer as we would like it to be – 'integrated holistic care' and the perceptions of many of our stakeholders, who often see us as focused on mental health alone
- Sometimes our approach is too bureaucratic, and colleagues and partners would like us to be faster in making decisions
- Our approach to change takes too long, and is not always as engaging as it needs to be

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.
- Through ACO/ MCP developments we have opportunities to secure sustainable services and engage local populations in their health
- We have an opportunity to become a national leader in shaping the future provision of low and medium secure forensic mental health
- 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.
- By fully rolling out our devolved approach to leadership we can empower and inspire more people – becoming an employer of choice and delivering great results in partnership with our service users
- We can use the learning from our stakeholder engagement work on brand and strategy to forge excellent relationships with primary care as the bed rock of place based care systems
- We can use our skills in health and wellbeing and health coaching, to support our revised workforce strategy with a focus on retention and wellbeing
- We can use the replacement of our clinical records IT system for mental health as an opportunity to improve quality, safety, and efficiency; and to create a system fit for the integrated place based systems of care envisaged in our MCP and ACO plans
- We have an opportunity to transform the approach to the delivery of our current services through innovation that makes greater use of our unique approaches such as creative minds, recovery colleges and altogether better

4.4 Threats

- Loss of autonomy arising from failure to achieve key financial and service delivery measures – resulting in increased regulatory attention, and diversion of effort away from progressive activities.

- If place based ‘accountable care’ systems are developed which result in significant loss of contracts for the trust this would be a de-stabilising factor requiring a step change reduction in organisational cost base, and therefore a threat to viability
- 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.
- Changes to the regulatory and financial oversight regime require urgent action, e.g. agency cap, but should not result in a singular focus on externally measured metrics. It is essential that a focus is maintained on the broader range of metrics that matter to our service users – e.g. access times in services which do not have ‘headline’ standards.
- 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).
- Threat of decommissioning – particularly in public health. While income reduction is manageable the costs of transition can destabilise
- Data quality and information governance issues may lead to regulatory action and reputational damage.
- There is a need to clarify strategy with regard to the re-procurement of one of the Trust’s main clinical information systems. Throughout any resulting transition it is critical that system functionality and user confidence is maintained
- Threat that the under-delivery of cost improvements reduces funding available for investment in required capital schemes including IM&T

5. Recommendation

Trust Board is asked to note the revised PESTLE and SWOT and confirm that they remain relevant in the context of the Trust’s revised strategy.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31January 2017
Agenda item 6.2

Title:	**Update to the Risk Management Strategy**
Paper prepared by:	Director of Corporate Development
Purpose:	The Trust's Risk Management Strategy ensures there are appropriate and adequate risk management processes in place within the Trust to manage and mitigate risk and is a key Strategy to support the Accounting Officer's Annual Governance Statement. The Strategy also ensures the Trust complies with Care Quality Commission and NHS Improvement requirements.
Mission/values:	The Risk Management Strategy provides a framework for the continuous development of systems and processes to support assurance, compliance and risk management.
Any background papers/ previously considered by:	The Risk Management Strategy was approved by Trust Board January 2016. The updated Strategy has been considered by the Chair of the Audit Committee, the Executive Management Team, and the Audit Committee who support its approval.
Executive summary:	The Risk Management Strategy has been reviewed to reflect changes in the internal and external environment in relation to risk and was last reviewed in January 2016. The Risk Management Strategy enables the Trust to identify key risks in the external environment and in its forward plans. Planned actions to mitigate risks are described in the Trust's Business Plan, and in its Assurance Framework and risk register, which are reviewed by Trust Board on a quarterly basis. The Strategy has been reviewed to ensure it is fit for purpose for a further two years and against best practice. The Strategy now incorporates as appendices the Boards Assurance and Escalation Framework as approved by Trust Board January 2016 (strategy appendix 7) and the Trusts Risk Appetite Statement as approved by the Trust Board July 2016 (strategy appendix 6). Other changes include: ➢ Update to branding and small amendments to wording to make them clearer. ➢ Update of directors responsibilities (appendix 5) in accordance with portfolio review. ➢ Update of the implementation plan (appendix 8). **Risk Appetite** The delivery of the Risk Management Strategy supports the Trust in providing safe, high quality and equitable services within available resources through an integrated approach to managing risk, improving the Trust's reputation in line with the Trust's Risk Appetite Statement. Further work is planned during Q4 through EMT to establish and embed a process for a risk scan across all Directorate registers, including risks scored

	below 15 (prior to mitigation) to ensure that all risks are managed within the risk appetite of the organisation and where not, are scrutinised by the relevant sub-committee of the Board.
Recommendation:	**Trust Board is asked to APPROVE the update to the Risk Management Strategy.** **The Board is asked to delegate authority to the Chief Executive and Director of Corporate Development to update the supporting Risk Management Procedure and the incorporation of the relevant appendix from the Risk Management Strategy as deemed appropriate.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

DRAFT

Risk management strategy

Version v0.8

Jan 2017 – Jan 2019

Document name:	**Risk Management Strategy**
Document type:	**Trust-wide Strategy**
What does this policy replace?	**Update of previous strategy (requirement for annual review by Trust Board)**
Staff group to whom it applies:	**All staff within the Trust**
Distribution:	**The whole of the Trust**
How to access:	**Intranet and internet**
Issue date:	V1 issued December 2008 V2 issued October 2010 V3 issued December 2011 V4 issued October 2012 V5 issued December 2013 V6 issued January 2015 V7 issued January 2016
Revised date:	**Revised January 2017**
Next review:	**January 2019**
Approved by:	Trust Board 20 December 2011 Trust Board 30 October 2012 Trust Board 17 December 2013 Trust Board 27January 2015 Trust Board 29 January 2016 Trust Board 31 January 2017
Developed by:	**Director of Corporate Development**
Director leads:	**Director of Corporate Development**
Contact for advice:	**Director of Corporate Development / Integrated Governance Manager**

Contents

1. Introduction

1.1. 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.

In 2016/17, our strategic objectives are to:

- Improve people's health and wellbeing
- Improve the quality and experience of all that we do
- Improve our use of resources.

This risk management strategy will support the achievement of the organisation's mission and objectives. Every aspect of the strategy will be delivered in line with our values.

1.2. Purpose and scope

The Trust is committed to ensuring the safety of the people who use its services, its staff and the public through an integrated approach to managing risk regardless of whether the risk is strategic, clinical, financial or commercial or relates to compliance. The Trust recognises the importance of effective integrated risk management arrangements to underpin the safe and effective delivery of its services, its reputation and its organisational viability and sustainability. As a foundation trust, the Trust must have the skills and systems in place to manage its own business. Trust Board must be assured of the safety and effectiveness of services and the financial sustainability of the organisation and, to this end, is responsible for developing the appetite of the Trust to take risks and the ability of the Trust to manage risk. In turn, Trust Board must be able to provide assurance to its regulators. This includes registration with the CQC to be a provider of NHS commissioned services and adherence to Monitor licensing conditions.

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

2. Context

2.1. Definition of risk and risk exposure

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

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

Trust Board takes a prudent and pragmatic attitude to risk, adopting a flexible approach and the determination of its response as the need arises. Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and determines its approach and its appetite for risk to suit the circumstances at the time. The organisations risk appetite is set out in Appendix 5. Where risks cannot be managed within the risk appetite of the Trust, they will be subject to scrutiny by the relevant sub-committee as identified within the Committee Terms of Reference.

Risks can be broadly defined as follows.

Strategic risks

Risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans.

Clinical risks

Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks.

Financial or commercial risks

Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income, inability to recruit or retain an appropriately skilled workforce, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.

Compliance risks

Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.

2.2. Risk reporting and procedures

The Trust uses Datixweb to support the recording, management and review of risks and production of risk registers across the Trust to ensure consistency of recording. Datix allows control measures to be recorded and actions to be scheduled, with a full audit trail of changes to risk assessment. Information feeds through levels of risk register from 'ward to board'. The system has the ability to report at different levels, look at themes across the organisation and risk areas, such as information governance, or health and safety, and record and manage actions. The Trust's has a document "Risk Management Procedure", which sets out the processes for this system and this can be found on the Trust's intranet.

2.3. Risk management processes

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

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

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

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

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

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

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

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

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

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

Annual plans are developed within each locality and support directorates and co-ordinated into a Trust plan. Annual plans are agreed with commissioners and support the delivery of the business plan. The plans identify service developments and changes, and the financial and workforce implications of those plans, including any required cost improvements (CIPs). Undertaken by the Director of Nursing and Quality, the Medical Director and the Director of Director of HR, OD and estates, each cost improvement is subject to a **Quality Impact Assessment**. The assessment covers three aspects of quality person-centred, safe, effective and efficient). The assessment tool provides a quality impact rating on RAG rated scale (Blue: Improves quality; Green: Neutral impact on quality; Amber: Potential impact on quality.

Requirement for mitigation and monitoring; and Red = Likely impact on quality. Requires further work or substitution). The assessment is based on the Care Quality Commission's five key domains: safe, effective, caring, responsive, and skilled. Where risks are considered to be substantive, plans may be changed or mitigating action put in place to manage the risk.

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

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

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

A risk management process based on the Australian/New Zealand Standard is used within the Trust. Appendix 2 sets out the Risk Management overview and process and the steps included. The whole system approach is continuously monitored by Trust Board and through the leadership and management framework to support learning and improvement. The aim of the approach is to support an organisational culture based on prudent ambition in relation to service development and learning from experience to minimise the likelihood of risks manifesting themselves and to enable the Trust to respond positively to mitigate the impact of unavoidable risks and maximise opportunities of doing so.

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

3. Risk management strategy objectives

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

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

- provide a framework for risk management that assures Trust Board that the Trust is delivering against the strategy set out in its plan;
- clarify responsibility and accountability for management of risk throughout the organisation from Trust Board to the point of delivery (from 'board to ward') and support greater devolution of decision-making as close to the user of Trust services as possible;

- define the processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust;
- promote a culture of performance monitoring and improvement, which informs the implementation of the Business Plan and ensure risks to the delivery of the Trust's plans and market position are identified and addressed;
- ensure staff are appropriately trained to manage risks within their own work setting and clear processes are in place for managing, analysing and learning from experience, including incidents and complaints;
- ensure approaches to individual risk assessment and management balance the rights of individuals to be treated fairly, the rights of staff to be treated reasonably and the rights of the public in relation to public protection;
- support Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislative responsibilities, including standards of clinical quality, Monitor compliance requirements and the Trust's licence.
- enable Trust Board to define the appetite for risk and ensure this is understood and acted upon at all levels in the organisation.

4. Delivery and outcome measures

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

The agenda and focus of Trust Board meetings is continuously reviewed to ensure attention is given to both strategy and implementation. Each quarter, there is a business and risk meeting, which is forward looking and risk-based, a performance and monitoring meeting, which provides a detailed retrospective review of performance, and a strategic meeting, which also informs Trust Board development.

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

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

Each of these committees has clearly defined **terms of reference** which set out the functions that the committee carries out on behalf of the Board including the specific risks they are responsible for reviewing assurance in line with the Trust Risk Appetite Framework. All Committees are chaired by a Non-Executive Director. Minutes are formally presented to Trust Board and assurance is provided to Trust Board by the Committee Chair. The Audit Committee Chair does not routinely attend any other committees to ensure objectivity; however, the Chair of the Audit Committee has the opportunity to attend each committee once a year as part of providing assurance to Trust Board on effectiveness of other risk committees.

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

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

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

The **Mental Health Act Committee** is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act (2005), as amended by the 2015 Act, and with reference to the guiding principles set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty Standards.

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

Trust Board also establishes time-limited Board-level groups as needed, to focus on the development and implementation of areas including the Trust's estates and information and management technology strategies, and embeds diversity and inclusion in everything it does to provide assurance to Trust Board. Each is chaired by a Non-Executive Director.

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

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

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

Staff Governors have been appointed as Freedom to Speak Up Guardians. Specific risks identified through this role will be escalated to the lead Director as appropriate, to be dealt with in accordance with the Risk Management Strategy.

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

Development of the Members' Council focuses on:

- development of the interface between the Trust Board and Members' Council;
- public and staff elections to attract people who represent the diversity of the community served by the Trust and effective induction of new members;
- development of individual and collective skills of the whole Members' Council;
- development of the interface between the Members' Council and the wider membership to optimise the Members' Council's role.

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

The Chief Executive provides leadership to the **Executive Management Team** (EMT). The EMT is made up of Executive and Operational Directors and is responsible for ensuring implementation of the strategy agreed by Trust Board. To ensure alignment with Trust Board meetings, EMT meetings are organised into forward-looking, externally-focused meetings (with a focus on transformation, risk and future vision with overarching scrutiny of the implementation of the transformation programme) and delivery (internal focus on delivery and performance). This also ensures risks to delivery of the Trust's plans are closely monitored and that the Trust remains forward looking.

The EMT reviews the risk register and scans clinical incidents, claims and complaints to ensure they are being effectively managed and action is being taken to minimise the risk of recurrence. The EMT also reviews the strategic position of the Trust and any potential threats to income or achievement of its plans.

The **Extended EMT** meets monthly. The Extended EMT provides an opportunity to engage all first line report staff in transformation, delivery and focus on potential risks. It comprises all Executive Directors and senior staff, including deputy directors and clinical, general management and practice governance leads from Business Delivery Units.

Business Delivery Units (BDUs) are responsible for delivering safe and effective services within agreed resources within geographical or specialist service areas, within a framework of devolved responsibility to ensure effective delivery of the Trust Plan and providing an effective performance framework for delivery.

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

Each BDU has a deputy district director to support District Directors to deliver services. They also manage the working relationship of the 'trio'-based approach at senior level, encompassing clinical, general management and practice governance to ensure excellence

in service quality and delivery in terms of effective clinical engagement and prioritisation, appropriate deployment of resources and effective clinical governance.

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

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

- combine the work of the voting executive directors, including corporate development, communications and engagement, and strategy;
- ensure key linkages and synergies between all portfolios to provide optimal support to delivery of services in BDUs;
- ensure ongoing quality improvement and associated compliance with regulatory requirements; and
- ensure linkage across key domains of the Quality Academy.

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

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

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

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

5. Risks

Risks identified in the delivery of this strategy include:

- Procedures, processes and systems not embedded throughout the Trust to support effective risk management.
- A lack of collective commitment internally in promoting a culture of effective risk management.
- A lack of personal responsibility for individually identifying, assessing and managing risk within their own area of responsibility.

Key risks will be mitigated in line with this strategy and risk appetite. An implementation plan for the Strategy is outlined at Appendix 8 and monitoring and compliance with the strategy is outlined at Appendix 1.

6. Resourcing, staffing and technology related issues

Risk management needs to be an integral part of our work right across the organisation. The strategy has been designed not to create additional activity, but to align resources and efforts based on Trust priorities. It is, therefore, vital the implementation plan is incorporated into the annual planning process rather than viewed as separate activities.

The Trust's approach to risk management training in respect of Trust Board and the Extended Executive Management Team is set out at Appendix 10.

7. Next steps and governance arrangements

This strategy will be agreed at Trust Board and delivered through our Executive Management Team. The Director of corporate development is accountable for delivery. Implementation of the strategy will see involvement from teams across the organisation, including those led by the Director of corporate development. An implementation plan for the Strategy is set out in Appendix 8.

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

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

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

- ensure adherence to Trust policies and procedures to support effective risk management;
- raise staff awareness of the key objectives in the risk management strategy;
- foster a supportive environment to facilitate the reporting of risks and incidents;
- manage clinical and non-clinical risks in their area, including risks to the Trust's reputation;
- manage communications, including adherence to Trust policy;
- ensure staff are aware (including sub-contractors) of risks in the working environment;
- ensure staff training needs are identified and addressed;
- ensure adherence to standing orders, standing financial instructions and scheme of delegation.

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

- awareness of organisational and health and safety risk assessments and of any measures (such as, policies and procedures) that are in place to mitigate risks;
- identifying and reporting hazards and risks arising out of work-related activities;
- awareness of the requirement to report risks and how this is done within the Trust;

- working within their area of competence and identify their own training needs;
- following Trust policies and procedures;
- contributing to identification of risks and follow up actions in the risk register.

8. Evaluation and review

This strategy covers a period of two years and will be evaluated at the end of 2018 and updated in January 2019.

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

- review of the Strategy by Trust Board bi-annually;
- scrutiny of Trust Board Committee minutes as a standing item on the Trust Board agenda;
- internal and external audit activity;
- scrutiny of the assurance framework and risk register by Trust Board quarterly and by the Executive Management Team monthly;
- areas of underachievement and potential risk highlighted through the Integrated Performance Report to Trust Board monthly;
- Directors' reviews with the Chief Executive;
- the Chief Executive's reviews with the Chair.

Compliance with the strategy will be monitored through established risk processes already in place within the organisation. These are outlined at Appendix 1.

9. Quality and equality impact assessment

From a quality perspective, in approving this strategy our Executive Management Team has confirmed that it:

- Will help improve service user experience
- Will help reduce harm
- Will help us to be more effective
- Is aligned to our mission and values
- Is aligned to our system intentions
- Is ambitious.

An equality impact assessment has been undertaken, and can be found in Appendix 13.

10. Appendices

10.1. Appendix 1 – Monitoring compliance with the strategy

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

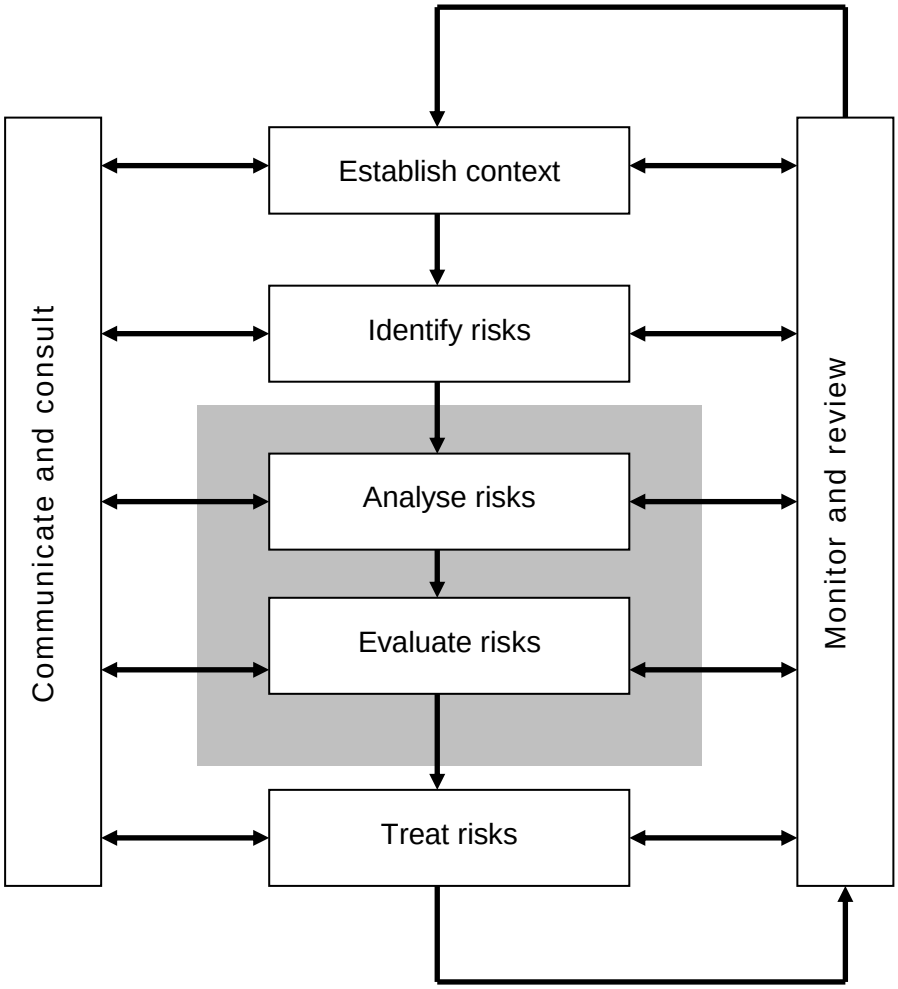
Risk process	Purpose	Frequency	Lead	Outcome
	internal controls are robust, appropriate and fit for purpose. The programme forms the basis of the Head of Internal Audit Opinion and the Accounting Officer's Annual Governance Statement.	programme	Finance	forms a key part of the Trust's annual reporting statements. Supported by independent review of Trust annual report, accounts and Quality Accounts.
Internal audit of risk management processes	To provide assurance that the Trust's processes are robust, appropriate (fit for purpose) and are followed.	Annual	Internal audit/ Director of Corporate Development	Presentation of report to Audit Committee.
Review of the Trust's appetite for risk.	To ensure that the Trust's strategic direction, objectives and annual plan reflect its appetite for risk and is consistent with the Trust's mission, vision and values.	Annual (as part of annual planning)	Chair and Chief Executive	Agreement of the Trust's strategic direction and annual plan to ensure the Trust meets its objectives and manages risk in an effective way at a level appropriate to the Trust.
Risk management training	To ensure that the Trust's approach to risk management is embedded at the highest level within the organisation.	Bi-Annual	Director of Corporate Development	Trust Board and members of the Extended Executive Management Team undertake mandatory risk management training on an annual basis.
Triangulation of risk, performance and governance	To triangulate performance, risk and governance to demonstrate that all key strategic risks are captured by the risk management process; risks are appropriately highlighted and managed through the governance committees and operational meetings; and there is a clear link between risk management and identifying areas of poor performance by cross referencing the content of the performance report to the risk register.	Quarterly	Director of Corporate Development	Presentation of report to Audit Committee.

10.2. Appendix 2 – Risk management process

The Trust's whole system approach to risk assessment and management requires the organisation to have in place a systematic process for evaluating and addressing the impact of risk in a cost effective way.

In order to achieve this, the Trust is committed to providing staff with the appropriate skills to identify and assess the potential for risk to arise. The system supports the use of professional judgement and decision-making. The Trust seeks to provide an environment in which people feel comfortable about reporting incidents and risk issues and discussing them in an open, non-accusatory way. It recognises that staff need to feel that they work in a safe and 'just culture', in which people who report risk or disclose unsafe practice are supported.

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



Risk Management Overview

Step 1: Identification of risks
A variety of sources of information, proactive and reactive, are used to identify risks. External sources include national guidance, market analysis, financial and workforce data, benchmarking, feedback from external compliance processes, patient safety notices and communications, external inquiry reports. The Trust also relies on intelligence to identify threats to income, gained through formal processes including contact with commissioners, which is fed into the Trust via the appropriate TAG and feedback from other sources such as patient surveys, complaints and compliments and direct communications with GPs.

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

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

Internal intelligence on risks is generated through data collection systems, including the Trust's clinical information system (RiO), which provides information about clinical activity, CQUIN targets, which provide key data relating to the quality of Trust services, the Datix system, which provides information about adverse events and complaints, and general risks identified by staff through environmental scanning of their work areas. Analysis of media coverage provides information about risks to the Trust's public reputation. A report is provided to the Trust Board quarterly on the strategic overview of business and associated risks.

Step 2: Analysis of risks
The objective of risk analysis is to separate minor acceptable risks from major risks. Risk analysis involves consideration of the sources of risk, their consequences and the likelihood of the risk manifesting itself. This information enables the Trust to plan actions to reduce the likelihood of the risk occurring and to put in place contingencies to reduce the impact if the risk manifests. Sources of information may include:

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

Step 3: Evaluation of risks
Risk evaluation involves applying established criteria to enable the organisation, team or individual to assess the negative impact that could occur if the risk to the organisation or to service users if the risk materialises compared to the opportunity (or positive impact) that could occur as a result of taking the risk. The ability to balance the positive impact of taking risks against the potential negative impact is particularly critical in a complex environment such as the delivery of clinical services, where a no risk culture would detrimentally affect clinical decisions.

The Trust also needs to be able to assess the likely benefits of opportunities that may present to attract new sources of income against the risks. For example, where there is an opportunity to develop a new service, the Trust needs to be assured that the income will exceed the required investment in buildings or staff or that there are significant benefits in

terms of partnerships, reputation or market position from developing new services which offer only a marginal financial contribution.
Evaluation should take account of the following criteria.

- Impact on service delivery and quality of services.
- Financial/value for money issues.
- Reversibility or otherwise of the risk.
- Quality or reliability of evidence surrounding the risk.
- Impact on the organisation, stakeholders of partners.
- Impact on the Trust's reputation.
- Whether, on balance, the risk is defensible.
- Application of risk appetite.

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

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

Step 4: Risk treatment
Risk treatment involves identifying the range of options for preventing or dealing with a risk, assessing the options and preparing and implementing 'treatment' plans. Options, which are not necessarily mutually exclusive, may include the following.

1. **Avoid the risk** – do not undertake the activity which is likely to generate the risk. Risk avoidance is not always appropriate and may in itself present alternative risks, such as:
   - decisions being taken to avoid or ignore risks even where the potential benefits outweigh the risks;
   - failure to treat or address risks;
   - leaving critical choices or decisions to other parties;
   - deferring decisions which the organisation cannot avoid.

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

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

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

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

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

A number of options for managing risk may be considered and applied either individually or in combination. Selection of the most appropriate option involves balancing the cost of implementing each option against the benefits derived from it. In general, the cost of managing risks needs to be commensurate with the benefits obtained. Decisions should take account of the need to carefully consider rare but severe risks, which may warrant risk

reduction measures that are not justifiable on strictly economic grounds. In general the adverse impact of risks should be made as low as reasonably practicable.

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

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

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

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

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

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

Guidance on completion of the risk register and the risk grading matrix applied in the Trust are included in appendices 3 and 4 and in the document 'Risk Management Procedure'.

Step 5: Monitoring and review
Risk management systems are scrutinised by the Audit Committee through the Triangulation of Risk, Performance and Governance report, supported by internal audit and external audit, and the overall management of risk is monitored by Trust Board, through the Assurance Framework and risk register.

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

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

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

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

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

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

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

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

Ongoing work focuses on embedding the Datix risk module at all levels, ensuring staff have the appropriate skills to identify and assess risk, the use of Datix in monitoring and managing risks, and embedding the role of risk co-ordinators within BDUs and support services, particularly the relationship with Practice Governance Coaches.

10.3. Appendix 3 – Guidelines for completion of risk register

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

Document Control	
Authors	
Version	
Circulation	
Date	
Status	

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

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

10.4. 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)

10.5. Appendix 5 – Risk appetite statement

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 (as set out in their Terms of Reference) setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. Through EMT, a scan across Directorate registers of both risks scoring below 15 and above 15 (before mitigation) will allow any themes / hot spots to be identified, mitigating actions agreed and referral to the appropriate sub-committee / forum of the Board as applicable.

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.

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**

10.6. Appendix 6 – Board assurance and escalation framework

Introduction

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

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

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

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

Culture

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

Staff Involvement

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

Service user/carer/public involvement

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

Internal and External Sources of Assessment and Assurance
The Trust has a number of internal and external sources of assessment and assurance, including the following:

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

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

The Trust also commissions additional external reviews of activities, services and events where a need for independent assessment and assurance has been identified.

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

Trust's Internal Quality and Performance Monitoring
The Trust has a number of fora where quality and performance is discussed. The key performance meetings are the Operational Management Group (bi-weekly) and Executive Management Team Delivery meeting (monthly). Trust Board Committees provide assurance regarding performance.

Performance is managed at a local level through monthly BDU performance and governance meetings which are chaired by the relevant BDU Director. Each BDU considers its performance against key performance targets and reviews the performance of individual service lines within the BDU against these indicators. Where performance issues are identified, actions plans are developed and implemented to address the issues.

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

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

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

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

Cost Improvement Plans

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

Quality Strategy and Account

The Trust has in place a Quality Strategy, which sets out the Trusts key priorities for quality improvement, which are aligned to the CQC domains. The delivery of the continuous quality improvement described by the strategy and plan is underpinned by the Trust's seven step Quality Improvement Framework.

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

Compliance with Regulators

Care Quality Commission

As a provider of health services the Trust is registered with the CQC and has systems in place to ensure compliance with its fundamental standards. This includes internal inspections based on five key questions in relation to whether services are safe, effective, caring, responsive and well led. A self-assessment tool kit is available for teams to benchmark against each of the fundamental standards.

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

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

NHS Improvement and Monitor

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

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

Risk Escalation Framework

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

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

Board Assurance Framework (BAF)

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

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

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

- Self-assessments such as Monitor's Well Led Framework;
- External effectiveness reviews
- Annual assessment against the Annual Governance Statement, completed in accordance with Monitor's annual reporting manual
- Board strategy and development sessions
- Scrutiny of Trust Board minutes, robust monitoring and follow up of the Board's action points and forward plan
- Board director induction and appraisal
- Annual review and assurance reports from the sub-committees of the Board.

Learning Lessons
The Trust is committed to learning lessons in an open and transparent way. It does this through the examination of complaints, serious incidents, staff feedback, service user and carer feedback, internal reports, external reviews, assessments, inspections and the review of national reports and reviews.

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

10.7. Appendix 7 – Director's responsibilities

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

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

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

Function	**Lead**
Accounting Officer	Chief Executive

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

10.8. Appendix 8 – Implementation plan

Action required	Action plan	Review date	Lead	Training implications
Review Board meeting cycle, agenda setting process and committee functions to ensure focus of each meeting is clear and ensure adequate focus on strategy, risk and performance.	Review agenda setting to ensure balance of focus on strategy and retrospective performance monitoring. Review terms of reference and membership of committees to ensure clarity of function and effective Board assurance.	Ongoing	Chair, Chief Executive and Director of Corporate Development	Board development sessions and strategy sessions built into cycle
Continue to develop improved performance reporting to Trust Board to ensure information is well integrated, timely and accessible.	Review Board approach to performance monitoring to ensure the information meets Board requirements.	Ongoing	Director of Finance and Director of Nursing and Quality	Individual and whole Board development to support effective governance
Each committee to undertake an annual self-assessment exercise and produce an annual report to Trust Board demonstrating how it has met its terms of reference.	Self-assessment exercise to be undertaken by each committee to review performance against annual plan and interface with other committees and reported to Trust Board by the Audit Committee	Annually (April)	Chair of Audit Committee, other Committee Chairs and lead director for each committee	None
Work programmes to be developed annually and reviewed regularly for each Committee to ensure efforts are focused on management and monitoring of risks identified in the assurance framework, risk register and annual plan.	Annual work programme to be developed for each committee and reported to Trust Board. Work programmes to be amended in the light of changes to risk register	Annually (February to April) Ongoing	Committee chair and lead director	To be identified as part of work programme
Assessment of effectiveness of Board and individual directors	External facilitated assessment of Trust Board effectiveness as part of the well-led review. Chair's appraisal. Chair's quarterly reviews with Non-Executive Directors. Chief Executive's quarterly reviews with Directors. Assessment of skills and experience of Trust Board to ensure remains fit for purpose as a	Every 3 years Annually (April) Quarterly Quarterly As part of role of Nominations Committee	Chair/CE led SID with Members' Council Chair Chief Executive Chair	None None None None Access to training as appropriate

Action required	Action plan	Review date	Lead	Training implications
	Foundation Trust Board.			
Assessment of effectiveness of Members' Council and individual governors	Annual evaluation session Individual reviews with Chair Individual induction meetings with the Chair Trust responsibility to ensure development and maintenance of skills and knowledge of governors	Annually (February) Annually (Jan/Feb/Mar) On joining Ongoing	Chair Chair Chair Chair	Access to NHS Providers GovernWell training modules and other training (both internal and external) as appropriate
Assurance provided by Committees specifically reported to Trust Board	Chairs of committees provide specific assurance to each Board meeting where they have responsibility for scrutiny of an issue	Ongoing	Chairs and lead directors	None
Ensure effectiveness and accessibility of approaches used by Trust Board to monitor risks and receive assurance	Continued embedding of risk register management through Datix and assurance framework to support the overall system of internal control.	Ongoing	Chair of Audit Committee, Chief Executive and Director of Corporate Development	
Develop internal control systems to support effective risk management in the context of devolved decision making	Develop and implement internal governance arrangements to support service line management and to support the introduction of payment by results.	Ongoing	Chief Executive, Deputy Chief Executive and Director of Corporate Development	
	Review Standing Orders, Standing Financial Instructions and Scheme of Delegation.	January 2017 then Bi-annually	Chief Executive, Director of Corporate Development and Director of Finance Audit Committee and Trust Board	

Action required	Action plan	Review date	Lead	Training implications
Risk management training relevant to individual roles to be undertaken	Trust Board to receive training in risk analysis and risk management relating to the role of a corporate board as part of Board development programme. Extended EMT to receive training on risk management. E-learning to be developed for Trust Board, Extended EMT and risk co-ordinators.	December 2016 then Bi-annually March 2017 then Bi-annually During 2017/18	Director of Corporate development Director of Corporate Development Director of Corporate Development	
All staff to be briefed about amendments to risk management strategy	Include in weekly staff news and reference to intranet	Following approval by Trust Board	Director of Corporate Development	As appropriate
Key policies and procedures on the intranet to be brought up-to-date to enable document store to support information governance requirements in relation to non-clinical records.	Complete work to update the document store.	Ongoing	Director of Corporate Development	Training relevant to roll out of individual policies as and when they are revised.

10.9. Appendix 9 – Risk related Trust documents – policies, procedures, protocols and guidelines

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

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

The following documents are key to risk management.

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

10.10. Appendix 10 – Risk management training arrangements

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

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

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

Several user guides are available on the internet to assist staff in using Datix. An e-learning package will be developed by during 2017/18 2016, which will be mandatory for Trust Board, members of Extended EMT and risk co-ordinators. The package will also be available for other staff.

10.11. Appendix 11 – Checklist for review and approval

Date: 12 January 2017

	Risk Management Strategy	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	N/A	
	Are people involved in the development identified?	N/A	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	N/A	
	Is there evidence of consultation with stakeholders and users?	Trust Board	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	N/A	
	Are the references cited in full?	N/A	
	Are supporting documents referenced?	YES	

6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

10.12. Appendix 12 – Version control sheet

Version	Date	Author	Status	Comment / changes
1	December 2008	Integrated Governance Manager	Final	Final version approved by Trust Board
2	October 2010	Integrated Governance Manager		Changes made to reflect transfer of services from NHS Barnsley. Approved by Trust Board
3	December 2011	Integrated Governance Manager	Final	Annual review approved by Trust Board
4	October 2012	Integrated Governance Manager	Final	Inclusion of Datix processes approved by Trust Board
5	December 2013	Integrated Governance Manager	Final	Annual review approved by Trust Board
6	January 2015	Integrated Governance Manager	Final	Annual review approved by Trust Board
7	January 2016	Integrated Governance Manager	Final	Annual review approved by Trust Board
8	January 2017	Integrated Governance Manager	Final	Annual review approved by Trust Board

10.13. Appendix 13 – Equality Impact Assessment tool

Date of Assessment: 3 January 2017

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

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.5	**Sexual Orientation**	No	N/A
8.6	**Religion or Belief**	No	N/A
8.7	**Transgender**	No	N/A
8.8	**Maternity & Pregnancy**	No	N/A
8.9	**Marriage & Civil partnerships**	No	N/A
8.10	**Carers*Our Trust requirement***	No	N/A
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		N/A
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		N/A
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		N/A
9c	**Promotes good relations between different equality groups;**		N/A
9d	**Public Sector Equality Duty – "Due Regard"**		N/A
10	**Have you developed an Action Plan arising from this assessment?**		No
11	**Assessment/Action Plan approved by**		**Signed:** Dawn Stephenson **Date:** 3 January 2017 **Title:** Director of Corporate Development

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 January 2017
Agenda item 7.1

Title:	**Integrated Performance Report Month 9 2016/17**
Paper prepared by:	Director of Finance
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for November, 2016.
Mission/values/objectives	All Trust objectives.
Any background papers/ previously considered by:	Not applicable.
Executive summary:	**Quality** • First year of "sign up to safety" plan shows positive results • Staffing fill rates maintained over festive season • Number of reported incidents within anticipated range • 6 serious incidents reported including tragic incident on Trinity 2 • CQC revisit inspections progressing and action plan on schedule • CQUIN – information for the quarter 3 submission is due at the end of the month • A number of specific risks relating to CQUIN achievement have been identified and focussed action plans are in place to improve our ability to deliver. Financially this risk equates to £0.5m of lost income if not achieved. The number of front-line staff vaccinated for flu exceeded 75% which safeguards £0.4m of CQUIN income. • A small number of IG incidents have been reported to the ICO. Actions in place to address **NHSI Indicators** • Based on current information available the Trust is meeting existing NHSI metrics including a continuation in improvement in IAPT access • There is a risk relating to the newly introduced metric for data completeness, particularly employment and accommodation status **Finance** • Net pre STF deficit of £27k in the month. Continued overspend on out of area bed placements (£457k) is the main driver of the deficit. There was a one-off upside of £165k in the month and a number of other savings across the Trust which partly offset the expenditure on beds. • Finance Risk metrics remains below plan due to the surplus position being lower than plan and the fact agency spend is 89% above the cap. • Year-to-date pre STF surplus of break-even which is £0.8m behind plan. This means Q3 STF monies of £0.3m have not been achieved. • Full year pre STF surplus forecast remains at £0.5m, but with very significant risk attached. Forecast has improved for successful position with flu CQUIN and recognition of reduction in discretionary spend, but these improvements have been offset by further deterioration in out of area bed expenditure and agency staff costs. • Agency spend increased to £0.9m in the month and remains well above both ceiling and forecast. Cumulatively agency spend is now £7.6m, which is in breach of our full year ceiling of £5.1m and is currently 89% above our cap. Total pay costs were below plan in the month. Actions being taken to address agency spend are highlighted in the report

	• Cost improvements delivery to date of £6.8m, which net of contingency is £0.5m lower than plan. Specific issues relate to the use of out of area bed placements and a range of other trust wide schemes. • Cash reduced to £26.1m in the month, which is £0.3m lower than plan **Workforce** • Sickness levels increased to 5.3% in the month, but remain at 4.8% cumulatively • Significant number of Information Governance training renewal due in January. Current compliance of 85% • Mental Health Act and Mental Capacity Act now mandatory in the Trust and reported on this month
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and comment accordingly.**
Private session:	Not applicable

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report

Strategic Overview

December 2016

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report for December 2016. The recent developments on the report now ensure that an owner has been identified for each key metric, and the alignment of the metrics with Trust objectives and CQC domains. This ensures there is appropriate accountability for the delivery of all our performance metrics and helps identify how achievement of our objectives is being measured. The report is now more in line with the vision of having a single report that plots a clear line between our objectives, priorities and activities. The intention is continue to develop the report such that it can showcase the breadth of the organisation and its achievements as well as meeting the requirements of our regulators and providing an early indication of any potential hotspots and how these can be mitigated.
It is recognised that for future development stronger focus on outcomes is required and a clearer approach to monitoring progress against Trust objectives would be beneficial.

The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions and will contribute towards streamlining the number of different reports that the board receives.

The Trust's three strategic objectives are:
• Improve people's health and reduce health inequalities
• Improve the quality and experience of care
• Improve our use of resources

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
• Strategic Summary
• Quality
• NHS Improvement (formerly Monitor)
• Locality
• Transformation
• Finance
• Contracts
• Workforce

Performance reports are available as electronic documents on the Trust's intranet and allow the reader to look at performance from different perspectives and at different levels within the organisation. Our integrated performance strategic overview report is publicly available on the internet.

Section	KPI	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Year End Forecast
NHS Improvement Compliance	NHS Improvement Governance Risk Rating (FT)	Green	Green	Green	Green	Green	Green	*Green*	Not applicable after 30th Sept 16						*N/A*
	NHS Improvement Finance Risk Rating (FT)	4	4	4	4	4	4	4	Not applicable after 30th Sept 16						*N/A*
	Single Oversight Framework metric		Not Applicable prior 1st Oct 16						2	2	2				2
CQC	CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green				Green

From 1st October 2016, the following ratings apply:
1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

Lead Director:
The performance information above shows the previous ratings for governance and finance to September. From October onwards the performance rating metrics have changed to be in line with the new Single Oversight Framework which captures Trust performance against quality, finance, operational metrics, strategy and leadership under one single overall rating. The most significant reasons for the Trust to be rated as 2 are the CQC rating of 'requires improvement' and the level of spend above our agency staff expenditure ceiling.

Areas to Note:
• First year of “sign up to safety” plan shows positive results
• Staffing fill rates maintained over festive season
• Number of reported incidents within anticipated range
• 6 serious incidents reported including tragic incident on Trinity 2
• CQC revisit inspections progressing and action plan on schedule
• CQUIN – information for the quarter 3 submission is due at the end of the month
• A number of specific risks relating to CQUIN achievement have been identified and focussed action plans are in place to improve our ability to deliver. Financially this risk equates to £0.5m of lost income if not achieved. The number of front-line staff vaccinated for flu exceeded 75% which safeguards £0.4m of CQUIN income.
• Based on current information available the Trust is meeting existing NHSI metrics including a continuation in improvement in IAPT access
• There is a risk relating to the newly introduced metric for data completeness, particularly employment and accommodation status
• Sickness rate increased to 5.3% in December, 4.8% year-to-date
• Mental capacity Act training shows 48% compliance and Mental Health Act 20.9%.
• Net pre STF deficit of £27k in the month. Continued overspend on out of area bed placements (£457k) is the main driver of the deficit. There was a one-off upside of £165k in the month and a number of other savings across the Trust which partly offset the expenditure on beds.,
• Finance Risk metrics remains below plan due to the surplus position being lower than plan and the fact agency spend is 89% above the cap.
• Year-to-date pre STF surplus of break-even which is £0.8m behind plan. This means Q3 STF monies of £0.3m have not been achieved.
• Full year pre STF surplus forecast remains at £0.5m, but with very significant risk attached. Forecast has improved for successful position with flu CQUIN and recognition of reduction in discretionary spend, but these improvements have been offset by further deterioration in out of area bed expenditure and agency staff costs.
• Agency spend increased to £0.9m in the month and remains well above both ceiling and forecast. Cumulatively agency spend is now £7.6m, which is in breach of our full year ceiling of £5.1m and is currently 89% above our cap. Total pay costs were below plan in the month.
• Cost improvements delivery to date of £6.8m, which net of contingency is £0.5m lower than plan. Specific issues relate to the use of out of area bed placements and a range of other trust wide schemes.
• Cash reduced to £26.1m in the month, which is £0.3m lower than plan.

Agency Staffing Costs

Financial information relating to agency expenditure is included within the finance report appended to the IPR. Reductions in expenditure have not been forthcoming as previously expected and as such it is important to focus on all those actions taking place to address this. At this point there are no notable or consistent monthly movements in the cost of either medical or nursing agency costs. We incur costs of circa £0.3m per month with each of these professions.
The weekly Operational Management Group is reviewing each clinical role which uses agency staffing on a regular basis. For each such role actions are identified with respect to how the role can be filled substantively or what other options exist. Focus is particularly applied to all agency staff that have been engaged over a longer term period (6 months or over) and those engaged at a higher cost. All breaches of agency cap are also reviewed weekly. The Trust is working collectively with other Mental Health providers in the region to progress nursing recruitment overseas. The Medical Director is progressing an overseas rotation scheme for doctors and we are introducing local nursing associate roles. These measures are expected to have an impact in the coming weeks.
No new admin agency usage is being reported and plans are in operation to recruit into key roles where there are longer term admin agency staff in place.

Out of Area Bed Placements

A number of actions have taken place with respect to the use of out of area bed placements.
Specific service demand has been analysed to identify where the increase in demand has occurred. There are issues in most services, but there has been particularly high demand for female acute beds and the internal capacity has been reduced for male acute beds following the Trinity fire. Demand for PICU beds has also increased, particularly for female beds.
Dialogue is taking place with loss adjusters with respect to an insurance settlement for the element of out of area bed usage that has occurred as a consequence of the fire on Trinity.
Additional internal capacity is being created and an agreement is being entered into with Pennine Care to utilise NHS beds at a lower rate than the private sector charge.
There is ongoing focus on patient flows to ensure there is a consistent approach across the Trust and reduce length of stay, and we are working with other Trusts that have been successful in reducing out of area bed usage to ensure we can learn from them.

Quality Headlines (& CQUINS performance on a quarterly basis)

As identified in previous months, work has been undertaken to identify additional quality metrics. These have now been included and are reported against from September 16 onwards - where historic data is available, this has been included. Where targets have not yet been agreed, a proposal will be taken to EMT regarding what they should be in January.

Section	KPI	Objective	CQC Domain	Owner	Target	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Year End Forecast Position *
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Quality & Experience	Safe	TB	6	0	3	0	0	0	0	0	0	0	0	0	0	1	4
C-Diff	C Diff avoidable cases	Quality & Experience	Safe	TB	0	0	0	0	0	0	0	0	0	0	0	0	0	data not avail	4
Outcomes	% SU on CPA in Employment	Health & Wellbeing	Responsive	DS	10%	7.2%	7.6%	7.4%	7.3%	6.9%	7.0%	7.2%	7.0%	6.7%	6.9%	6.5%	6.5%	6.2%	1
	% SU on CPA in Settled Accommodation	Health & Wellbeing	Responsive	DS	60%	64.4%	62.8%	64.1%	62.3%	60.0%	67.9%	64.6%	65.8%	67.0%	64.4%	64.4%	63.7%	62.9%	4
Complaints	% Complaints with Staff Attitude as an Issue	Quality & Experience	Caring	DS	< 25%	14% 23/179	13% 20/156	14% 20/140	15% 31/211	8% 4/53	23% 12/53	11% 7/62	8% 4/52	9% 4/45	6% 4/65	22% 12/54	18% 8/44	13% 8/60	4
Service User Experience	Friends and Family Test - Mental Health	Quality & Experience	Caring	DS	80%	77%	83%	79%	78%	74%	72%	70%	70%	77%	64%	67%	76%	71%	2
	Friends and Family Test - Community	Quality & Experience	Caring	DS	95%	98%	99%	97%	98%	99%	98%	99%	98%	98%	97%	97%	98%	99%	4
Quality	Total number of reported incidents	Quality and Experience	Safety Domain	TB	N/A					1082	1195	1229	1166	1129	1106	992	1147	1078	N/A
	Total number of patient safety incidents resulting in severe harm and death	Quality and Experience	Safety Domain	TB	N/A					3	6	1	3	11	8	7	7	8	N/A
	Total number of patient safety incidents resulting in moderate or severe harm and death	Quality and Experience	Safety Domain	TB	N/A					17	35	21	21	31	34	31	26	26	N/A
	MH Safety thermometer - Medicine Omissions	Quality and Experience	Safety Domain	TB	17.7%					11.8%	20.7%	17.7%	17.4%	19.6%	16.0%	18.7%	22.9%	data not avail	3
	Safer staff fill rates	Quality and Experience	Safety Domain	TB	90%					108%	107%	111%	111%	109%	109%	113%	117%	112%	4
	Safer Staffing % Fill Rate Registered Nurses	Quality and Experience	Safety Domain	TB	80%					98%	98%	101%	98%	93%	91%	95%	99.5%	96.1%	4
	Number of pressure ulcers (attributable) 1	Quality and Experience	Safety Domain	TB	N/A					24	40	34	23	38	34	21	23	34	N/A
	Number of pressure ulcers (avoidable) 2	Quality and Experience	Safety Domain	TB	0					0	0	1	1	1	2	0	2	0	3
	Complaints closed within 40 days	Health & Wellbeing	Responsive	DS	TBC	Reporting established from Sept 16									8	8	1	0	
	Complaints closed over 40 days	Health & Wellbeing	Responsive	DS	TBC	Reporting established from Sept 16									13	14	14	10	
	Referral to treatment times	Health & Wellbeing	Responsive	KT/SR/CH	TBC	KPI under development													
	Un-outcomed appointments	Quality and Experience	Effective	KT/SR/CH	TBC	To be included from October 16									2.2%	3.2%	3.5%	2.9%	
	Data completeness	Quality and Experience	Effective	KT/SR/CH	TBC	KPI under development													
	Number of Information Governance breaches 3	Quality and Experience	Effective	MB	<=8	Reporting from April 16				16	8	12	8	10	7	10	8	11	n/a
	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Quality and Experience	Caring	AD	80%	To be included from October 16									79.26%	Avail end of Q4			N/A
	Staff FFT survey - % staff recommending the Trust as a place to work	Quality and Experience	Caring	AD	N/A	To be included from October 16									65.19%				N/A
	Number of compliments received	Quality and Experience	Caring	DS	N/A	To be included from October 16									26	33	79	29	
	Eliminating Mixed Sex Accommodation Breaches	Quality and Experience	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
	Number of Duty of Candour applicable incidents	Quality and Experience	Caring	TB	N/A					73			86			31	26	26	N/A
	Duty of Candour - Number of Stage One exceptions	Quality and Experience	Caring	TB	N/A	Reporting established from Oct 16										0**	0**	0**	N/A
	Duty of Candour - Number of Stage One breaches	Quality and Experience	Caring	TB	0	Reporting established from Oct 16										0***	0***	0***	
	% Service users on CPA given or offered a copy of their care plan	Quality and Experience	Caring	KT/SR/CH	80%	85.8%	84.3%	85.2%	85.6%	85.8%	85.6%	85.6%	85.3%	85.0%	85.0%	85.2%	83.0%	83.0%	4
	% of prone restraint with duration of 3 minutes or less	Quality and Experience	Safety Domain	KT/SR/CH	80%	Reporting Established from July 16							72%	89%	80%	80%	83%	data not avail	

** See key included in glossary*

1 - Attributable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary

2 - Avoidable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage

3 - The IG breach target is based on a year on year reduction of the number of breaches across the Trust. The Trust is striving to achieve zero breaches in any one month

*** we currently have no confirmed breaches but housekeeping is underway regarding any outstanding incidents where clarification is required.

Further work has been undertaken this month to identify some additional key quality measures, these relate to eliminating mixed sex accommodation, Duty of Candour, service users on CPA given or offered a copy of their care plan and prone restraint. These metrics are now available in the report in the table above and reporting commenced from April 16 onwards where data is available (please note, historic data has been provided where available). The indicators are reported both monthly and quarterly to EMT and Trust Board. There are a few areas remaining that require additional development; these relate to:

- Referral to Treatment waiting times - we are awaiting some national guidance on this - this was anticipated to be received during November but remains outstanding. This will relate to CAMHS services. We will align our reporting to this once the report criteria is published.
- Data completeness - this indicator is being developed and will focus on the completeness of the clinical record.
- Some of these KPIs are new, work is now taking place to identify appropriate threshold and forecast trajectories.

Historically we have not reached the target in achieving 10% of CPA service users in employment and the current trajectory does not suggest this will be achieved at the year end. The indicator parameters only include clients on CPA within the age range 18-69 years old. The Trust is currently undertaking a pilot project in Barnsley covering all mental health service users (regardless of CPA status or age) which is focusing on employment, volunteering and training. Focus will also be placed on the collection of this data for all adults to align to the NHSI Single Oversight Framework; the baseline for this is currently being identified.

NHS Safety Thermometer - Medicines Omissions – this is an indicator within the CQUINs for the west and has been identified as at risk of achievement. Detail of the issues behind this can be seen in the CQUIN section below.

Duty of Candour (DoC) – a programme of housekeeping is currently underway to provide assurance to this reporting, data included at the moment is provisional and may change subject to the review. Once the housekeeping is completed we will have a final number of DoC incidents which have resulted in breaches. The DoC data is now being reported on a monthly basis to the operational management group where information is provided by locality to allow operational ownership.

Quality Headlines (& CQUINS performance on a quarterly basis)

Commissioning for Quality and Innovation (CQUIN)

The Trust is due to submit its quarter 3 return at the end of January.

Following tremendous engagement from our staff over 75% of front-line staff received the flu vaccination which has safeguarded this CQUIN income. We have already held a learning event to identify what enabled this success and how we can continue to improve

A financial loss of £119k is anticipated in Q3. Areas of under-performance are expected to relate to:
• Mental Health Currencies adherence to red rules in Barnsley and Calderdale.
• Cluster review (clusters 4-17 and cluster 18-21) in Barnsley and Calderdale.
• Medicine omissions - some risk associated with achievement of this for Calderdale, Kirklees and Wakefield.
The Trust forecast out turn for 16/17 based on Q3 forecast performance is 87% achievement. Focus is on improving this position.

The final Q3 position as agreed with the commissioner is anticipated to be available in next month's report.

For 2017/18 the CQUIN schemes will be part of a national two year scheme and will run until 2018/2019. The scheme is intended to deliver clinical quality improvements and drive transformational change, supporting the ambitions of the Five Year Forward View and directly linking to the NHS Mandate. A number of the indicators work across partner organisations and collaboration will be required. The national CQUIN indicators on improving the health of our staff, and Physical Health for people with Severe Mental Illness are retained from the 2016/17 scheme and new indicators for the Trust will be:
• Proactive and Safe Discharge
• Wound Care
• Preventing ill health by risky behaviours – alcohol and tobacco
• Personalised Care / support planning
• Child and Young Person MH Transition
• Improving services for people with mental health needs who present to A&E
Work has commenced on identifying Trust leads for each of these indicators, reviewing the indicators in conjunction with the commissioner and work streams are being established. This will be monitored via the Trust CQUINS leads group.

0.5% of CQUIN for 17/18 is dependent upon achievement of 16/17 control total and 17/18 STP performance.

Forensic services will continue with the national forensic scheme, this will include 2 indicators, both of which the indicators are a continuation of the 2016/17 scheme:
• Recovery colleges for medium and low secure patients
• Reducing restrictive practices within adult low and medium secure services

Safety First

Summary of Q1, Q2, Q3

Summary of Incidents	Q1	Q2	Oct-16	Nov-16	Dec-16	Q3
Green no harm	2148	2039	590	675	634	1899
Green	978	966	290	367	318	975
Yellow	292	310	96	96	92	284
Amber	80	73	21	24	25	70
Red (should not be compared with SIs)	9	15	7	8	9	24
Total	**3507**	**3403**	**1004**	**1170**	**1078**	**3252**

• All serious incidents are investigated using Root Cause and Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly incident reports, available on the patient safety support team intranet pages.
• Incident reporting levels remain within the normal range.
• Risk panel remains in operation and scans for themes that require further investigation. Monthly report for Operational Management Group to commence 25/1/17

No never events reported in December.

Summary of SIs reported in Q1, Q2, Q3

Summary of Serious Incidents	Q1	Q2	Oct-16	Nov-16	Dec-16	Q3
Suicide (incl apparent) - community team care - current episode	2	7	2	1	2	5
Death - other cause	1	1	1	2	0	3
Suicide (incl apparent) - community team care - discharged	3	0	0	0	1	1
Self harm (actual harm) with suicidal intent	1	0	1	0	1	2
Pressure Ulcer - grade 3	1	1	0	0	1	1
Information disclosed in error	2	0	0	0	0	0
Physical violence (contact made) against other by patient	1	0	0	0	1	1
Slip, trip or fall - patient	1	0	1	0	0	1
Suicide (incl apparent) - inpatient care - current episode	0	1	1	0	0	1
Fire / Fire alarm related incidents	0	0	0	1	0	1
Formal patient absent without leave	0	1	0	0	0	0
Inappropriate Sexual Behaviour (including assault)	0	1	0	0	0	0
Physical violence (contact made) against patient by patient	0	1	0	0	0	0
Physical violence (contact made) against staff by patient	1	0	0	0	0	0
Total	**13**	**13**	**6**	**4**	**6**	**16**

Mortality Review Training – Mortality Reviews – Work continues with Mazars to improve reporting and review arrangements. Mortality Review training took place on 2/12/16. 26 members of staff were trained. A Trust process for mortality reviews is being developed.

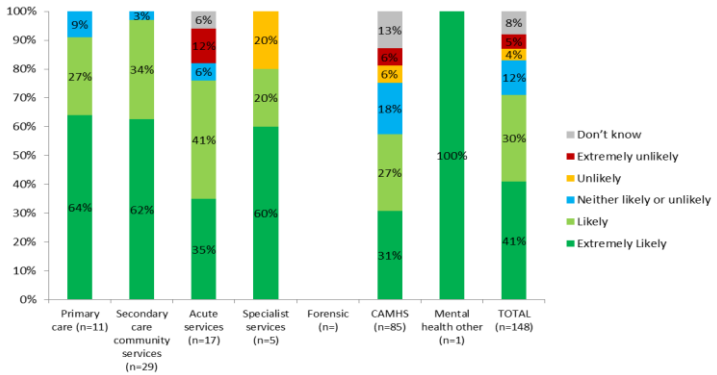
Quality Headlines (& CQUINS performance on a quarterly basis)

Patient Experience

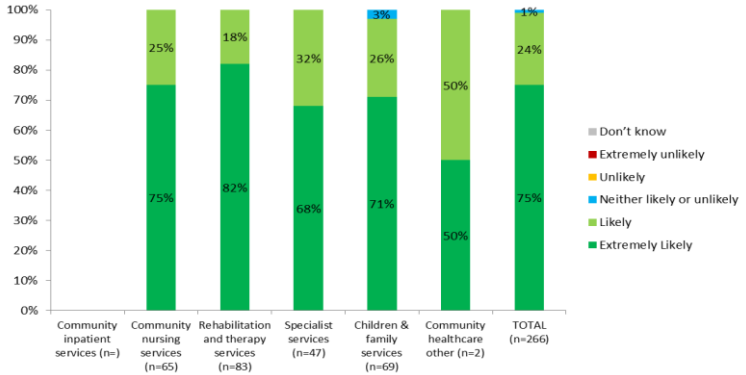
Friends and family test shows

- Community Services – 99% would recommend community services.
- All service lines achieved 50% or above for patients/carer's stating they were extremely likely to recommend the Trust's services.
- Mental Health Services – 71% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust– between 31% (CAMHS) and 100% (Mental Health Other)
- Small numbers stating they were extremely unlikely to recommend.

Mental Health Services



Community Services



Safer Staffing

% Fill Rate for Registered Nurses - 96.1%

112% overall Trust - safer staff fill rates

Average Fill Rate by BDU

Average Fill Rate			
BDU	Oct-16	Nov-16	Dec-16
Specialist Services	224%	237%	222%
Barnsley	110%	113%	111%
C & K	114%	121%	111%
Forensic	109%	112%	107%
Wakefield	110%	109%	109%
Grand Total	**113%**	**117%**	**112%**

No inpatient wards fell below a 90% overall fill Rate in December 2016

23 (77%) wards achieved 100% and above fill rate. On night duty, 21 inpatient areas (70%) achieved over 100% registered nurses with no area falling below 80% escalation threshold. On day duty three wards met the below 80% escalation threshold for registered nurses, however safe services were maintained. There continues to be high levels of acuity, in particular levels of observation and bespoke care packages, and the resultant need being fulfilled through non-registered staff. Going forward we will also be looking at the shift numbers to attain a more diverse picture of fill rates and acuity.
Escalation threshold of below 80% for registered nurses and 90% for overall fill rates remains in place.

Quality Headlines (& CQUINS performance on a quarterly basis)

Sign up to Safety

In 2014, the Trust joined the national Sign up to Safety campaign, and made five pledges to improve patient safety. The pledges are being addressed through the Patient Safety Strategy implementation plan. In addition to this, the Trust committed to reduce avoidable harm by 2018 in five main areas.

The data for 2016 has been reviewed against baseline figures, and at present this is showing positive outcomes. Inpatient falls have reduced by 24.6% (target 15%), pressure ulcers (attributable and avoidable) have reduced by 52.3% (target 50%). We aim to reduce moderate harm and above in incidents that resulted in restraint, currently 42.8% (target by 30%). We have continued to improve our recording and monitoring of data since 2014 and consequently refined some of the measures and targets. The duration of prone restraint has recently been introduced (July 2016) and we aim to have 90% of prone restraints with a duration of less than 3 minutes by 2018. This is currently 78%. Work is progressing towards a reduction in unintended missed doses by 25% by 2018. Care should be taken not to compare this data with performance information as criteria and date ranges are not the same.

Safety improvement plans have been updated for 2017 for each area of harm reduction, which are led by specialist advisors. Data is monitored through Datix Dashboards and discussed in the Patient Safety Strategy Implementation group.

CQC inspection update

CQC action plan headlines
• Services continue to actively progress with their action plans, which reflects in the increased percentage of blue 'completed actions'.

Monitoring of actions against our CQC action plan

The CQC have re-visited our core services that required improvement or had a regulatory breach.
The inspectors have revisited the teams within the community mental health services for older people, long stay rehabilitation and recovery, inpatient wards for older people, Forensic services, CAMHS and LD community services. In January we are expecting a re-inspection of our Acute and PICU wards and latterly a well led review.

Revisit draft reports are expected within approximately 40 days of the visit date for factual accuracy checking. To date we have received the CQC re-inspection report for Community Mental Health Teams for Older People, for factual accuracy checking.

A new process for factual accuracy has been implemented by the CQC, which in essence means the person who has wrote the report no longer responds to the factual accuracy queries. We anticipate a short turn- around time for factual accuracy as the timescale for the report publication is 50 days from the day of visit.

The well led review will take place between 30th January to 1st February, and preparation has commenced with the interview and focus groups schedule planned. We have been informed that approximately 12 inspectors will be on site during this time, led by Jenny Wilkes and supported by Kate Gorse Brightmore (SWYPFT relationship manager).

	Dec-16	
	MUST	SHOULD
	(n =33)	(n=60)
Blue	27 (82%)	53 (88%)
Green	3 (9%)	5 (8%)
Amber/Green	1 (3%)	0
Amber/ Red	1 (3%)	0
Red	1 (3%)	2 (3%)

	Nov-16	
	MUST	SHOULD
	(n =33)	(n=60)
Blue	13 (39%)	35 (58%)
Green	11 (33%)	10 (16%)
Amber/Green	7 (21%)	10 (16%)
Amber/Red	1 (3%)	4 (7%)
Red	1 (3%)	1 (2%)

The red actions all have action plans in place to address the must or should do actions. These actions are red as we have missed the original deadline date, these actions can only now turn blue upon completion now initial deadline has been missed.

Serious incident Trinity 2

Sadly, a service user died on Trinity 2, our acute male mental health ward at Fieldhead. We're currently working with West Yorkshire Police as they conduct their investigation. There are no immediate suspicious circumstances to report and we will await the verdict of the coroner to determine cause of death.

Our thoughts are with the individual's family and friends during this difficult time and we have offered them our full support. We're also supporting the staff involved in the incident, who, along with emergency service colleagues, responded well in difficult circumstances.

It appears that the individual died as a result of asphyxiation due to a ligature.

Our serious incident policy has been followed - the incident has been STEIS reported and the CQC and our commissioners have been informed. An initial review has taken place to identify any immediate action required and a full investigation is underway.

All managers are now checking ligature audits and they have been asked to confirm current mitigations. We are checking to see if any additional measures can be implemented.

We are firmly committed to learning from all incidents that occur in our organisation. We will make sure that all lessons are shared as soon as possible.

Quality Headlines (& CQUINS performance on a quarterly basis)

Safeguarding Children and Adults Quality Headlines

Both safeguarding adults and safeguarding children training remains above the Trust mandatory 80% requirement.
Recent feedback from a review of the Prevent/Channel process within Kirklees, identified that SWYPFT make a positive contribution and appropriately share information in a timely manner.
The positive impact of awareness raising and training has been evidenced in an increase of advice calls taken by the safeguarding team
There are now 13 qualified Prevent trainers across the Trust, three are specifically identified to deliver training to CAMHS.
Future challenges include the expected return of both adults and children from Syria, the Trust will need to be sighted on this issue.

Infection Prevention & Control

The IPC team have been thanked for their contribution to the flu programme by Helen Whitlam who said they have made a 'huge contribution to the target'.

There has been an outbreak of Influenza A at Mount Vernon Hospital Barnsley BDU which affected a number of patients, 12 of which were confirmed cases.
The 2 wards comprise a total of 48 beds and all the remaining patients were treated prophylactically . This along with other outbreak measures including isolating patients , coherting patients and deep cleaning has led to minimum disruption across health economy and effective IPC outcome for patients ,relatives and staff.
Wards closure to admissions commenced on the 17th January 2017 and re-opened on 24th to ward 5 (male) There is anticipated opening of ward 4 (female) on 27th January .

Business Delivery Units Learning Events from incidents

Along with learning events following individual serious incidents the Business delivery Units are continuing to have learning events that further explore themes from incidents. Three events have recently been attended by Commissioners and they commented how impressed they were in demonstrating to on going learning from incidents. Each of these events focussed on different learning :- Suicide from trends, work taking place across the STP, clinical examples of improved recording of risk and how we look after staff and families following a person taking their life. Another event was on improving hospital discharges and the third was veterans pathways.

Information Governance

There have been a small number of reportable incidents to the Information Commissioner's Office in recent weeks. These have largely been a consequence of personal information being sent to an incorrect address. Regular communications are taking place to reinforce our responsibilities relating to personal information. In addition an exercise is being undertaken to identify where different address details are held between systems (RiO and The Spine) with the aim of ensuring both are consistent with respect to the address information they hold.

NHS providers must strive to meet key national access standards, including those in the NHS Constitution. From the 1st October, NHS Improvement have introduced a new framework for monitoring providers performance. One element of the framework relates to operational performance and this will be measured using a range of existing nationally collected and evaluated datasets, where possible. The following table lists the metrics that will be monitored and identifies baseline data where available and identifies performance against threshold. The frequency of the monitoring against these KPIs will be monthly and quarterly depending on the measure. The Trust will continue to monitor performance against all KPIs on a monthly basis where possible and will flag up any areas of risk to the board.

KPI	Objective	CQC Domain	Owner	Target	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Q1 16/17	Q2 16/17	Q3 16/17	Year End Forecast Position *	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Health & Wellbeing	Responsive	SR	92%	98.4%	98.8%	98.8%	98.1%	97.8%	98.0%	99.1%	98.4%	95.9%	96.5%	96.2%	98.9%	96.2%	98.2%	97.0%	97.5%	4	
Maximum 6-week wait for diagnostic procedures	Health & Wellbeing	Responsive	SR	99%	100%	100%	100%	100%	100%	100%	98.8%	100%	100%	100%	100%	100%	100%	99.6%	100%	100%	4	
% Admissions Gatekept by CRS Teams	Health & Wellbeing	Responsive	SR/KT	95%	95.5%	97.3%	95.7%	98.3%	96.8%	96.8%	97.1%	95.7%	100.0%	100%	98.7%	99.1%	98.9%	96.9%	99.3%	99.2%	4	
% SU on CPA Followed up Within 7 Days of Discharge	Health & Wellbeing	Safe	SR/KT	95%	98.7%	98.0%	95.5%	97.4%	95.1%	96.6%	98.6%	96.2%	100.0%	97.1%	97.6%	96.3%	98.4%	96.7%	97.8%	97.3%	4	
Data completeness: Identifiers (mental health)	Health & Wellbeing	Responsive	SR/KT	95%	99.6%	99.5%	99.5%	98.5%	98.8%	98.4%	98.1%	98.8%	99.8%	99.7%	99.8%	99.7%	99.8%	98.1%	99.7%	99.8%	4	
Data completeness: Priority Metrics (mental health)	Health & Wellbeing	Responsive	SR/KT	85% *(by end March 17)*	Reporting developed from Oct 16										42.1%	42.6%	42.3%	Data not avail			2 **	
IAPT - proportion of people completing treatment who move to recovery	Health & Wellbeing	Responsive	SR/KT	50%	Reporting from 1st Oct 16				50.2%	61.4%	42.1%	55.2%	52.8%	49.1%	42.4%	46.8%	56.9%	50.1%	52.5%	47.9%	3	
IAPT - Treatment within 6 Weeks of referral	Health & Wellbeing	Responsive	SR/KT	75%	77.8%	75.9%	71.6%	70.5%	74.0%	74.2%	80.0%	83.8%	81.3%	86.2%	91.0%	85.7%	91.0%	76.1%	83.6%	88.9%	4	
IAPT - Treatment within 18 weeks of referral	Health & Wellbeing	Responsive	SR/KT	95%	99.1%	99.1%	99.4%	98.1%	98.6%	98.4%	99.2%	99.6%	99.0%	99.2%	94.7%	100%	99.0%	98.9%	99.3%	97.9%	4	
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Health & Wellbeing	Responsive	SR/KT	50%	N/A	N/A	85.2%	86.0%	73.9%	78.3%	80.0%	83.3%	93.8%	73.1%	80.9%	93.7%	69.2%	77.5%	82.0%	82.2%	4	
% clients in settled accommodation	Health & Wellbeing	Responsive	DS	*60%*	Reporting developed from Sept 16									82.7%	83.4%	82.8%	82.7%	Data not avail			4	
% clients in employment	Health & Wellbeing	Responsive	DS	*10%*	Reporting developed from Sept 16									9.0%	8.9%	8.6%	8.4%	Data not avail			1	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards / b) early intervention in psychosis services / c) community mental health services (people on Care Programme Approach)	Health & Wellbeing	Responsive	SR/KT		Reporting being developed - due quarter 4																2	

** See key included in glossary.*

Areas of concern/to note:

• Data completeness: Priority Metrics (mental health) ** – this is a new metric and the reporting has been developed in line with currently available guidance. The indicator is required to be achieved by 2016/17 year-end. Comprising: ethnicity, employment status (for adults only), school attendance (for CYP only), accommodation status (for adults only), ICD10 coding. Note: ICD10 for Children and Young People (CYP) may be supplanted by capture of a problem descriptor, rather than a formal medical diagnosis. Some risk associated with recording of employment and accommodation status for all adults (previously reported for CPA only) and school attendance and ICD10 coding for non CYP as this has not routinely been collected for all records. Performance from the December primary MHSDS submission shows this indicator to be an area of risk. The data is being reviewed and action plans for improvement are being developed to target hotspot areas.

• IAPT – Proportion of people completing treatment who move to recovery: Trust wide performance for the month of December has seen a significant increase and now reports above threshold in all three teams, however, under performance in the earlier months of the quarter has resulted in the QTD position for this KPI being under threshold at 47.9%. QTD performance by service is broken down as follows: Barnsley 45.6%; Calderdale 47.2%; Kirklees 49.5%. Some focused work has taken place within the services to focus on data quality and referral appropriateness and this is evident in the December position – this work will continue.

• Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely for inpatient wards; early intervention in psychosis services; community mental health services (people on Care Programme Approach) - this aligns to the 2016/17 CQUIN and some risk has been identified in achievement of this. Barnsley BDU achieved this partially in 2015/16, a robust programme of work has been put in place during 16/17 to improve performance. Results will be available during Quarter 4.

• The technical guidance regarding the reporting criteria for these indicators is not detailed at this stage, this may lead to some discrepancy in interpretation of requirements or reporting criteria. The Trust have identified a number of queries regarding the reporting parameters which are being queried with NHSI.

This section of the report is to be developed during 2016/17 and populated with key performance issues or highlights as reported by each BDU.

Barnsley BDU:
• IAPT - improvement seen in month related to the number of clients moving to recovery and this is now meeting the 50% threshold. Underperformance continues related to the proportion of people with depression/anxiety disorders receiving psychological therapies. The data is being closely monitored in conjunction with the commissioner.
• Sickness - seasonality impacting the December position.
• We have experienced extreme pressure in our community nursing and therapy services, and particularly Intermediate Care beds on the wards at Mount Vernon hospital and our community virtual beds, which was linked to the Acute Hospital (BHNFT) extreme pressures in A and E and medical beds over the Christmas period which is continuing to date . We have continued service delivery successfully proactively with our partners, with particular thanks to all our staff involved.
• The BDU have been successful in ensuring that all admissions to acute mental health wards since April 16 have been gatekept prior to admission by the intensive home based treatment team.

Calderdale & Kirklees BDU:
• Delayed transfers of care in Calderdale Older Peoples services (Beechdale) have improved significantly in the month and are now within Monitor target. Continuing issues re- the lack of suitable nursing home placements in Calderdale. Positive progress has been sustained with Calderdale council to resolve social work engagement and speed of assessments. Analysis carried out which points at joint health and social care funding decisions are a problem which is leading to increase LOS.
• Significant pressure on Adult beds which has led to Bronze status in BDU with daily teleconferences with all teams to look at flow and capacity.
• Sickness absence positively improved again this month due to management and HR focus.
• Physical Violence – There have been an increased number of incidences of violence against staff members.

Forensics BDU:
• The first group of the new band 4 practitioners are due to start towards the end of February. They will support each of the care pathways as part of the multidisciplinary teams and provide excellent career development for non-registered staff.
• The forensic team are planning a refresh of the 25 hours structured activity requirements to improve understanding, application and recording of the requirements.
• There has been an increase in number of incidents compared to previous quarter and the same quarter last year. Reasons are being reviewed and increased acuity appears to be one reason.
• An incident on Hepworth Ward has been re-graded from amber to red. A member of staff was injured following an assault. This follows a violent incident earlier in the quarter that is still subject to investigation. The findings of both investigations will inform the learning outcomes.

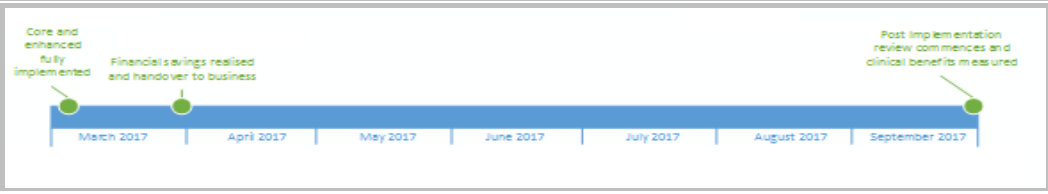
Specialist BDU:
• Plans have been agreed with each CCG for short term investment into CAMHS waiting list initiatives. Although this increases agency use, it provides opportunity to significantly reduce waiting lists for treatment moving into the next financial year.
• Targeted management action is underway to understand and address low level information governance incidents and to improve IG training.
• Access to CAMHS tier 4 beds remains a challenge. Learning is being used from specific cases where young people have been admitted to adult beds to review procedures. SWYPFT will contribute to the STP work on tier 4 access.
• The Horizon Centre is expecting to start work in February towards opening all 8 beds. A bespoke package of care is expected to finish at the end of January, which will also reduce agency spend.

Wakefield BDU:
• The BDU continues to experience significant bed pressures following the Fire, which reduced the overall bed complement by 8 Acute and 4 PICU beds. There is currently an unusually high demand for female admissions
• There has been an increase in sickness absence across the BDU. The majority of these absences are long term and all are being managed in accordance with Policy
• All routine access targets across the BDU have been met and exceeded across all specialties

This section of the report reports the Trust's progress against the identified transformation projects.

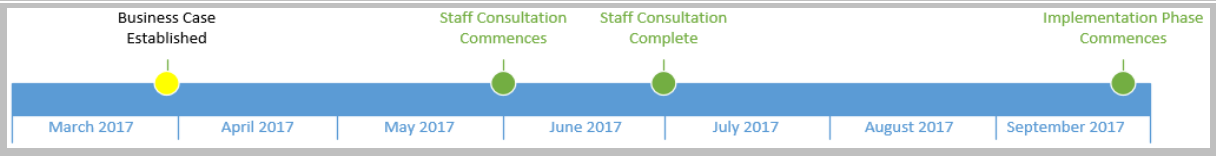
Acute & Community Mental Health Transformation Project

The Trust is currently implementing the 'core and enhanced' community pathways which have been devised through this project. This is due to be completed in Q4 of 2016/2017.	Delivery against plan	
New emerging issues in relation to Rio and possible resource and cost impacts of moving data in the system. For example 15,000 medic outpatient appointments need to be manually moved, with resource implications and risks of data entry errors. Separately a mass transfer of other data is required and we are working with the system provider to undertake this.	Management of risk	
Benefits arising from this project will be: more flexible and responsive deployment of resources; simpler and faster core pathway, supporting sustainable recovery; savings are being realised in Q4 16/17, already counted in BDU CIP delivery for the year.	Benefits Realisation	
QIA has been sent to the Quality Team in August 2016. A benefits framework has been established to track the delivery of the quality improvements and these will be tracked post implementation.	Quality impact	



Older Peoples Mental Health Transformation Project

The preferred community model was signed off by directors for development of a business case; workforce modelling will commence and degrees of tolerance to local variations will be agreed through this process. Initial strategic review of in patient bed usage now undertaken. Business case in development for completion by March 2017 with formal consultation to commence in Spring 2017.	Delivery against plan	
A cost pressure of £60k in 2017/18 is anticipated to enable dedicated clinical leadership and change management resource to deliver the project. Risk that some financial benefits identified can't be fully realised if parts of the community workforce require enhancing.	Management of risk	
Benefits of £1M are targeted for realisation in 18/19 via a reduction in the number of older peoples mental health beds, enabled by provision of dedicated intensive support as a community alternative to admission. This will be modelled in terms of demand and capacity and financial assumptions in the business case which is due end of March 2017.	Benefits Realisation	
Extensive engagement around clinical model provides assurance of positive quality impact.	Quality impact	



Rehab and Recovery Transformation Project

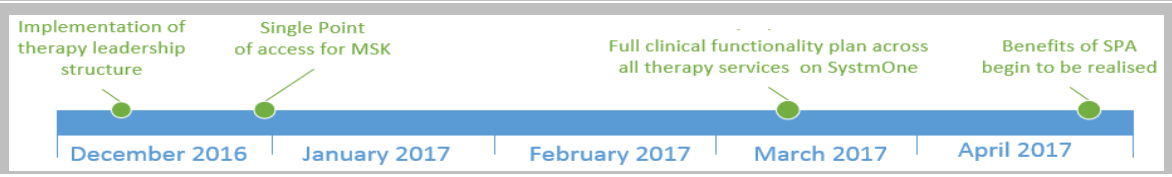
Community model agreed in principle with local CCGs. Implemented in Wakefield with savings achieved for commissioners and providers. Implementation in Calderdale expected in 2017/2018. A feasibility report for a High Dependency Unit has been developed and a decision on whether to progress this work will impact on the rehab model in Kirklees.	Delivery against plan	
Challenges remain to develop capacity required in Kirklees to establish new ways of working. A paper has been developed to seek clarity on the future rehab services model and required resources to support the transition. Resourcing of delivery remains a block to progress – this is being addressed within the MH Transformation Programme Board.	Management of risk	
Financial benefits have already been realised in Wakefield and further financial savings have been put forward for CIP/ QIPP in Calderdale upon change of delivery model towards community delivery. This is anticipated to be realised in 2017/18.	Benefits Realisation	
The project undertook a Quality Impact Assessment in design phase, and a new QIA plus further engagement is likely to be required following decisions on how to progress activity in Kirklees.	Quality impact	

Barnsley Administrative Services Review

At the December 2016 meeting of the General Community Transformation Board an action was agreed to prepare a project closure report to formally close the project and move to 'business as usual' to support community services by April 2017.	Delivery against plan	
	Management of risk	
Benefits of this project are: remodelling the inpatient and reception admin functions; provide a 0830-1900 admin service; create clear development pathways/apprenticeship opportunities. Savings of £58k have already been realised as a result of the reconfiguration of admin services, cashiering and franking services, and amalgamation of reception functionality. These benefits will be summarised in the project closure report.	Benefits Realisation	
This project had a QIA conducted in the business case phase – it indicated a positive impact on quality through extended hours of reception, improving customer experience, and extended availability of administrative support to services.	Quality impact	

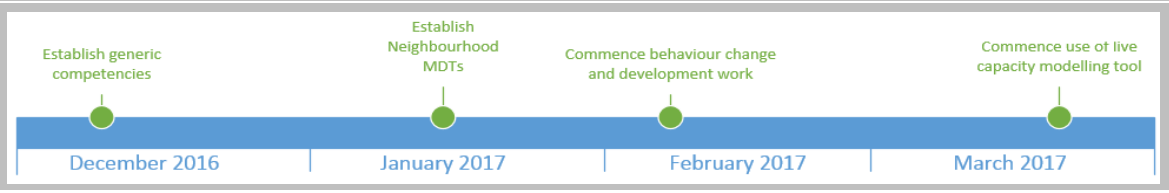
Barnsley Therapy Services Review

At the December 2016 meeting of the General Community Transformation Board an action was agreed to prepare a project closure report to formally close the project and move to 'business as usual' to support community services by April 2017.	Delivery against plan	
Impact of re-specification of Intermediate Care services not yet fully known. MSK services are also under review with expected re-specification and tender in 2017/18.	Management of risk	
The purpose of this project was to establish Therapy clinical centres with appropriate satellite clinical provision. These benefits will be summarised in the project closure report.	Benefits Realisation	
This project had a QIA conducted in the business case phase – it indicated a positive impact on quality through co-location and creation of centres of excellence, but also noted that consolidation of services moves some provision further from communities.	Quality impact	



Barnsley Community Nursing Transformation

The project is currently mobilising workforce changes required to move the service to a six neighbourhood model and supporting new ways of working. Rebranding of the service to 'Neighbourhood Nursing Service' has taken place and communications held with primary care practices.	Delivery against plan	
There are key elements of service to mobilise in January 2017, which require significant collaboration between partner agencies. Engagement is good and associated risks are being managed.	Management of risk	
The purpose of this project is to: ensure the right person, right contact, and right time; and to equip more patients to self-care; better integrate community nursing, care navigation teams, and establish integrated teams in localities which align with primary and social care. In 2016, the delivery direction of the project changed to reflect local commissioner intentions and the issue of a new service specification. Benefits tracking is now required to realise benefits from delivering a new outcomes based delivery model and the significant OD support to staff to implement new ways of working.	Benefits Realisation	
This project had a QIA conducted in the business case phase – it indicated positive impact on quality. To be repeated when implemented.	Quality impact	



Key for Transformation:			
Implementation deliverables		**RAG Ratings**	
	On Target to deliver within agreed timescales		On Target to deliver within agreed timescales/project tolerances
	On Trajectory but concerns on ability/confident to deliver within agreed timescales		On Trajectory but concerns on ability/confident to deliver actions within agreed timescales/project tolerances
	Off Trajectory and concerns on ability/capacity to deliver within agreed timescales		Off Trajectory and concerns on ability/capacity to deliver actions within agreed timescales/project tolerances
	Action will not be delivered within agreed timescales		Actions will not be delivered within agreed timescales/project tolerances
	Action Complete		Action Complete

Overall Financial Performance 2016 / 2017

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast	Narrative
1	NHS Improvement Risk Rating	3	3	The NHS Improvement risk rating remains capped at level 3 due to the agency metric rating of 4. Other metrics score as 1 or 2.
2	Normalised Surplus	£0.7m	£1.9m	December 2016 financial performance excluding STF is a deficit of £27k. The post STF deficit is £224k given the non-achievement of plan at Q3. The cumulative position excluding STF is a surplus of £22k, £739k surplus including STF. The main factors being continued and increased cost pressures on Out of Area beds partly offset by savings in other services and support. Full year pre STF surplus remains at £0.5m, but with very significant risk attached.
3	Agency Cap	£7.6m	£9.9m	Agency expenditure in December 2016 is £0.9m which represents a £0.1m increase compared to November. This is primarily within the nursing workforce. Year to date this position is 89% over the NHSI cap.
4	Cash	£26.1m	£21.8m	The Trust cash position is £0.3m less than plan at month 9. Variances arising from creditor payments, lower than plan surplus and the impact of non cash transactions. These have been offset by reduced levels of debtors and receipts from asset disposals (£1m for year to date).
5	Capital	£7m	£11.4m	Capital expenditure is behind plan at December by £1.6m excluding VAT reclaims. All schemes have been reviewed and as such the year end forecast has been reduced by £0.7m. Some schemes will be deferred, some have ceased and others recognise latest and more accurate cost estimates.
6	Delivery of CIP	£6.8m	£9.2m	Year to date CIP delivery is £0.5m behind plan. Overall the forecast position includes £0.9m of red rated schemes. There has been no movement on this position in month.
7	Better Payment	96%		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

Contracting

Contracting Issues - 2017-18 Negotiations

Contracts with CCGs and NHS E were agreed in principle by the 23rd December planning deadline. Memorandums have been inserted into CCG contracts to ensure continued review of investment into MH services in line with the requirements of Five Year Forward View.

CQUIN

A key priority remains the drive to secure maximum CQUIN income. The Trust has achieved the 75% threshold for flu vaccinations at a Trust wide level. Efforts are continuing to maximise uptake in every service and locality. Negotiation is currently taking place with commissioners regarding the Mental Health Currency CQUINs. There continues to be invested Trust wide scrutiny and support in order to assist with CQUIN delivery.

Key Contract Issues – Barnsley

Contracting negotiations have resulted in positive outcomes related to significant current pressures for continence products and MH Out of Area Locked Rehabilitation Placements. A significant proportion of services including neighbourhood nursing and intermediate care will transfer from the main contract into new Alliance Contracts during 17/18. Intermediate care is not funded in the 17/18 baseline contract beyond July 2017 which in effect sets the timescale for resolution. Another key movement is the commissioning of a Learning Disability bed. SWYPFT is taking legal advice before signing the Alliance Contract which currently covers Rightcare and Neighbourhood Nursing Services.

Key Contract Issues – Calderdale

Calderdale CCG have supplied a letter of commitment to investment in Five Year Forward View priority areas, and the contract has been agreed on that basis. Final contract documentation received for signature w/c 10th January 2017.

Key Contract Issues – Kirklees

Final contract documentation received for signature w/c 10th January 2017.

Key Contract Issues- Wakefield

Final contract documentation received for signature w/c 10th January 2017.
Urban House (Asylum Seekers) - the Wakefield Commissioner has informed SWYPFT that confirmation of funding for 2017/18 has been received from NHSE. The CCG has also confirmed the planned continuation of the contract for provision of TB services. These smaller contracts fell outside of the 23rd December national planning. Work continues to finalise these contracts.
The CCG is making increased investment in both Dementia and IHBT.

Contracting Issues - Forensics

NHSE Contract Offer includes an equitable arrangement regarding financial risk share in relation to bed occupancy in recognition of the significant progress made in local implementation of the Transforming Care Agenda (CTR). It has also been agreed to continue with 2 existing CQUINs which enhance quality for service users. Draft Contract documents were issued on 30-Dec.

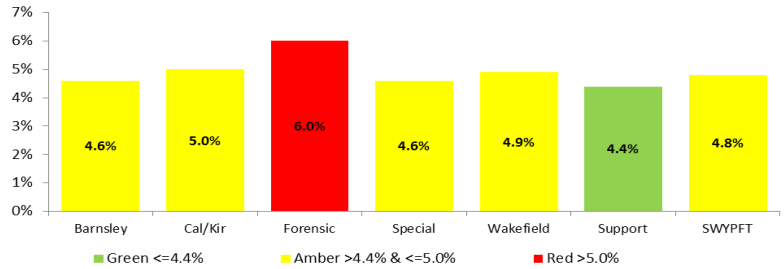
Key Contract Issues – Other

Contracts are awaited from Rotherham/Doncaster and Sheffield LAs related to 17/18 contract extensions for Smoke Free services. Kirklees LA confirmed their commissioning intention to decommission Smoke Free Services in Kirklees and an exit plan is being developed. In Calderdale work is ongoing with commissioners to secure a smooth continuation of CAMHS services from April 2017. Kirklees - Work is ongoing with Locala to secure a smooth continuation of CAMHS within a wider 0-19 contract which is due to commence in April 2017.

Workforce

Human Resources Performance Dashboard - December 2016

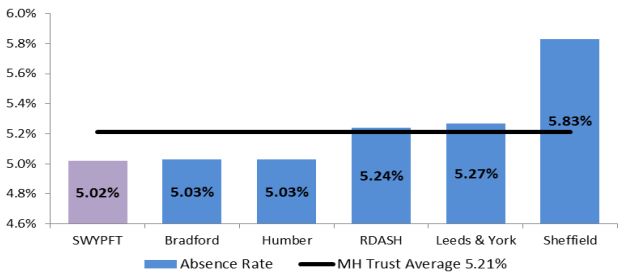
Sickness Absence



Current Absence Position - November 2016

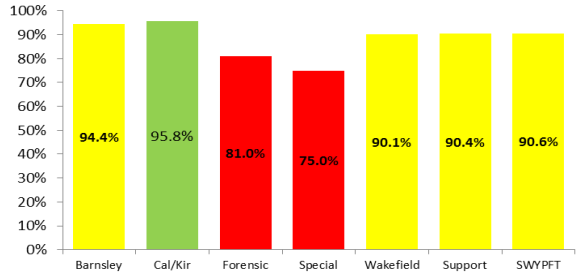
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	6.2%	4.0%	6.1%	4.3%	5.5%	5.2%	5.3%
Trend	↓	↑	↓	↔	↔	↑	↓

The Trust YTD absence levels in November 2016 (chart above) were above the 4.4% target at 4.8%.



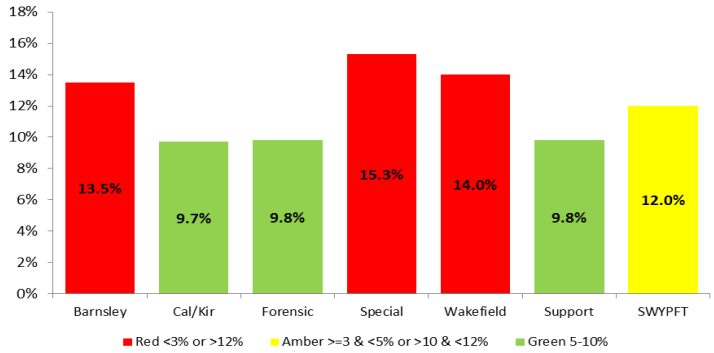
The above chart shows the YTD absence levels in MH/LD Trusts in our region for the 12 months to the end of March 2016.
During this time the Trust's absence rate was 5.02% which is below the regional average of 5.21%.

Appraisals - All Staff

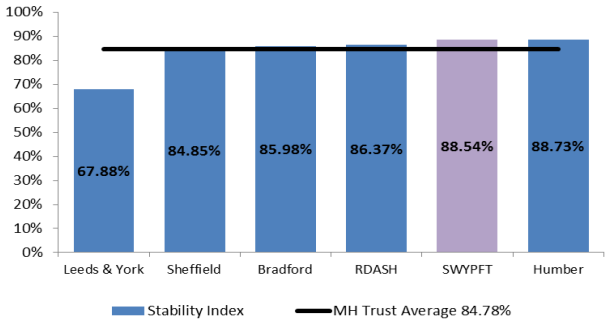


The above chart shows the appraisal rates for all staff for the Trust to the end of December 2016. The figures are calculated over the financial year from April 2016 to March 2017. The total percentages have decreased slightly since the inclusion of Band 1-5 but all staff groups continue to show improvement over the course of the financial year.

Turnover and Stability Rate Benchmark

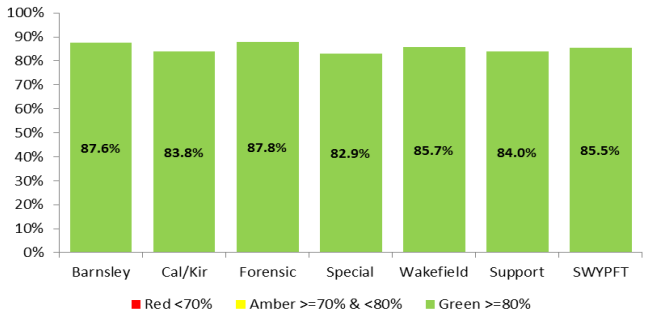


This chart shows the YTD turnover levels up to the end of December 2016.
All staff TUPE'd outside the Trust have been excluded from from the above data.



This chart shows stability levels in MH Trusts in the region for the 12 months ending in April 2016. The stability rate shows the percentage of staff employed with over a year's service. The Trust's rate is better than the average compared with other MH/LD Trusts in our region.

Fire Training Attendance



The chart shows the YTD fire lecture figures to the end of Dec 2016. The Trust continues to achieve its 80% target for fire lecture training; Specialist Services have improved their performance and are now above the target level.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.0%	4.7%	4.5%	4.6%	4.7%	4.7%	4.8%	4.7%	4.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.8%	4.7%	4.4%	4.8%	5.0%	4.9%	4.7%	4.7%	5.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	1.3%	20.1%	43.1%	56.7%	71.0%	81.4%	84.8%	89.8%	93.2%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	0.1%	6.3%	14.1%	26.8%	44.3%	68.5%	76.8%	84.9%	89.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.3%	82.6%	81.7%	80.8%	81.0%	82.4%	80.0%	78.8%	78.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80% by 31/3/17				62.0%	60.6%	63.2%	65.0%	66.9%	69.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80% by 31/3/17				28.2%	39.0%	41.0%	39.9%	45.1%	53.5%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.8%	92.0%	91.5%	91.9%	91.7%	90.9%	90.3%	89.4%	90.1%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.2%	83.2%	82.8%	84.5%	85.1%	84.6%	83.7%	82.9%	85.5%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	78.4%	79.1%	80.0%	80.8%	82.2%	81.8%	82.6%	82.9%	83.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	85.6%	83.4%	84.5%	84.8%	83.4%	82.5%	81.3%	81.9%	83.8%
Information Governance	Resources	Well Led	AD	>=95%	93.6%	90.0%	89.9%	90.2%	89.2%	88.2%	86.5%	85.9%	86.5%
Moving and Handling	Resources	Well Led	AD	>=80%	85.0%	84.4%	82.2%	82.2%	79.4%	78.2%	77.0%	78.1%	78.8%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80% by 31/3/17								12.9%	46.0%
Mental Health Act	Quality & Experience	Well Led	AD	>=80% by 31/3/17								11.0%	20.9%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	90.3%	89.0%	90.0%	90.1%	89.7%	89.2%	89.0%	88.6%	89.5%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	88.4%	87.1%	88.0%	88.3%	88.2%	88.0%	86.7%	87.0%	87.8%
Sainsbury's Tool	Health & Wellbeing	Well Led	AD	>=80%				97.1%	96.9%	96.6%	93.2%	93.8%	94.8%
Bank Cost	Resources	Well Led	AD	-	£463k	£370k	£434k	£434k	£512k	£605k	£486k	£458k	£477k
Agency Cost	Resources	Effective	AD	-	£805k	£842k	£925k	£791k	£989k	£833k	£833k	£753k	£885k
Overtime Costs	Resources	Effective	AD	-	£31k	£33k	£35k	£23k	£17k	£9k	£16k	£14k	£26k
Additional Hours Costs	Resources	Effective	AD	-	£87k	£60k	£68k	£78k	£52k	£48k	£40k	£41k	£47k
Sickness Cost (Monthly)	Resources	Effective	AD	-	£497k	£469k	£456k	£481k	£504k	£501k	£462k	£457k	£513k
Business Miles	Resources	Effective	AD	-	345k	321k	267k	286k	300k	273k	328k	330k	316k

Workforce - Performance Wall cont…

Notes:

Whilst the Trust continues to have the lowest sickness rate in Yorks and Humber for Mental Health/LD Trusts a proactive internal audit review was commissioned to look how we can improve our systems to reduce absence rates further. The report has been received and although identifies areas of good practice relating to the management of sickness absence it has also picked up areas where we can improve and strengthen, particular on local implementation of the policy. The areas for improvement, which will be incorporated in an action plan.

Sickness

- Year to date absence levels remain at 4.8% which is lower than the same period last year. The trend is for sickness rates to be at there highest during November, December and January.
- Whilst Kirklees and Calderdale sickness levels are at 5% year-to-date they are improving (only 4% in December). Year-to-date absence in Forensic services is 6%.
- Barnsley BDU sickness levels have seen an increase over the last 2 months and this has now taken the year to date levels over threshold. Only support services now remain within tolerance for the year to date position.

Mandatory Training

- The Trust is achieving above threshold for all areas with the exception of Information Governance (86.5%); Moving & Handling (78.8%)
- Continued focus being placed on IG across the trust given recent ICO reportable incidents.
- In March 2016, a review of MCA and MHA training reported to EMT revealed that 47% of staff within SWYPT had received training in the previous three years. Since March 2016, MCA/MHA training has been made mandatory and we have conducted a detailed training needs analysis around MCA/MHA training to ensure the mandatory training provided matches the competencies and needs of the staff. We have developed new, up-to-date evidence-based training and learning resources on the MHA and MCA and we are currently running extensive training programmes for all staff across the Trust. The Mental Health Act training figure is the overall figure for staff that have completed the MHA component of training that are required to i.e All Clinical Staff working in MH and LD services. The Mental Capacity Act/DoLs training figure is for all staff in the workforce both clinical and non-clinical that have completed training, as all staff are required to complete some level of training. Although a challenge to achieve across the whole Trust, our trajectory for mandatory MCA/MHA training compliance is 80% by end of March 2017. We are continuing to work on mapping and accrediting previous training and learning to the current mandatory training performance wall, although this might not be fully represented until March 2017.
- Cardiopulmonary and clinical risk training are recently introduced training programmes provided throughout the financial year on a trajectory to reach 80% compliance by 31st March 2017

Publication Summary

Department of Health

NHS reference costs 2015 to 2016

This document provides the most up-to-date information about how NHS expenditure was used to provide health care by NHS trusts and NHS foundation trusts. Reference costs are the unit costs to the NHS for providing defined services in a given financial year to NHS patients in England.

Click here for link to report

Department of Health (DH)

2016-17 guidance for financial monitoring and accounts and management information forms

The financial monitoring and accounts and management information forms for 2016 to 2017 contains guidance on completing the forms for the completion of the 2016 to 2017 Q3 and year-end finance returns. The forms are sent directly to NHS trusts.

Click here for guidance

NHS Improvement

Consultation on use of resources and well-led assessments

This consultation contains proposals for how NHS trusts and foundation trusts can make effective use of resources, leadership and governance enabling them to provide sustainable high quality services for patients. The deadline for responses is 14 February 2017.

Click here for consultation

Care Quality Commission (CQC)

Our next phase of regulation: a more targeted, responsive and collaborative approach - cross-sector and NHS trusts

CQC are consulting on changes they are planning to the way health and adult social care services are regulated. These plans reflect the priorities that CQC set out in a five year strategy for a more targeted, responsive and collaborative approach. The consultation closes on 14 February 2017.

Click here for consultation

National Institute for Health and Care Excellence (NICE)

Asthma management

Comments and feedback are being sought on this draft guidance on the management of asthma. The guidance calls for a change to how the medicines are offered to enable the NHS to make savings of potentially £3 million per year. The draft guideline also describes how health professionals should help people self-manage. It recommends they offer people a written plan with details of their triggers, how to adjust medicines and when to seek help. The draft guideline is out for public consultation until 16 February 2017.

Click here for draft guidance

Publication Summary cont…

NHS Improvement

Safe, sustainable and productive staffing: an improvement resource for learning disability services

This draft guidance aims to help standardise staffing decisions for learning disability services in community and inpatient settings. It is designed to help commissioners and providers of NHS commissioned services, create, review and sustain safe and effective specialist health services for people with a learning disability, who have a wide range of needs and varying levels of disability. The closing date for comments on the draft guidance is 3 February 2017.

Click here for guidance

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

NHS safety thermometer report, England - November 2015 - November 2016 (this report includes data from applicable services in Barnsley BDU)

Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England (Care Quality Commission)

NHS safety thermometer report, England - November 2015 - November 2016

Winter health watch summary, 8 December 2016

NHS Improvement: provider bulletin, 14 December 2016

HPV vaccination coverage, September to August 2016

Winter health watch summary, 15 December 2016

Direct access audiology, referral to treatment waiting times, October 2016

NHS workforce statistics, September 2016, provisional statistics

NHS staff earnings estimates to September 2016, provisional statistics

NHS sickness absence rates, August 2016

Provisional monthly hospital episode statistics for admitted patient care, outpatient and accident and emergency data: April to October 2016

Learning disability services monthly statistics: commissioner census (assuring transformation), November 2016, experimental statistics

Diagnostic imaging dataset - August 2016

Mental health services monthly statistics: final September, provisional October 2016

Improving access to psychological therapies report: September 2016 final, October 2016 primary

Seasonal flu vaccine uptake in healthcare workers: 1 September 2016 to 30 November 2016

Seasonal flu vaccine uptake in children of primary school age: 1 September 2016 to 30 November 2016

NHS Provider bulletin: 21 December 2016

NHS provider bulletin: 4 January 2017

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 9 (2016/2017)

Appendix 1

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	3	3	The NHS Improvement risk rating remains capped at level 3 due to the agency metric rating of 4. Other metrics score as 1 or 2.
2	Normalised Surplus	£0.7m	£1.9m	December 2016 financial performance excluding STF is a deficit of £27k. The post STF deficit is £224k given the non-achievement of plan at Q3. The cumulative position excluding STF is a surplus of £22k, £739k surplus including STF. The main factors being continued and increased cost pressures on Out of Area beds partly offset by savings in other services and support. Full year pre STF surplus remains at £0.5m, but with very significant risk attached.
3	Agency Cap	£7.6m	£9.9m	Agency expenditure in December 2016 is £0.9m which represents a £0.1m increase compared to November. This is primarily within the nursing workforce. Year to date this position is 89% over the NHSI cap.
4	Cash	£26.1m	£21.8m	The Trust cash position is £0.3m less than plan at month 9. Variances arising from creditor payments, lower than plan surplus and the impact of non cash transactions. These have been offset by reduced levels of debtors and receipts from asset disposals (£1m for year to date).
5	Capital	£7m	£11.4m	Capital expenditure is behind plan at December by £1.6m excluding VAT reclaims. All schemes have been reviewed and as such the year end forecast has been reduced by £0.7m. Some schemes will be deferred, some have ceased and others recognise latest and more accurate cost estimates.
6	Delivery of CIP	£6.8m	£9.2m	Year to date CIP delivery is £0.5m behind plan. Overall the forecast position includes £0.9m of red rated schemes. There has been no movement on this position in month.
7	Better Payment	96%		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 - Use of Resources

With effect from month 7 (October 2016) the way that NHS Improvement assess financial performance and efficiency has changed. This is now regulated under the Single Oversight Framework and the financial metric is based on the Use of Resources.

This retains the 4 previous metrics but adds a 5th to compare agency expenditure against the Trust agency ceiling (set for the Trust as £5.1m for the full year).

Additionally the Use of Resources metric changes the scoring regime. This is now rated from 1 to 4 with 1 being the best possible weighted average score. NHS Improvement will use this score to inform which segmentation the Trust falls under and if and when any support is required.

				Actual Performance		Plan - Month 9	
	Financial Criteria	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Continuity of Services	Balance Sheet Sustainability	20%	Capital Service Capacity	4.2	1	3.5	1
	Liquidity	20%	Liquidity (Days)	16.8	1	10.3	1
Financial Efficiency	Underlying Performance	20%	I & E Margin	0.4%	2	1.0%	1
	Variance from Plan	20%	Variance in I & E Margin as a % of income	-0.6%	2	-0.4%	2
Agency Cap	Variance from Plan	20%	Agency Margin	89%	4	#N/A	#N/A
	Weighted Average - Financial Sustainability Risk Rating				3		1

Impact

The impact of the breach of the agency cap by more than 50% means that this metric scores 4. As a result any trust scoring 4 on a particular metric can only score a maximum of 3 overall.

The weak financial performance in November 2016 and below plan cumulative performance has resulted in a deterioration in financial efficiency scores from 1 to 2.

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.

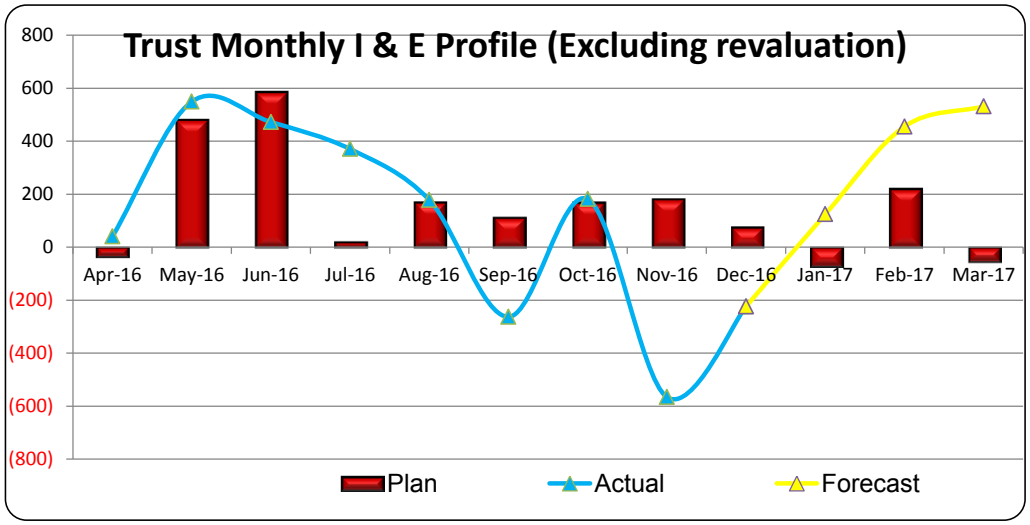
Liquidity - how many days expenditure can be covered by readily available resources; rating from 1 to 4 relates to the number of days cover.

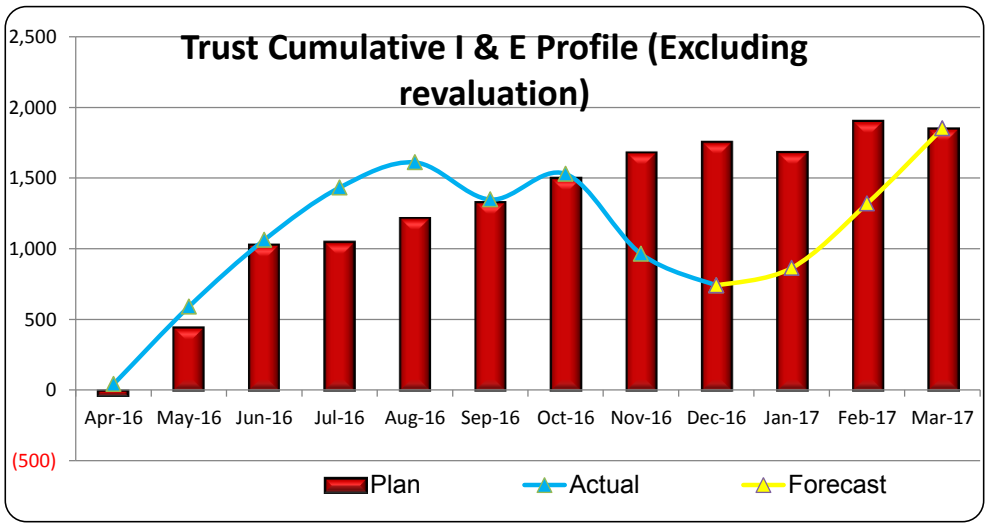
I & E Margin - the degree to which the organisation is operating at a surplus/deficit

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

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**
				17,352	17,003	(349)	Clinical Revenue	159,430	158,949	(481)	211,480	211,611	132
				17,352	**17,003**	**(349)**	**Total Clinical Revenue**	**159,430**	**158,949**	**(481)**	**211,480**	**211,611**	**132**
				1,475	1,442	(34)	Other Operating Revenue	11,982	11,825	(157)	15,586	15,680	93
				18,827	**18,444**	**(382)**	**Total Revenue**	**171,412**	**170,774**	**(638)**	**227,066**	**227,291**	**225**
4,330	4,029	(301)	6.9%	(14,241)	(14,050)	191	Pay Costs	(130,777)	(129,135)	1,642	(173,293)	(172,041)	1,252
				(3,718)	(3,847)	(129)	Non Pay Costs	(33,464)	(34,328)	(864)	(44,003)	(46,196)	(2,193)
				54	31	(23)	Provisions	2,284	1,437	(846)	2,317	3,139	822
4,330	**4,029**	**(301)**	**6.9%**	**(17,904)**	**(17,865)**	**39**	**Total Operating Expenses**	**(161,957)**	**(162,026)**	**(68)**	**(214,979)**	**(215,098)**	**(119)**
4,330	**4,029**	**(301)**	**6.9%**	**922**	**579**	**(343)**	**EBITDA**	**9,454**	**8,748**	**(706)**	**12,087**	**12,193**	**106**
				(596)	(550)	46	Depreciation	(5,444)	(5,751)	(308)	(7,233)	(7,326)	(94)
				(257)	(257)	0	PDC Paid	(2,310)	(2,310)	0	(3,080)	(3,080)	(0)
				6	4	(3)	Interest Received	56	53	(4)	75	63	(12)
4,330	**4,029**	**(301)**	**6.9%**	**76**	**(224)**	**(300)**	**Normalised Surplus / (Deficit)**	**1,757**	**739**	**(1,017)**	**1,850**	**1,850**	**0**
				0	0	0	Revaluation of Assets	0	(4,189)	(4,189)	0	(4,189)	(4,189)
4,330	**4,029**	**(301)**	**6.9%**	**76**	**(224)**	**(300)**	**Surplus / (Deficit)**	**1,757**	**(3,450)**	**(5,207)**	**1,850**	**(2,339)**	**(4,189)**





Income & Expenditure Position 2016 / 2017

Trust Normalised Surplus Position (Pre and Post Sustainability and Transformation Funding)

The Trust year to date and forecast finance position including and excluding STF funding are highlighted below. This is calculated, by NHS Improvement, upon the normalised surplus value. This therefore excludes exceptional items such as the revaluation of Trust Estate. As a result of the unfavourable performance in the third quarter the STF for this period has not been achieved (£0.3m) and this is reflected in our position. It remains possible to receive these monies if the full year control total plan is achieved. The forecast position remains in line with plan, it is expected that the Trust will deliver a balanced position at year end and recover the Q3 loss.

	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k
Surplus (Excluding STF)	744	22	(722)	500	500	0
STF	1,013	717	(295)	1,350	1,350	0
Surplus - Total	**1,757**	**739**	**(1,017)**	**1,850**	**1,850**	**0**
Two key components need to be achieved in order to receive STF monies.						
Financial Performance	886	591	(295)	1,181	1,181	0
Referral to Treatment	127	127	0	169	169	0
STF - Total	**1,013**	**717**	**(295)**	**1,350**	**1,350**	**0**

Month 9

In month there have been adverse movements in the financial position resulting in a deficit position for month 9 / December 2016 of £224k. Excluding the removal of the Quarter 3 STF funding (£295k) this would have shown as an in month surplus of £71k.

The normalised year to date position is a surplus of £739k. This is £1 million less than planned and the key headlines are below:

	£k	
Income	(638)	Includes £295k STF shortfall and £482k shortfall in CQUIN. The Flu CQUIN assumes £170k shortfall and performance against target will be validated during January 2017. Subsequently there has been excellent progress with the take up of the flu vaccination which has led to the Trust achieving its target of having 75% of staff vaccinated. This will be reflected in the January accounts.
Pay	(7,615)	Agency staff continue to be employed by the Trust to meet clinical and service requirements. Actions continue to ensure that the clinical and financial consequences are minimised. Actions include ongoing recruitment, expansion of the peripatetic staffing model.
	9,257	Offset by underspends in pay arising from vacancies
Non Pay	(1,958)	Out of Area expenditure remains a key financial pressure with issues arising from demand for Trust services and a reduced bed capacity as a result of a ward fire in November 2016. Work is ongoing to reduce the use of placements and capital works progress in the development of the new bed capacity.
	(905)	Redundancy costs including those for services decommissioned.
	1,999	Offset by underspends elsewhere within non pay including non clinical areas such as office costs (£488k), travel (£188k) and training costs (£409k).
	(846)	Provisions, and budgets held centrally, have been released in order to achieve this position. This includes not spending Trust contingencies.
	(311)	Capital Charges higher than plan due to accelerated charges arising from the decision to undertake the Fieldhead Non-secure capital programme. (reduce the asset value for buildings which are planned to be demolished)
	(1,017)	

Forecast

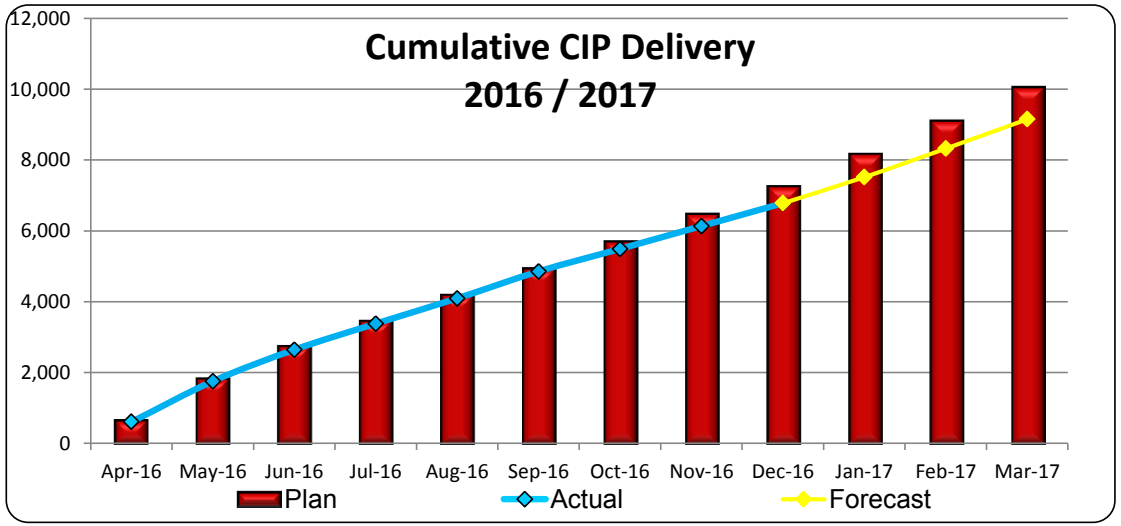
The full year pre STF surplus forecast remains at £0.5m but acknowledges the significant risk attached with its delivery. These risks, and also any opportunities, continue to be assessed to ensure that the plan is delivered.

If the financial position is not back in line with plan this risks achievement of the STF funding and cash. This would total £675k for Quarter 3 and 4. The Q3 STF has not been achieved but can be recovered if the full year control total is delivered.

Discussions are taking place with loss adjusters regarding the impact of the fire at Trinity on out of area bed usage. Any agreement in terms of insurance claims will be communicated to the Board once known.

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	6,192	8,837
Target - Non Recurrent	9	509	259	49	49	49	49	49	49	49	49	49	1,075	1,223
Target - Monitor Submission	670	1,172	922	715	729	744	766	772	777	912	940	940	7,267	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	7,267	10,059
Delivery as planned	452	1,446	2,147	2,686	3,232	3,826	4,338	4,859	5,379	5,993	6,676	7,379	5,379	7,379
Mitigations - Recurrent	0	6	9	14	18	22	26	30	34	38	42	46	34	46
Mitigations - Non Recurrent	146	299	485	678	841	1,005	1,125	1,245	1,365	1,485	1,606	1,726	1,365	1,726
Total Delivery	**598**	**1,751**	**2,641**	**3,377**	**4,091**	**4,853**	**5,489**	**6,134**	**6,779**	**7,517**	**8,324**	**9,151**	**6,779**	**9,151**
Shortfall / Unidentified	72	92	123	101	116	99	229	356	488	663	796	908	488	908



The Trust identified a CIP programme for 2016 / 2017 which totals £10.1m. (£11.0m recurrent full year effect) This was subject to an external review.

The forecast shortfall has increased from £822k to £908k in month due to revised assumptions on procurement savings. The majority of schemes are rated as green (and delivering), although £1.4m is non recurrent for the year to date, with notable exceptions being:

Procurement / Non pay savings which are delayed compared to original milestones. The main financial impact relates to the re-tendering of medical and nursing agency providers (fye - £750k).

Drugs expenditure reductions which are unlikely to materialise in the short term.

3.0 Balance Sheet 2016 / 2017

	2015 / 2016 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	114,134	118,917	110,308	1
Current Assets				
Inventories & Work in Progress	190	190	190	
NHS Trade Receivables (Debtors)	2,623	2,573	1,663	2
Other Receivables (Debtors)	7,541	5,367	7,149	3
Cash and Cash Equivalents	27,107	26,371	26,113	4
Total Current Assets	**37,461**	**34,501**	**35,115**	
Current Liabilities				
Trade Payables (Creditors)	(6,430)	(6,130)	(6,184)	5
Other Payables (Creditors)	(3,481)	(4,251)	(4,209)	5
Capital Payables (Creditors)	(785)	(785)	(892)	5
Accruals	(8,576)	(11,076)	(7,161)	6
Deferred Income	(789)	(789)	(945)	
Total Current Liabilities	**(20,060)**	**(23,030)**	**(19,390)**	
Net Current Assets/Liabilities	**17,401**	**11,471**	**15,725**	
Total Assets less Current Liabilities	**131,535**	**130,388**	**126,033**	
Provisions for Liabilities	(10,017)	(8,127)	(7,927)	
Total Net Assets/(Liabilities)	**121,518**	**122,261**	**118,106**	
Taxpayers' Equity				
Public Dividend Capital	43,492	43,492	43,665	
Revaluation Reserve	19,446	19,446	19,311	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	53,361	54,103	49,911	7
Total Taxpayers' Equity	**121,518**	**122,261**	**118,106**	

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 value of fixed assets is below plan. This is due to the current year capital spend (less than plan) and accelerated depreciation charges. This also includes the impact of the revaluation exercise, and recent asset impairments.

2. NHS debtors are currently below plan.

3. As per previous months other debtors are higher than plan with the main reason being accrued income. £1.5m of this relates to the timing of salary sacrifice scheme payments (the profile of which will be considered in future cashflow plans).

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 shown on page 11.

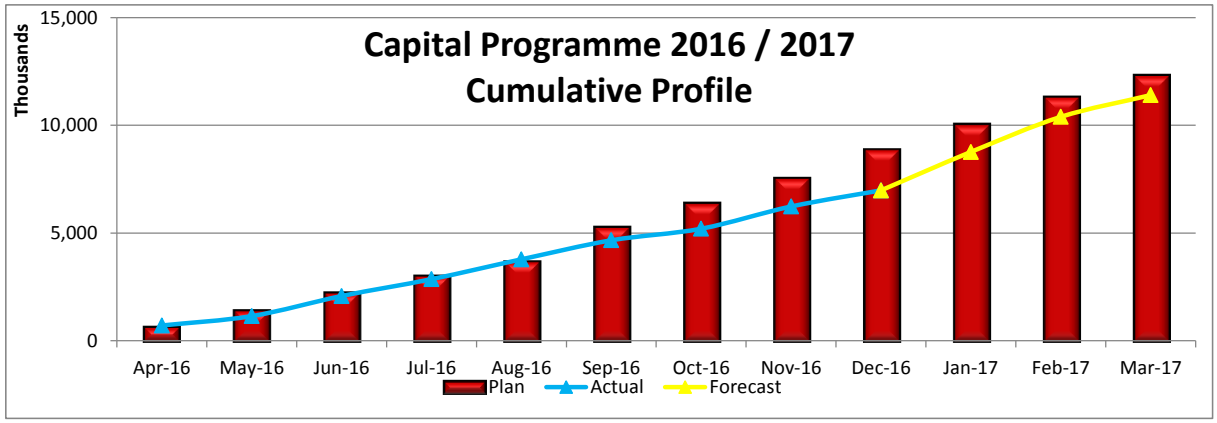
5. Overall creditors are broadly in line with plan. Payments continue to be made to support the Trust Better Payment Practice Code and ensure that no issues remain outstanding.

6. As per previous months the level of accruals remains lower than planned and lower than previous trends.

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	1,540	935	(606)	1,815	(236)	3
IM&T	1,210	947	209	(738)	992	(218)	
Total Minor Capital & IM &T	**3,260**	**2,487**	**1,143**	**(1,344)**	**2,807**	**(454)**	
Major Capital Schemes							
Pontefract Hub	1,795	1,795	1,889	94	1,939	144	4
Wakefield Hub	735	735	746	11	790	55	4
Fieldhead Non Secure	4,725	2,574	2,897	323	4,829	104	
Fieldhead Development	1,300	850	205	(645)	794	(506)	
Other	498	448	422	(25)	565	67	
Total Major Schemes	**9,053**	**6,402**	**6,159**	**(243)**	**8,916**	**(137)**	
VAT Refunds	0	0	(324)	(324)	(324)	(324)	
TOTALS	**12,313**	**8,889**	**6,978**	**(1,911)**	**11,398**	**(915)**	2

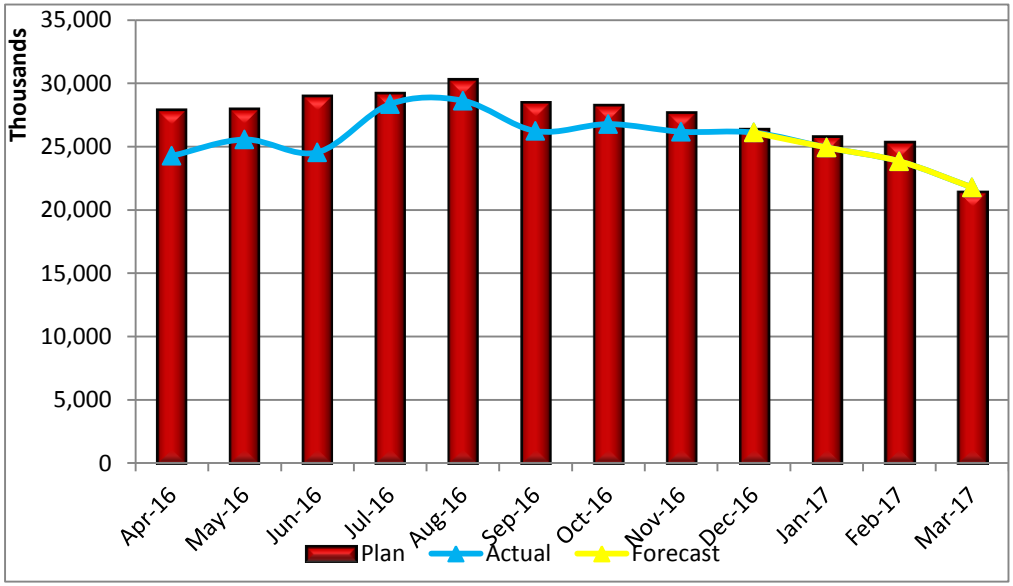


Capital Expenditure 2016 / 2017

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 £1.9m behind plan (22%). Excluding the benefit arising from successful VAT recovery agreed with HRMC this would be £1.6m behind plan (18%).

In month a senior review of the 16/17 capital programme has been conducted. As such the forecast has been revised to reflect the impact with schemes either continuing as planned, continuing within a reduced financial envelope, deferred or ceased. This exercise has reduced the forecast by £724k

3.2 Cash Flow & Cash Flow Forecast 2016 / 2017



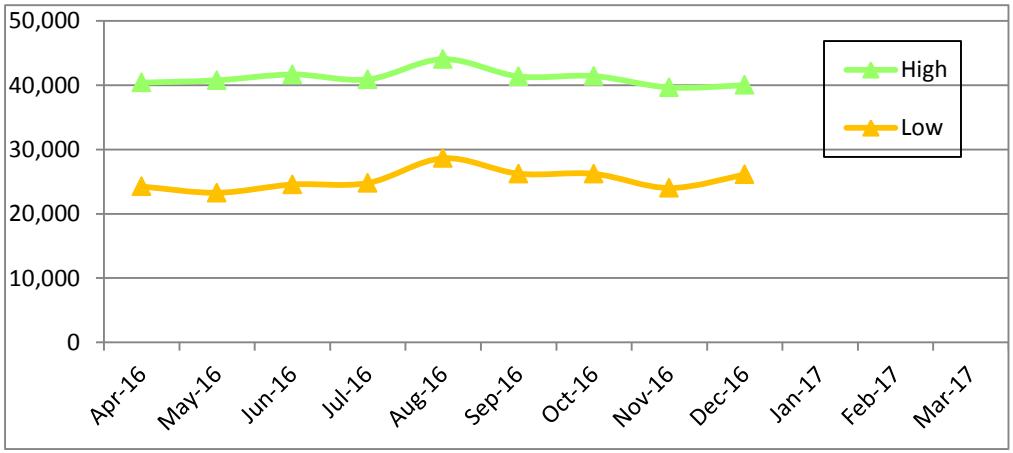
	Plan £k	Actual £k	Variance £k
Opening Balance	27,107	27,107	
Closing Balance	26,371	26,113	(258)

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.

The key cash variance to plan remains higher than planned levels of accrued income and lower than planned levels of accruals (meaning that the Trust has received invoices earlier than planned and paid those)

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



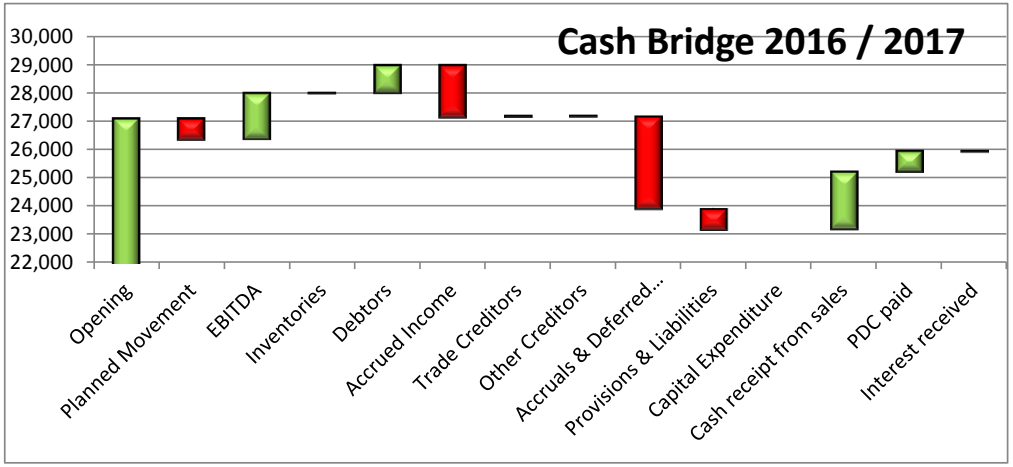
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£40m
The lowest balance is:	£26.1m

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)	7,102	8,729	1,627	1
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	2,425	3,416	991	
Accrued Income	0	(1,839)	(1,839)	4
Trade Payables (Creditors)	(300)	(246)	54	
Other Payables (Creditors)	0	(22)	(22)	
Accruals & Deferred income	2,000	(1,258)	(3,258)	5
Provisions & Liabilities	(1,890)	(2,614)	(724)	6
Movement in LT Receivables:				
Capital expenditure & capital creditors	(8,889)	(6,871)	2,018	2
Cash receipts from asset sales	299	1,045	747	3
PDC Dividends paid	(1,540)	(1,560)	(20)	
PDC Dividends received		173	173	
Interest (paid)/ received	56	53	(4)	
Closing Balances	**26,371**	**26,113**	**(257)**	



The plan value reflects the April 2016 submission to NHS Improvement.

Factors which increase the cash positon against plan:

1. The normalised surplus position at month 9 is behind plan although year to date remains in a surplus position. This position includes higher than plan depreciation charges and also an element of contingency release, both of which are non-cash transactions.

2. Capital expenditure, including capital creditors, is less than plan as noted within the capital expenditure report.

3. The Trust has disposed of 1 property in month (£325k). This was included within the plan as £299k and originally assumed for August 2016.

Factors which decrease the cash position against plan:

4. Accrued income continues to be higher than planned. Invoices will be raised as soon as possible to maximise the cash position.

5. Expenditure accruals remain at a low level. Issues with receiving invoices from NHS bodies, and reflected in the plan, have not been experienced to date in 2016 / 2017.

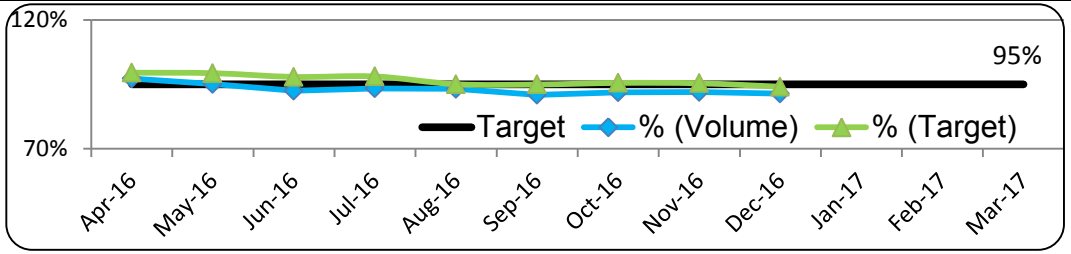
6. Provisions released are higher than planned.

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

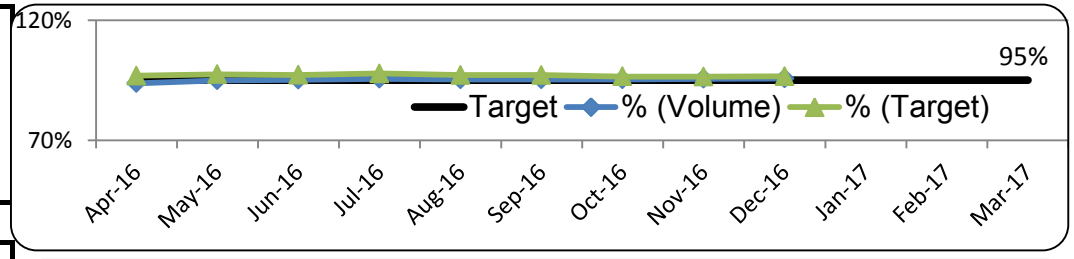
4.0 Better Payment Practice Code

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.

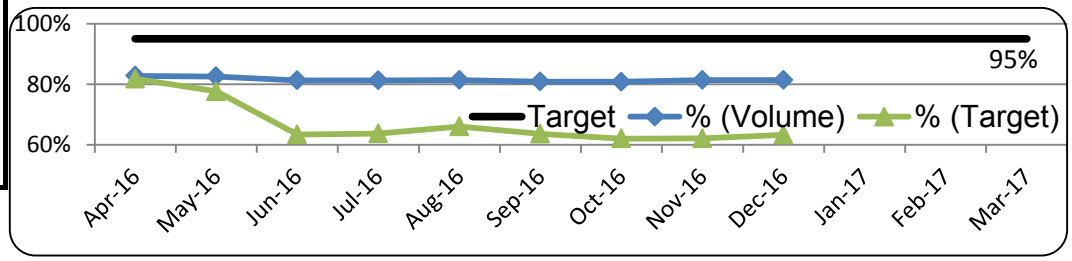
NHS	Number %	Value %
Year to November 2016	92%	95%
Year to December 2016	91%	94%



Non NHS	Number %	Value %
Year to November 2016	96%	96%
Year to December 2016	96%	97%



Local Suppliers (10 days)	Number %	Value %
Year to November 2016	81%	62%
Year to December 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 (£)
14/12/2016	Availability Charge SLA	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3019232	209,476
26/10/2016	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	3013774	119,857
01/12/2016	Rent	Kirklees	Kirklees Council	3017761	60,425
22/11/2016	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	3016734	48,170
16/12/2016	CNST contributions	Trustwide	NHS Litigation Authority	3019744	33,986

4.2 Agency Expenditure Focus

Agency costs continue to remain a focus for the NHS nationally including publication by NHS Improvement performance against maximum levels of spend. The results of December 2016 (Quarter 3) will be published shortly and this will highlight that for the year to date the Trust is 89% above cap. This is an increase from the month 6 published position of 82%.

The financial pressure, alongside clinical and other considerations, continues to be a high priority area for the Trust. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible use of resources and providing a cost effective strategy.

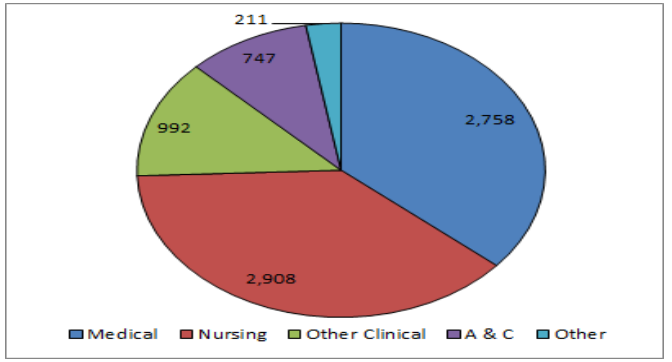
The Trust has seen increased levels of agency expenditure rising from £3.6m in 2013 / 2014 to £8.6m in 2015 / 2016. The introduction of an agency cap for 2016 / 2017 identified a capped level of spend of £5.1m. This represented a significant reduction of £3.3m (39%).

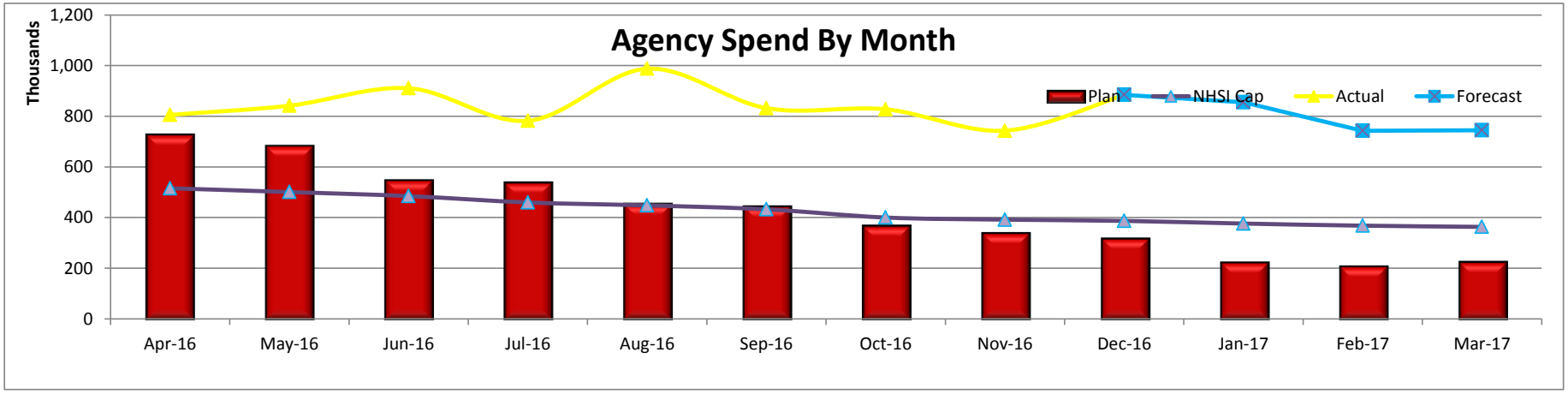
Agency expenditure, for the year to date is £7.6m, with average spend of £846k per month. Based upon current projections this results in a year end forecast position of £10m which is nearly double the Trust cap value and a further increase over previous year expenditure.

As shown by the graph below expenditure has increased in December 2016 (£885k from £743k in October 2016). In month expenditure on medical staff has remained the same (£302k per month) whilst nursing staff have increased from £245k to £429k in month. As a result additional actions have been agreed ensuring clarity on the reasons for agency usage and what plans are in place to reduce it.

Actions include monitoring at an individual / individual shift level the reason for each shift and what action is being undertaken to reduce or mitigate it. This will be reviewed, again at an indiviudal level, by OMG which includes Directors and representatives from each BDU.

	Year to Date £000	Forecast £000
Total Trust Position	**7,615**	**9,950**
Less Agency Social Workers	(416)	(559)
Less Bespoke Packages of Care	(771)	(840)
Net Trust Position	**6,428**	**8,551**





4.2 Out of Area Expenditure Focus

In this context the term Out of Area expenditure refers to spend incurred in order to provide clinical care to Service Users in non-Trust facilities. The reasons for taking this course of action can often be numerous and complex but some key trends are highlighted below.

- Specialist health care requirements of the Service User not available directly from the Trust or not specifically commissioned.
- No current bed capacity to provide appropriate care

On such occasions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where ever possible service users are placed within the Trust footprint.

This analysis excludes activity relating to Barnsley, specifically that relating to Locked Rehab. This is directed commissioned and is subject to ongoing negotiations.

Out of Area Expenditure 2015 / 2016 & 2016 / 2017

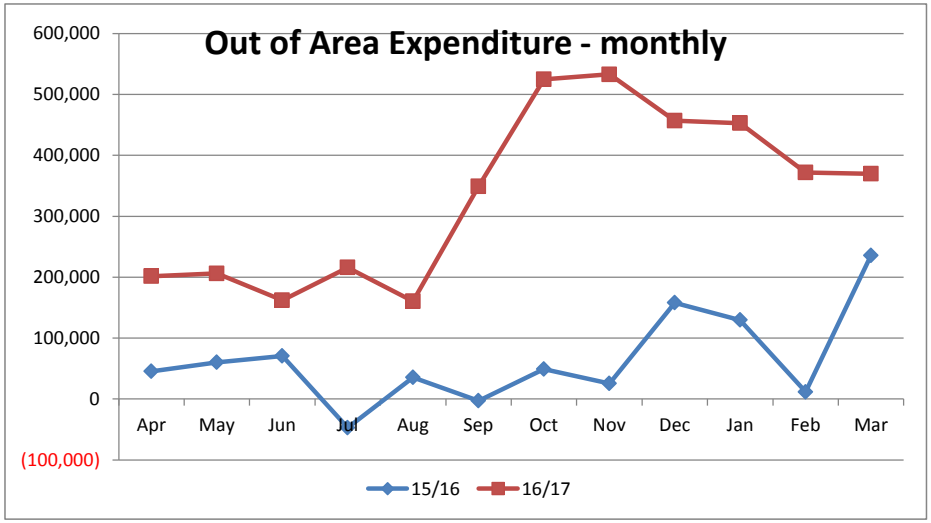
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
15/16	46	60	71	(47)	36	(3)	49	25	158	130	12	236	**772**
16/17	202	206	162	216	160	349	525	533	457	453	372	370	**4,004**

Bed Day Information 2015 / 2016 & 2016 / 2017

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
15/16	104	152	192	190	246	42	92	119	180	338	439	504	**2,598**
16/17	294	272	343	310	216	495	755	726	679				**4,090**

Bed Day Information 2016 / 2017 (by category)

PICU	138	167	196	144	70	211	367	377	222				**1,892**
Acute	96	43	100	89	62	154	288	309	426				**1,567**
Gender	60	62	47	77	84	130	100	40	31				**631**



This shows that expenditure has increased from £0.8m in 15/16 to forecast spend of £4.0m in 16/17. (400% increase). Expenditure in December 2016 has been less than the previous 2 months but remains higher than previous trends. Factors which have influenced this increase have been:

- Reduced bed capacity arising from bed closures (staffing shortages)
- Reduced bed capacity (12) due to fire on the Fieldhead site
- Increased demand meaning that demand exceeds full operational capacity

Actions being undertaken include:

- OOA bed project focussing on pathways and patient flow
- Trustwide bed management team approach
- ensure that wards are appropriately staffed to allow full bed capacity to be used
- options appraisal of Trust estate with a view to safeguarding additional capacity

4.3 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.

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.0%	4.1%	4.3%	4.3%	4.4%	4,6%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.1%	4.6%	4.6%	4.5%	5.5%	6.20%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	69.9%	82.1%	91.5%	92.1%	94.1%	95%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	41.7%	60.4%	77.5%	83.2%	91.4%	94.10%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.7%	83.9%	88.0%	84.5%	83.2%	84.10%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	75.5%	75.7%	76.8%	79.0%	80.8%	81.90%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	47.5%	55.3%	58.5%	64.3%	66.5%	70.80%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.7%	92.6%	92.6%	92.1%	90.4%	91.70%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.5%	88.4%	88.5%	87.5%	86.2%	87.60%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	76.9%	79.9%	79.0%	80.7%	81.5%	81.30%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	89.7%	89.3%	88.5%	87.3%	87.7%	88.40%
Information Governance	Resources	Well Led	AD	>=95%	90.8%	89.9%	89.0%	89.1%	88.8%	87.50%
Moving and Handling	Resources	Well Led	AD	>=80%	83.7%	80.6%	80.3%	79.6%	80.5%	80.60%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	91.7%	90.9%	91.2%	91.2%	91.4%	91.90%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	89.5%	89.3%	89.5%	89.3%	90.1%	90.30%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%	98.9%	97.4%	97.4%	96.3%	95.7%	97.10%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%					16.8&%	45.00%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%					11.3%	33.70%
Agency Cost	Resources	Effective	AD		£127k	£169k	£180k	£152k	£143k	£190k
Overtime Costs	Resources	Effective	AD		£6k	£6k	£4k	£6k	£5k	£6k
Additional Hours Costs	Resources	Effective	AD		£44k	£25k	£24k	£22k	£26k	£26k
Sickness Cost (Monthly)	Resources	Effective	AD		£151k	£171k	£171k	£157k	£169k	£192k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		154.87	156.73	173.89	97.45	116.31	133.76
Business Miles	Resources	Effective	AD		114k	123k	116k	130k	115k	112k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.3%	5.4%	5.4%	5.3%	5.1%	5.00%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	5.7%	5.9%	5.5%	4.8%	3.8%	4.00%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	56.5%	67.5%	82.4%	85.0%	95.1%	98.50%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	23.1%	35.6%	63.5%	72.3%	87.9%	93.80%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.3%	83.5%	84.3%	80.8%	79.7%	78.30%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	47.3%	47.6%	53.7%	57.9%	61.0%	66.70%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	19.1%	34.6%	35.6%	41.9%	50.0%	57.60%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.5%	92.3%	89.3%	88.1%	88.1%	89.10%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	84.4%	84.5%	83.0%	83.1%	82.2%	83.80%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	77.4%	77.4%	79.9%	79.8%	79.9%	81.30%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	84.1%	80.0%	77.9%	74.8%	78.0%	79%
Information Governance	Resources	Well Led	AD	>=95%	91.7%	89.7%	88.7%	84.0%	83.8%	86.60%
Moving and Handling	Resources	Well Led	AD	>=80%	80.2%	76.5%	73.5%	72.7%	73.4%	75.80%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	91.2%	90.8%	90.0%	89.4%	89.5%	90.70%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	86.9%	86.4%	85.3%	84.1%	85.5%	86.30%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%	98.3%	97.5%	96.4%	95.4%	95.9%	96.60%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%					13.1%	30.80%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%					12.4%	19.80%
Agency Cost	Resources	Effective	AD		£162k	£179k	£165k	£165k	£195k	£228k
Overtime Costs	Resources	Effective	AD		£2k	£2k	£2k	£5k	£2k	£6k
Additional Hours Costs	Resources	Effective	AD		£6k	£1k	£2k	£3k	£1k	£0k
Sickness Cost (Monthly)	Resources	Effective	AD		£126k	£125k	£119k	£98k	£77k	£83k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		73.49	78.74	69.49	61.86	55.8	50.95
Business Miles	Resources	Effective	AD		57k	56k	50k	64k	71k	75k

Workforce - Performance Wall cont…

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.7%	5.9%	6.1%	6.00%	5.9%	6.00%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	7.1%	6.7%	6.7%	5.80%	5.3%	6.10%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	55.6%	67.6%	80.9%	87.30%	90.5%	92.0%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	13.6%	26.5%	49.2%	62.20%	71.8%	77.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	77.6%	78.9%	80.7%	80.30%	82.9%	83.7%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	70.0%	62.6%	60.8%	51.60%	49.2%	53.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	0.0%	0.0%	0.0%	0.00%	0.0%	10.50%
Equality and Diversity	Resources	Well Led	AD	>=80%	93.1%	92.2%	91.9%	90.50%	89.2%	90.80%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	83.5%	84.0%	84.6%	85.10%	84.8%	87.80%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	89.6%	90.0%	88.5%	86.60%	88.3%	89.00%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	87.7%	84.1%	83.0%	81.10%	81.9%	83.90%
Information Governance	Resources	Well Led	AD	>=95%	88.6%	85.5%	84.6%	83.90%	84.6%	85.20%
Moving and Handling	Resources	Well Led	AD	>=80%	86.3%	85.2%	83.6%	83.40%	84.1%	84.40%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	88.9%	88.8%	88.1%	86.60%	85.3%	89%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	89.3%	88.2%	88.4%	89.00%	85.5%	87.30%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%	0.0%	12.5%	80.0%	82.40%	77.8%	78.90%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%					12.30%	29.10%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%					8.90%	14.20%
Agency Cost	Resources	Effective	AD		£130k	£163k	£62k	£117k	£80k	£95k
Overtime Costs	Resources	Effective	AD			£0k	£0k	£0k	£0k	£9k
Additional Hours Costs	Resources	Effective	AD			£0k	£0k	£0k	£0k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£60k	£60k	£62k	£49k	£51k	£58k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		61.91	56.93	49.49	41.34	33.25	37.55
Business Miles	Resources	Effective	AD		14k	6k	9k	8k	7k	8k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.2%	5.1%	4.9%	4.8%	4.6%	4.60%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.8%	4.8%	4.2%	4.1%	3.9%	4.30%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	31.4%	48.5%	58.9%	63.8%	69.3%	82.70%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	22.9%	35.6%	50.4%	55.6%	61.8%	62.50%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	69.9%	75.8%	78.2%	77.0%	73.5%	74.60%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	49.5%	38.9%	52.0%	61.2%	65.9%	65.70%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	13.6%	0.0%		9.6%	15.8%	28.60%
Equality and Diversity	Resources	Well Led	AD	>=80%	93.2%	92.4%	92.3%	89.5%	89.3%	89.90%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	83.2%	80.8%	82.0%	75.6%	75.7%	82.90%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	68.1%	54.2%	60.0%	57.7%	53.8%	60.00%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	83.6%	86.5%	85.1%	84.2%	84.5%	87.40%
Information Governance	Resources	Well Led	AD	>=95%	87.7%	85.9%	85.0%	81.0%	82.7%	84.20%
Moving and Handling	Resources	Well Led	AD	>=80%	81.4%	80.1%	79.0%	77.3%	79.5%	80.70%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	87.3%	86.9%	86.5%	84.8%	84.1%	85.90%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	86.9%	87.1%	86.7%	84.4%	86.7%	88.90%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%	90.9%	72.7%		83.6%	87.4%	88.50%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%					4.2%	28.90%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%					4.3%	9.50%
Agency Cost	Resources	Effective	AD		£172k	£269k	£227k	£266k	£197k	£185k
Overtime Costs	Resources	Effective	AD		£3k	£2k	£1k	£2k	£2k	£2k
Additional Hours Costs	Resources	Effective	AD		£6k	£12k	£10k	£3k	£2k	£5k
Sickness Cost (Monthly)	Resources	Effective	AD		£44k	£46k	£40k	£38k	£40k	£40k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		76.05	81.08	76.83	86.37	77.57	75.78
Business Miles	Resources	Effective	AD		32k	33k	20k	43k	47k	40k

Workforce - Performance Wall cont…

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.0%	4.1%	4.1%	4.2%	4.3%	4.4%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	3.7%	4.2%	4.3%	4.4%	4.3%	5.2%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	52.4%	71.2%	79.3%	83.7%	89.7%	91.6%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	13.7%	34.2%	76.9%	84.3%	87.2%	89.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	75.2%	70.8%	70.3%	70.1%	66.8%	64.1%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	66.7%	62.5%	66.7%	65.6%	64.7%	90.9%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	0.0%	0.0%	0.0%	100.0%	50.0%	100.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	86.7%	87.0%	87.2%	87.8%	87.1%	85.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	82.2%	82.5%	81.4%	82.3%	82.0%	84.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	93.7%	96.3%	92.2%	95.9%	95.0%	97.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	77.0%	74.6%	75.4%	76.9%	76.3%	82.2%
Information Governance	Resources	Well Led	AD	>=95%	86.7%	88.7%	88.3%	86.2%	86.1%	89.2%
Moving and Handling	Resources	Well Led	AD	>=80%	83.4%	82.3%	81.3%	77.6%	80.0%	79.7%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	87.3%	87.2%	86.2%	88.1%	87.2%	87.4%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	90.0%	90.7%	89.9%	87.5%	88.0%	88.8%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%	0.0%	0.0%	0.0%	50.0%	50.0%	100%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%					9.2%	90.1%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%					9.1£%	16.30%
Agency Cost	Resources	Effective	AD		£57k	£39k	£48k	£34k	£42k	£40k
Overtime Costs	Resources	Effective	AD		£0k	£6k	£0k	£4k	£3k	£2k
Additional Hours Costs	Resources	Effective	AD		£16k	£10k	£9k	£10k	£10k	£11k
Sickness Cost (Monthly)	Resources	Effective	AD		£47k	£54k	£57k	£56k	£60k	£75k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		80.4	71.62	73.63	66.29	57.40	58.60
Business Miles	Resources	Effective	AD		37k	39k	39k	44k	50k	46k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.0%	4.9%	4.8%	4.8%	4.8%	4.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.9%	4.3%	4.5%	5.1%	4.9%	5.5%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	50.3%	69.1%	80.6%	88.5%	91.5%	93.3%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	23.1%	43.8%	58.8%	74.8%	78.8%	87.6%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	85.9%	86.3%	86.9%	83.9%	83.2%	83.3%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	47.4%	45.1%	50.8%	52.8%	55.2%	56.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	30.4%	34.2%	36.6%	40.2%	41.8%	52.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	94.5%	94.1%	93.0%	93.3%	92.8%	93.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.8%	83.7%	82.6%	81.2%	81.2%	85.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	73.9%	76.0%	75.2%	77.8%	76.5%	78.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	80.8%	81.4%	81.6%	80.1%	79.0%	78.8%
Information Governance	Resources	Well Led	AD	>=95%	94.9%	92.4%	90.8%	90.9%	85.2%	81.8%
Moving and Handling	Resources	Well Led	AD	>=80%	76.1%	70.4%	70.6%	70.8%	69.7%	71.1%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	89.9%	89.7%	89.3%	89.0%	87.6%	87.0%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	84.2%	84.5%	86.1%	83.1%	80.1%	80.4%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%	99.3%	98.8%	97.6%	95.0%	94.1%	95.0%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%					15.3%	33.00%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%					15.4%	25.60%
Agency Cost	Resources	Effective	AD		£143k	£170k	£152k	£97k	£96k	£146k
Overtime Costs	Resources	Effective	AD		£12k	£1k	£1k		£3k	£1k
Additional Hours Costs	Resources	Effective	AD		£5k	£3k	£2k	£3k	£1k	£5k
Sickness Cost (Monthly)	Resources	Effective	AD		£53k	£50k	£57k	£57k	£57k	£66k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		66.14	64.72	67.1	73.43	75.95	75.44
Business Miles	Resources	Effective	AD		32k	43k	37k	38k	40k	35k

Glossary

ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoC	Duty of Candour
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
ICD10	International Statistical Classification of Diseases and Related Health Problems
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
KPIs	Key Performance Indicators
LAs	Local Authorities
LD	Learning Disability
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement
NICE	National Institute for Clinical Excellence
NK	North Kirklees
OOA	Out of Area
OPS	Older People's Services
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YTD	Year to Date

KEY for dashboard Year End Forecast Position / RAG Ratings	
4	On-target to deliver actions within agreed timeframes.
3	Off trajectory but ability/confident can deliver actions within agreed time frames.
2	Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame
1	Actions/targets will not be delivered
	Action Complete

NB: The Trusts RAG rating system was reviewed by EMT during October 16 and some amendments were made to the wording and colour scheme.

NHSI Key - 1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 January 2017
Agenda item 7.2

Title:	**Customer services report – Quarter 3 (September to December) 2016/17**
Paper prepared by:	Director of Corporate Development
Purpose:	To note feedback on experience of using Trust services received via the Customer Services function, the themes arising, learning, and action taken in response to feedback. To note also the summary Friends and Family Test results, comments and benchmarking and the number and types 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 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; with a review included in the January 2017 agenda. The Board also reviews feedback received via the Customer Services function on a quarterly basis. Trust Board reviews KPIs on complaints management in the Integrated Performance Report. Work is currently underway to improve the number of complaints closed within 40 days. This includes an improved toolkit to assist investigators in answering all the questions, and faster turnaround times for response letters in the checking process. (Responses have been subject to increased scrutiny, with a detailed review of the issues and the Trust's response undertaken by the Chief Executive). Further enhancement to the sign off process now includes final review by the director responsible for the service before Chief Executive review to ensure: • Ownership of the response by the service • Quality assurance of the response in terms of addressing the root causes • Actions are consistently learned and applied across services and in the system. Bi-weekly 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. The customer services team continue to promote the function through leaflets and posters and are currently distributing material updated with the Trust's branding. The team also work with services and team to encourage signposting to Customer Services as a single gateway to raise issues with the Trust.
Executive summary:	**Customer Services Report – Q3 2016/17** This report provides information on feedback received through Customer Services, the themes indicated, lessons learned and action taken in response

	to feedback. This report supplements information supplied to BDUs every 2 weeks. In Q3, there were 64 formal complaints, 133 compliments, 326 issues were responded to and 89 requests to access information under the Freedom of Information Act. Most complaints contain a number of issues; the most frequently raised issues were access, communication, clinical treatment and facilities. **Key areas to note:** ➢ The PHSO was not requested to review any new complaints during quarter 3, continuing to drive local resolution. EMT now reviews all action plans arising from PHSO decisions in respect of upheld or partially upheld complaints. ➢ CAMHS service information by district continues to be reported separately to highlight hotspots in terms of feedback and respond to commissioner requests for information by locality. Access to assessment for ASD/Autism continues to be a key concern for parents. [SWYFT services are just one component of multidisciplinary assessment process; the Trust is in dialogue with commissioners re collaborative solution to improving access]. ➢ Compliments from one Health Professional to another are now captured. ➢ Results of the Newton Lodge ward round involvement survey are included. The service has developed action plans to ensure a continued focus in this area. ➢ The report includes Friends and Family Test results, comments themes and benchmarking data for October 2017. Interrogation of the Trust's low score identifies that CAMHS services represent 59% of Trust responses and have only a 49% recommend rate for that period. It should be noted that all other SWYPFT mental health services combined had a recommend rate of 93%, with general community services having a recommend rate of >97% every month. 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 at BDU governance meetings. **Risk Appetite** The Customer Services report provides information to the Board on feedback about the quality of Trust services. Issues are escalated to the medical and nursing director and to the relevant service director to ensure action in line with the Trust's Risk Appetite Statement. Complaint responses are reviewed by service directors and signed off by the Chief Executive. Delivery of action plans in response to learning from feedback is monitored by BDU governance groups and overseen by service directors.
Recommendation:	**Trust Board is asked to REVIEW and NOTE the feedback received through Customer Services in Q3 of financial year 2016/17.**
Private session:	Not applicable.

South West Yorkshire Partnership
NHS Foundation Trust

Customer Services Report - Quarter 3 (October – December) 2016/2017

OVERVIEW

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. All formal complaints are acknowledged within a 3 working days timescale. Urgent issues or potential risks identified through Customer Services procedures are highlighted to the relevant BDU and the nursing or medical director as appropriate. In addition, all complaints are risk assessed. During Qtr. 3, no complaints were assessed as red or amber. At the close of Qtr. 3, 46 complaints had been closed, 78 remained open. The average time to investigate and respond to complaints was 71 days, with 27 cases taking over 40 days to respond. This was due to delays in allocation for investigation, length of time to investigate and assurance at sign off that complaint was appropriately addressed and learning captured. The team is working with directors, deputy BDU directors and general managers to understand the causes of delays and required mitigation.

During the Qtr. an improved investigation toolkit was introduced to promote identification of learning and development of action plans to remedy issues. The complaints sign off process has also been enhanced to ensure the director responsible for the service reviews the issues and draft response before review by the Chief Executive. This is to ensure three things:

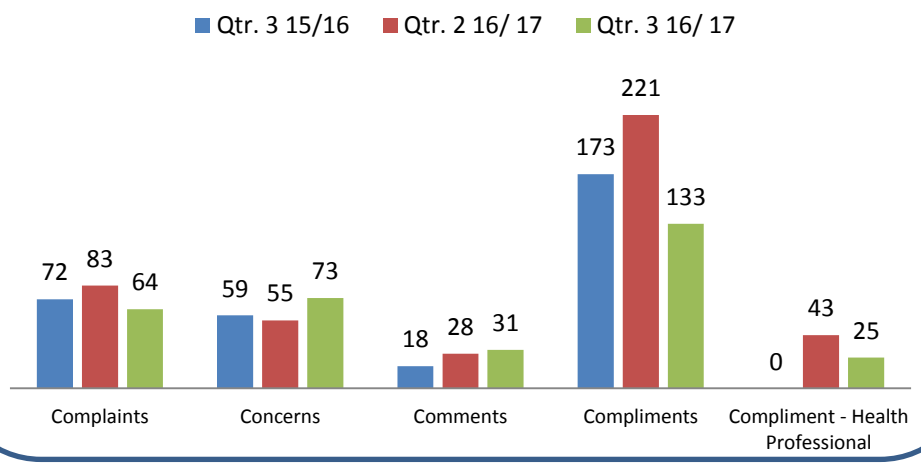
- Ownership of the response by the service
- Quality assurance of the responses in terms of addressing the root causes
- Actions are consistently learned **and** applied across services and in the system.

Customer Services continue to promote the function through distribution of leaflets and posters and encouraging staff to signpost to the team.

CONTACT

The Customer Services Team responded to 168 general enquiries in Qtr. 3, in addition to '4 Cs' management. Consistent with past reporting, signposting to Trust services was the most frequently requested advice. Other enquiries included requests for information about Trust Services, providing contact details for staff and information on how to access healthcare records. The team also responded to over 340 telephone enquiries from staff, offering support and advice in resolving concerns at local level .
BDUs receive bi-weekly reports updating on 'live' issues and progress on complaints management.

Trust wide



FEEDBACK RECEIVED

In Qtr. 3. The Customer Services Team responded to 326 issues (430 in Qtr. 2); 64 formal complaints were received (83 in Qtr. 2) and 133 compliments were recorded on Datix, (221 recorded in Qtr. 2).

Values and behaviours (staff) was identified as the most frequently raised negative issue (29). This was followed by access to treatment or drugs (26), communications (22), admission and discharge (16) , patient care (11), and waiting times (11) Most complaints contained a number of themes.

Response times declined in the period. Contributory factors include the increased scrutiny of issues and responses as part of the director sign off process. Complainants are kept updated throughout the process from raising their concern until the formal response letter is issued.

In Qtr. 3, 71% of people using mental health services across the Trust who completed the Friends and Family Test said they would recommend them, 98% would recommend community health services.

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. 3, 6 individuals posted comments on NHS Choices and Patient Opinion. 2 service users recorded positive experiences but did not identify the service. 4 negative comments were noted, 3 related to unnamed services, 1 related to Psychology Services, Calderdale & Kirklees.

Feedback is acknowledged with customer services contact details provided should the author wish to discuss their concerns directly with the Trust.

Mental Health Act (MHA)

2 complaints were raised during the quarter regarding detention under the Mental Health Act. Both were raised by service users, and further information was offered about the process followed.

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, including ethnicity information where this is provided.

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. During the quarter the Trust has worked with Healthwatch Kirklees on 2 issues – feedback received via their website and on behalf of an individual discharged from services.

PHSO (Ombudsman)

During Qtr. 3 no service users or carers requested the PHSO to review their complaints about Trust services. During the period, the Trust received formal decisions from the Ombudsman regarding 3 cases:

- Calderdale & Kirklees CAMHS – complaint partially upheld. Action plan has been signed off by the specialist services director and reviewed by the Director of Nursing and Quality and the Director of Corporate Development. The plan will be shared with the family and delivery monitored by the directorate.
- Calderdale & Kirklees CAMHS – complaint not upheld.
- Barnsley Community Mental Health services /Community Inpatient services – complaint partially upheld in relation to section 117 aftercare following mental health inpatient care, community mental health care and social services input. Action plan will be prepared by the respective services.

CQC / ICO

During Quarter 3 the Trust received 3 requests for information from the CQC:

- Forensic services - information received by CQC from a service user alleging staff shortages.
- Calderdale and Kirklees Mental Health Inpatient services – information received by CQC from a service user raising concerns about staff shortages and care and treatment.
- Barnsley Mental Health inpatient services - information received by CQC from unidentified source raising concerns about staff shortages and care and treatment.

All enquiries were responded to with no further follow-up from CQC.

Information Commissioner (ICO) - No contact in the period.

	complaint	concern	comment
Barnsley Hospital NHS Foundation Trust	1	1	0
Calderdale and Huddersfield NHS Foundation NHS Trust	1	0	0
Health Watch - Kirklees	0	1	0
NHS Greater Huddersfield CCG	0	1	0
Sheffield Teaching Hospital	1	0	0
Member of Parliament	1	6	4
Care Quality Commission	1	0	1

Equality and Inclusion – Formal Complaints - Protected Characteristics Data

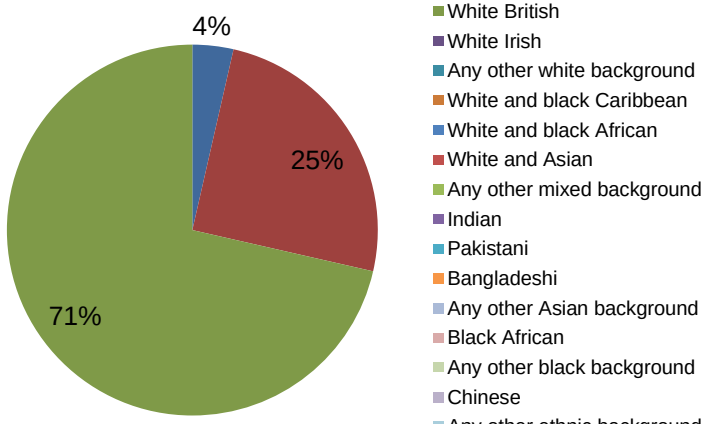
Equality data is an indicator of who accesses the complaints process. It is about the person raising the issue, who is not necessarily the person receiving services. Data is captured, where possible, at the time a formal complaint is made, or as soon as telephone contact is made following receipt of any written concerns. Information is shared with the complainant explaining why collection of this data is important to the Trust to measure equality of access to the complaints process. We offer assurance that providing data has no impact on care and treatment or on progressing a complaint.

During quarter 3 – of the 46 formal complaints closed, equality data was collected from 28 complainants - 7 from services users and 21 from carers and/or family members. 5 out of the 46 complaints closed were raised by third parties (professional advocates) where data was not collected. 13 service users/ complainants declined to provide their personal information.

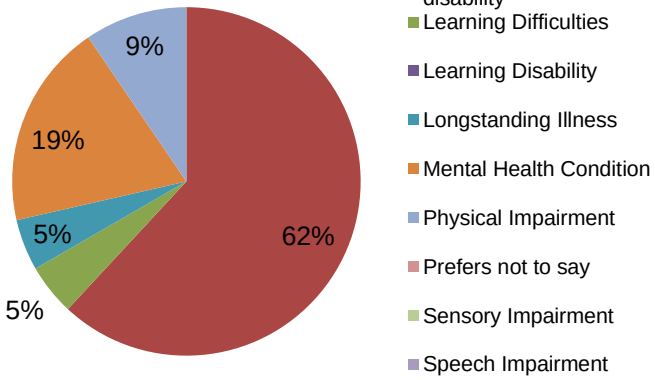
The Team continues to explore best practice in equality data capture, both internally with teams and externally with partner organisations and networks, and incorporates any learning into routine processes.

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

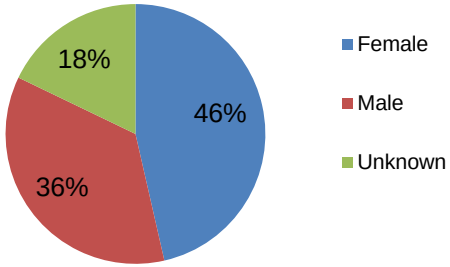
Trust wide - Ethnicity



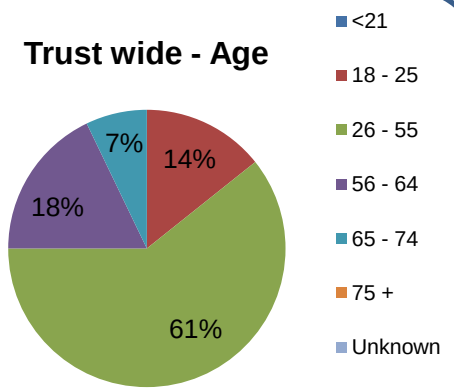
Trust wide - Disability



Trust wide - Gender

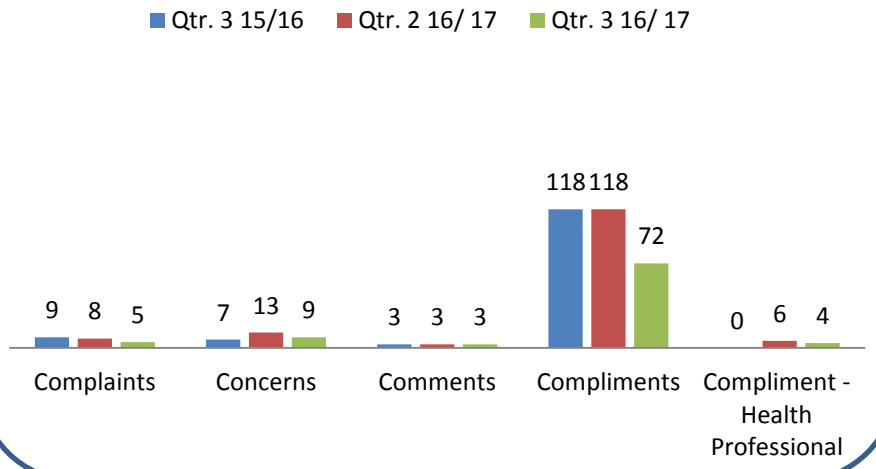


Trust wide - Age



Barnsley Business Delivery Unit – General Community Services

Barnsley - Community



Actions Taken:

- Staff to ensure that information to support best care is gathered from all sources and appropriately recorded. Staff to ensure they introduce themselves properly to service users. Service to monitor this through routine supervision processes. **Long Term Conditions – District Nurses**
- Audit process has been implemented to monitor call logs to ensure the right level of detail is captured and an appropriate response is made to meet individual need. **Long Term Conditions – Adult Epilepsy Service**

Complaints closed <25 days 50%

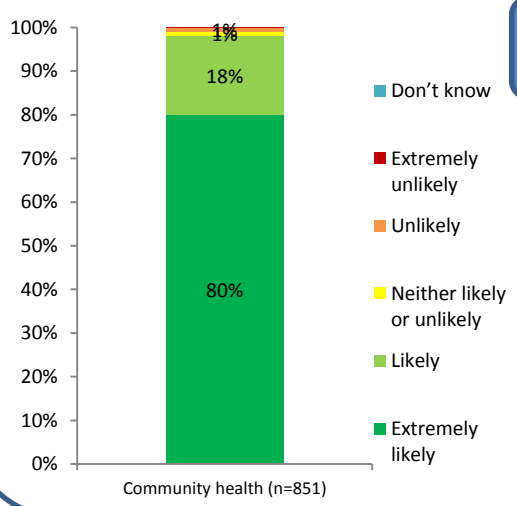
Complaints closed 26 - 39 days 5%

Complaints closed 40> days 45%

There has been a decrease in the number of complaints closed within the 25 day timeframe since last quarter. This has been due to the length of time taken to investigate the issues raised. Scrutiny of responses prepared through the sign off process has also added to delays in responding. Bi-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.

'Thank you for the superb care and support you gave to our father. Your kindness helped us all get through this very hard time. We cannot thank you enough '- **District Nurses**

Friends and Family Test



98% of respondents Extremely Likely / Likely to recommend

Comment themes

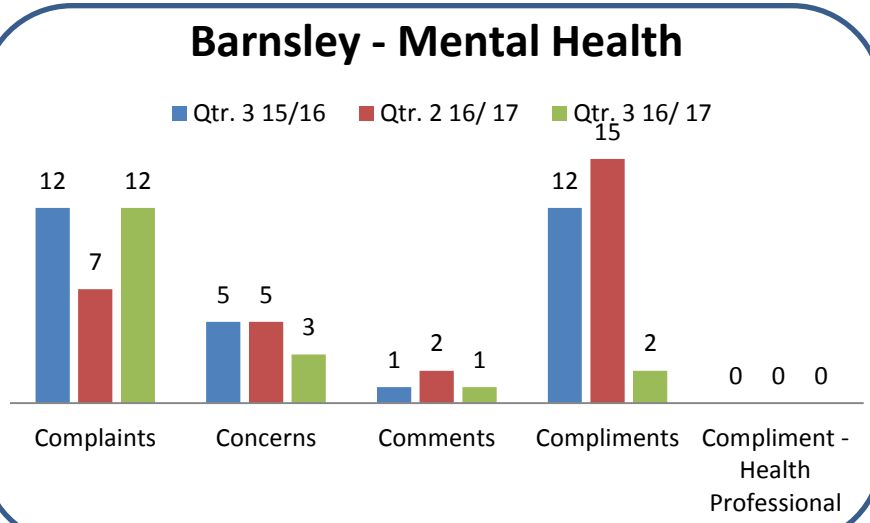
What was good about your experience?

- Greeting received
- Communication
- Staff

What would have made your experience better?

- Waiting times
- Drinks
- Food

Barnsley – Mental Health Services



Action Taken:

- Staff to ensure service users and carers are appropriately signposted to additional sources of support where indicated. **CMHT Dearne Barnsley**
- Improved information will be made available to service users on the ward regarding the use of seclusion and the circumstances when this might be necessary. **Clark Ward, Barnsley.**
- Staff to ensure discussion with services users (and appropriate family members) following any period of seclusion. This will be monitored through monthly team meetings. Staff will ensure appropriate documentation is completed following any restraint, monitored through clinical supervision and subject to regular audit. **PICU Inpatient Services – Melton Ward.**
- Improved information will be provided regarding the process for initial appointments. Additional signage will also be erected at premises used by Trust. **IAPTS**

'I found the group really helpful. Thank you' – **Early Intervention Service**

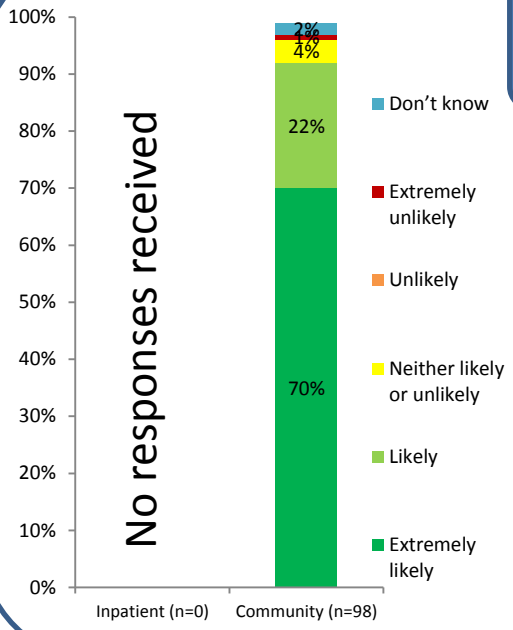
Complaints closed <25 days 0%

Complaints closed 26 - 39 days 20%

Complaints closed 40> days 80%

No complaints were closed within the 25 day timeframe in the quarter. Scrutiny of issues and responses has added to delays in responding to complainants. Bi-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



92% of respondents Extremely Likely / Likely to recommend

Comment themes

What was good about your experience?

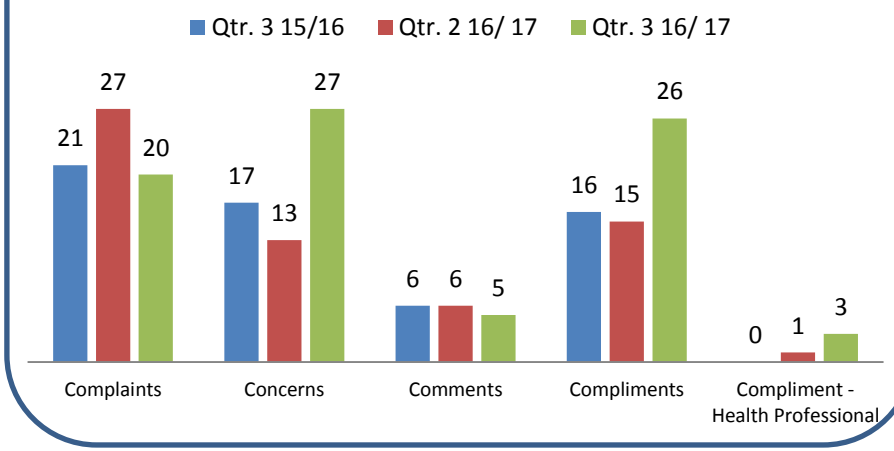
- Staff
- Greeting received
- Communication

What would have made your experience better?

- Communication
  - ➢ Easier /clearer
- Access to talking treatments

Calderdale & Kirklees Business Delivery Unit

Calderdale & Kirklees



Action Take:

- Service to review the process for management and follow-up of test results to ensure information acted on at the earliest opportunity. **Memory Service (OPS)**
- Staff to ensure clear information regarding care and treatment decisions is shared sensitively and without delay. To be monitored through clinical supervision. **CMHT Lower Valley Calderdale**
- Learning from feedback has been shared with staff as follows:
  - All to ensure risk assessment is completed in advance of leave. Ward notices are also displayed to this effect.
  - All to ensure information is shared with carers where appropriate consent is available.
  - Compliance with safe haven processes to be subject to regular audit.
  - All to ensure IG training in date; ward manager to review.
  - All to ensure information packs are offered to family members to help explain the ward routine and associated processes.
  - All to ensure the leaflet explaining the Mental Health Act is available to service users and carers. **Acute Services – Ward 18**
- Staff to ensure conversations with carers, including explanations regarding clinical decisions, are fully recorded. **Older peoples Services – Inpatient – Ward 19**
- Staff to ensure written information (leaflet) is available when undertaking Mental Health Act assessment in general hospital setting. **CMHT - Care Management Team (N Kirk)**

Complaints closed <25 days 8%

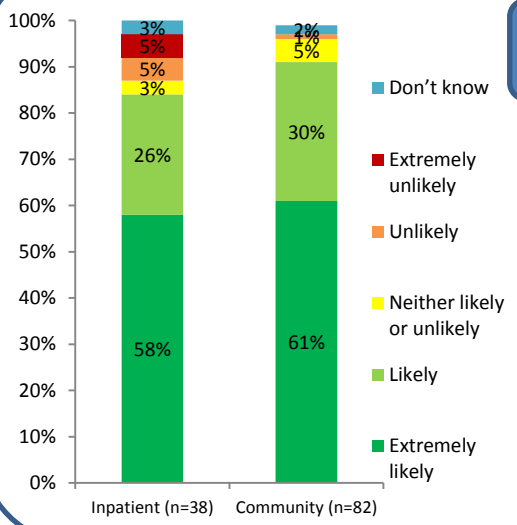
Complaints closed 26 - 39 days 15%

Complaints closed 40> days 77%

The BDU was successful in de-escalating a number of potential complaints to concerns in the period through resolution at service level. There has been a decrease in the number of complaints closed within the 25 day timeframe since last quarter. Delays in responses were due to obtaining consent and agreeing specific issues with complainants. Bi-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.

'I want to thank the team for their continued support. If it wasn't for the care and support of my CPN I would no longer be living, so a great big thanks to her and her team' – **Lower Valley CMHT**

Friends and Family Test



89% of respondents Extremely Likely / Likely to recommend

Comment themes

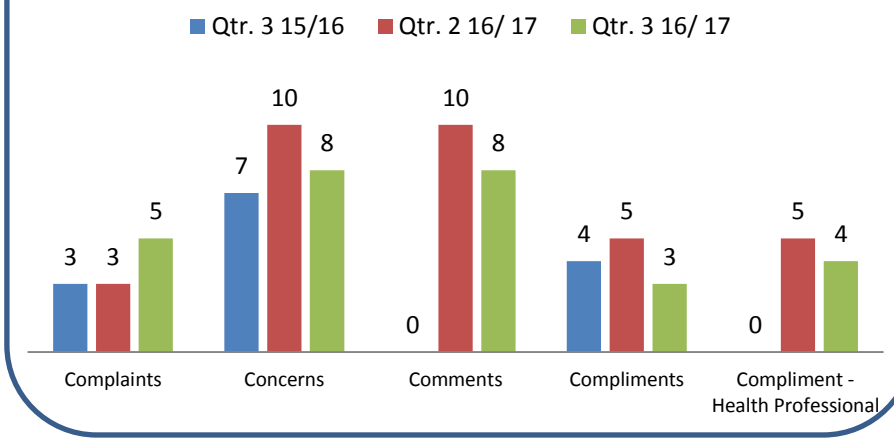
What was good about your experience?

- Staff
- Greeting received
- Communication

What would have made your experience better?

- Waiting times
- Staff
- Food

Forensics Business Delivery Unit



Action taken:
Team to ensure appropriate response to changes in service user presentation to reduce risk of allegations against staff.
PICU/Acute inpatient units - Bronte, Hepworth ward.

'I would like to say that the staff are good and very pleasant' – **Waterton Ward, Newton Lodge**

There has been a decrease in the number of complaints closed within the 25 day timeframe since last quarter. Delays in responses were due to issues regarding capacity to consent, and length of time taken to investigate complaints. Bi-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.

Complaints closed <25 days 0%

Complaints closed 26 - 39 days 0%

Complaints closed 40> days 100%

Newton Lodge Review of Involvement Structures

At Newton Lodge a review of involvement structures has been completed using a benchmarking tool. 10 standards were assessed in a variety of ways including workshops, focus groups, by wards, peer review and self assessment. Each standard consists of a number of indicators. Each indicator was RAG rated:
- Green – Fully meeting
- Amber – Some activity
- Red – no activity

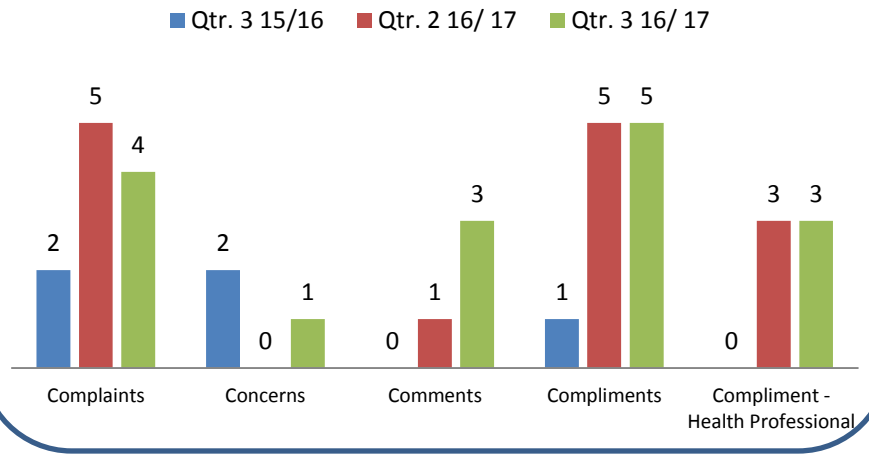
Each indicator was then evidenced with further comments.

Standard	Standard fully implemented 3	Action in progress 2	Recommendations agreed but not yet actioned 1
1. Involvement Standards		✓	
2. Recovery Standards		✓	
3. CPA Standards		✓	✓
4. MDT Standards	✓	✓	
5. Collaborative Risk Assessment		✓	
6. Supporting Carer Involvement		✓	
7. Technology			✓
8. Recruitment and Selection		✓	
9. Meaningful Activity		✓	
10. The Dining Experience		✓	

The results show that 1 standard is green, 7 are amber and 2 are red. An overarching action plan has been developed by the service to ensure compliance and improve involvement structures. Delivery will prioritised based on assessed risk and monitored through BDU governance processes , overseen by the specialist services director .

Specialist Services Business Delivery Unit (excluding CAMHS)

Specialist Services



Action Taken:

- Team to check service user understanding of discharge arrangements and signposting to additional sources of support. **ADHD Service**
- Review underway of caseload management to ensure delays are minimised. **Children's Learning Disability Team, Calderdale.**

'The work undertaken by the staff significantly and imaginatively adapted to address my child's needs, was very successful and my child is now able to cope with seeing the clinician and now has a positive assessment of his needs. This has resulted in a good improved health outcome. Thank you for your help '– **Children's Learning Disability Team, Calderdale**

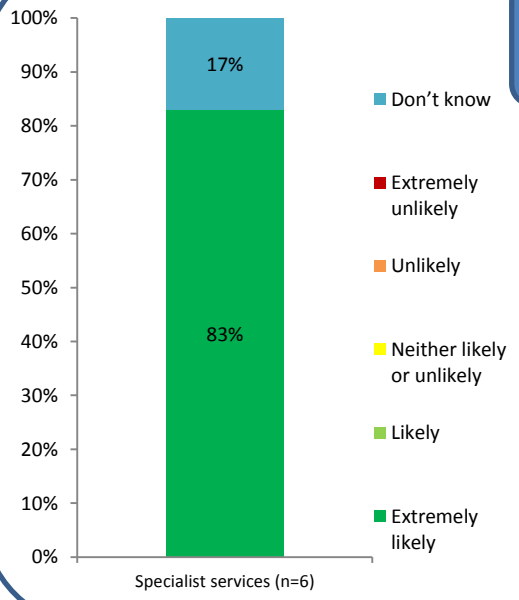
Complaints closed <25 days 33%

Complaints closed 26 - 39 days 0%

Complaints closed 40> days 67%

There has been an increase in the number of complaints closed within the 25 day timeframe. 2 out of the 3 cases investigated took longer than 40 days to close. This has been due to the length of time the investigation has taken to respond to the concerns. Bi-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



83% of respondents Extremely Likely / Likely to recommend

Comment themes

What was good about your experience?

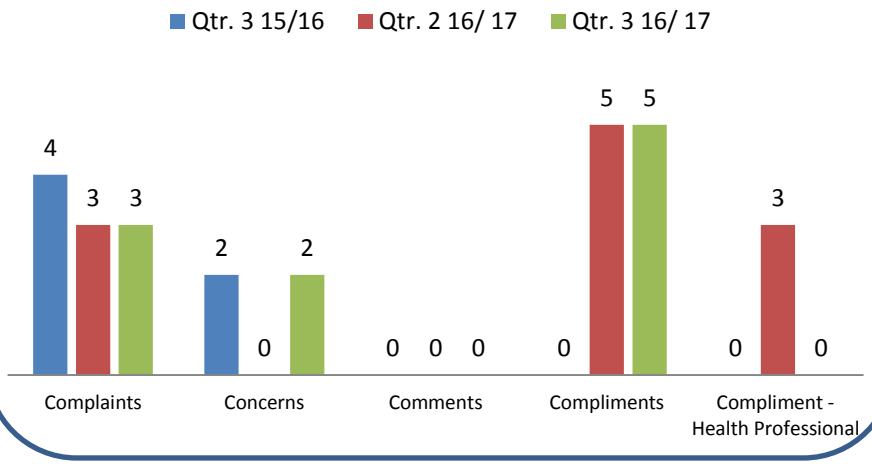
- Greeting received
- Communication
- Staff

What would have made your experience better?

- Staff

Child and Adolescent Mental Health Services – Barnsley

CAMHS - Barnsley



Action Taken:

- Team to ensure appropriate support and advice is in place during the wait time for an appointment.
- Staff to ensure clear information is provided regarding the separate waiting lists that operate.
- The team manager to review the process for telephone contact with the service, relay of messages to clinicians and response times.
- Team has noted the need to better explain discharge from the service and referrals to tier 2 services.

Complaints closed <25 days 0%

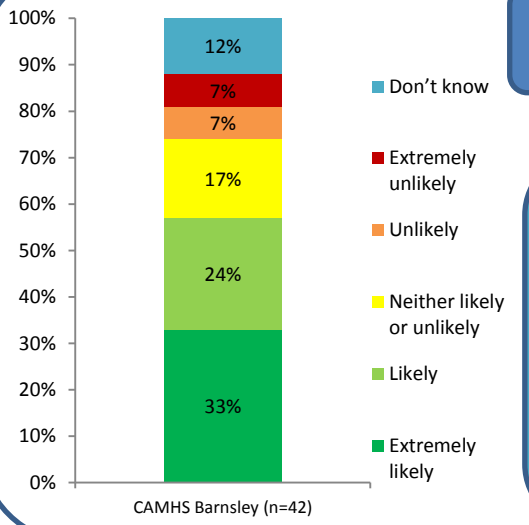
Complaints closed 26 - 39 days 0%

Complaints closed 40> days 100%

One re-opened case was closed in the period. This took longer than 40 days to respond due to the length of time taken to investigate the complaint. Scrutiny of responses prepared through the sign off process has also added to delays in responding 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.

'Praise for the help and support provided by the member of staff to a student in crisis' – **Barnsley CAMHS**

Friends and Family Test



57% of respondents Extremely Likely / Likely to recommend

Comment themes

What was good about your experience?

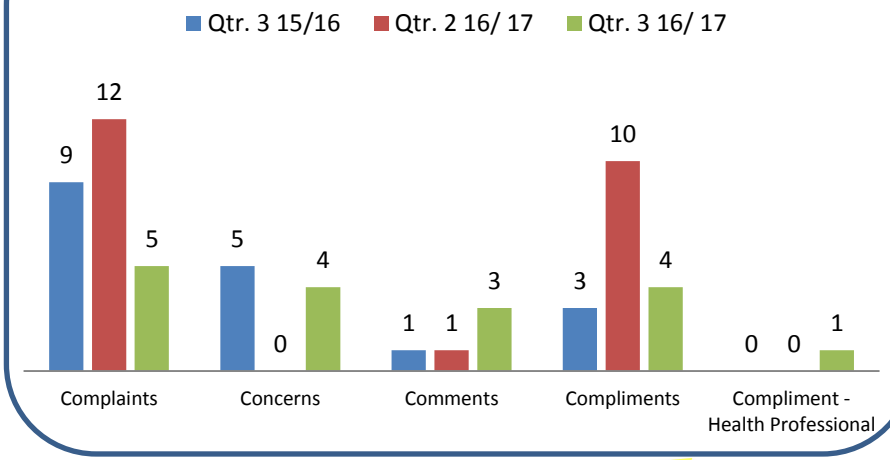
- Staff

What would have made your experience better?

- Waiting times

Child and Adolescent Mental Health Services – Calderdale and Kirklees

CAMHS - Calderdale and Kirklees



Action Taken:

- Staff to ensure all parties present before commencing any review.
- Staff to ensure all discussion regarding the rationale for clinical decisions is fully documented to support improved communication.

'The staff were fantastic and just what we needed. Thank you for managing the crisis' – **CAMHS, Calderdale**

'Thank you for the timely support from the team. The response has been nothing but positive and the advice and guidance has been very helpful '- **CAMHS, Kirklees**

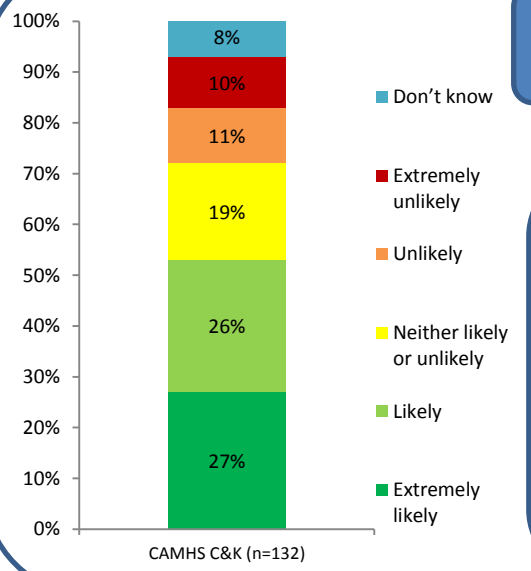
Complaints closed <25 days 0%

Complaints closed 26 - 39 days 50%

Complaints closed 40> days 50%

No complaints were closed within the 25 day timeframe. Scrutiny of responses prepared through the sign off process has also added to delays in responding Bi-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



53% of respondents Extremely Likely / Likely to recommend

Comment themes

What was good about your experience?

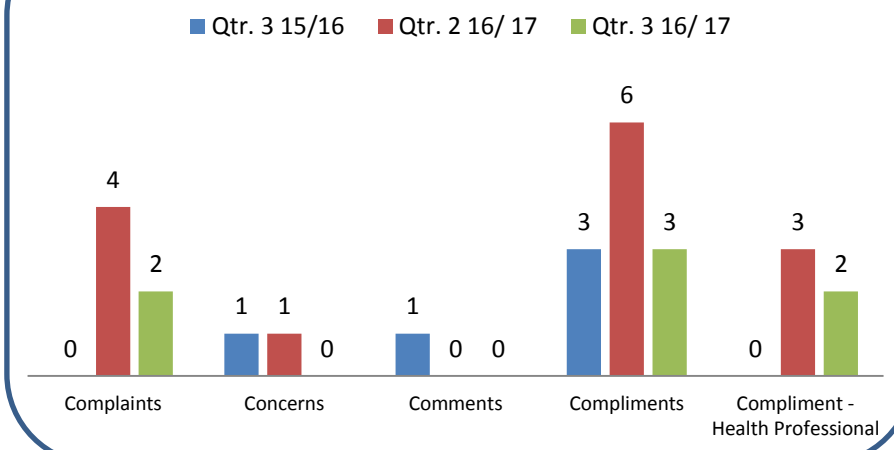
- Staff

What would have made your experience better?

- Waiting times

Child and Adolescent Mental Health Services – Wakefield

CAMHS - Wakefield



Action Taken:

- Staff to check out understanding of information shared with service users and families and to ensure decisions and actions are fully documented.

'We would like to take this opportunity to thank you for your kind, caring and dedicated professional support' - **Mulberry House CAMHS**

'Thank you so much for your help. Things have calmed down now which is very positive' – **Beech House CAMHS**

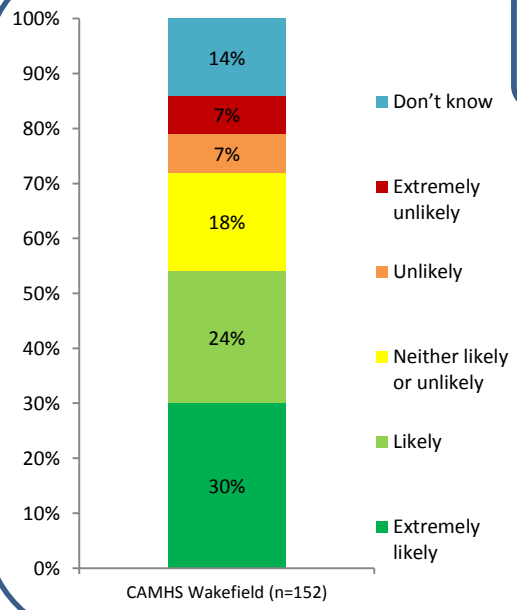
Complaints closed <25 days 0%

Complaints closed 26 - 39 days 0%

Complaints closed 40> days 100%

No complaints were closed within the 25 day timeframe. Bi-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



54% of respondents Extremely Likely / Likely to recommend

Comment themes

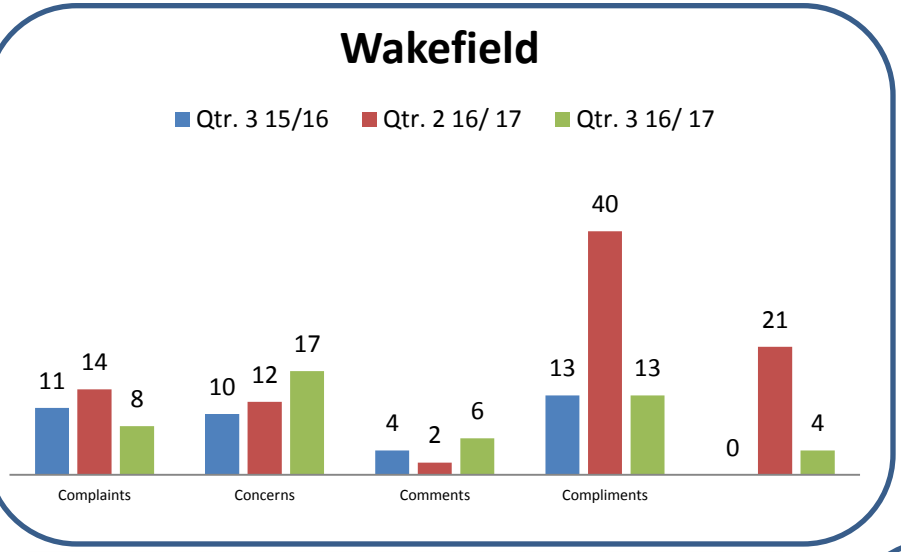
What was good about your experience?

- Staff

What would have made your experience better?

- Waiting times

Wakefield Business Delivery Unit



Action Taken:

- Team to ensure any changes to appointments are notified as soon as possible. Staff have received additional information to support signposting veterans and their families to sources of support. **CMHT 3, Horbury.**
- Team to check understanding of information provided regarding referrals made to other services and about additional sources of support. **CMHT 1.**

'Staff gave me clear information, were very punctual and supportive. Their support has been very much appreciated' - **Rapid Access Service**

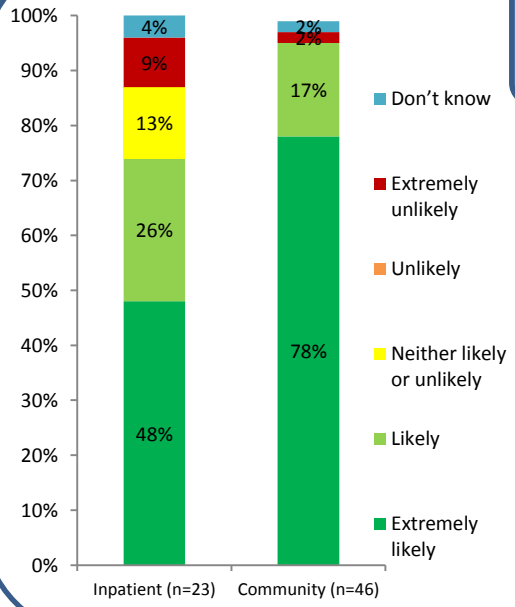
Complaints closed <25 days 0%

Complaints closed 26 - 39 days 33%

Complaints closed 40> days 77%

No complaints were closed within the 25 day timeframe. This was due to the length of time taken to investigate complaints raised. Bi-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



88% of respondents Extremely Likely / Likely to recommend

Comment themes

What was good about your experience?

- Staff
- Greeting on arrival
- Communication

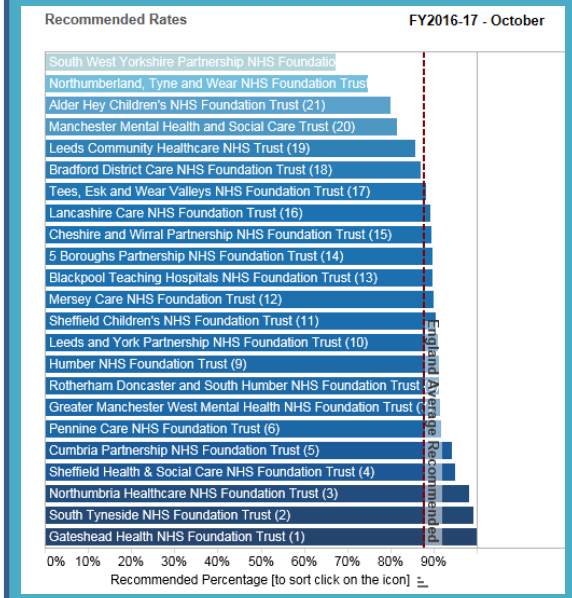
What would have made your experience better?

- Communication
- Staff
- Waiting times

Friends and Family Test Comments and Benchmarking

Benchmarking

NHS Improvement has launched the 'Patient Experience Headlines Tool'. The tool was developed in partnership with Trusts to enable staff to access key sources of published patient experience measures in one place.



The graph left shows a comparison of Mental Health Trusts from the North of England's FFT recommend rate. SWYPFT was the lowest scoring Trust in the area for October with a recommend rate of 67%. Analysis of the results for that period shows that CAMHS represented 59% of Trust responses with a 49% recommend rate for that service. Trust mental health services combined had a recommend rate of 93%. Best practice in collecting data will be explored with local partners.

Nursing, governance and safety staff continue to work with CAMHS service colleagues to review methodology for collecting data and explore alternatives methods of gathering feedback given agile service offer and move to new premises.

The Trust's general Community Health Services consistently have a recommend rate of >97% every month.

What was good?

"At a critical time when I needed help in looking after my wife you were there to help me, 24hr a day and every day until the crisis was over" – Kirklees Outreach Team

"Everything was discussed in full. Recommendations made and nurse very friendly and understood our situation (Alzheimer's). He was wonderful at explaining things simply for mum to understand" – District Nursing

"Learned a lot of life skills that can help with my day to day life. Felt safe and welcome. Lovely staff and coordinators. Calming place to be" – Barnsley Recovery College

"Clear presentation, friendly environment, visual activities, opportunity to experience activities. Lots of support." – Community Physiotherapy

"The support that I had from all staff, they believed in me when I had no faith in myself" – Ward 18 Therapy Team

What could have been better?

"Would like more one to one sessions with nursing staff. Although nursing staff are hard pressed. More staff meetings involving service users as well" – Ward 19

"I prefer the old idea of making next appointment while I am there instead of having to change it later" – Podiatry

"Path access is outside parameters for NHS wheelchair access. No accessibility feature in the glass screen at reception" – Wakefield Primary Care Therapy Team

"Easier car parking, although I appreciate the turmoil around in this respect" – Barnsley Older Adults CMHT

"Would like regular follow-up with doctor at memory clinic" – Kirklees Early Onset Dementia Team

"Better listening and understanding. Do not keep people inside. Activities in day" – Priory 2

Freedom of Information requests

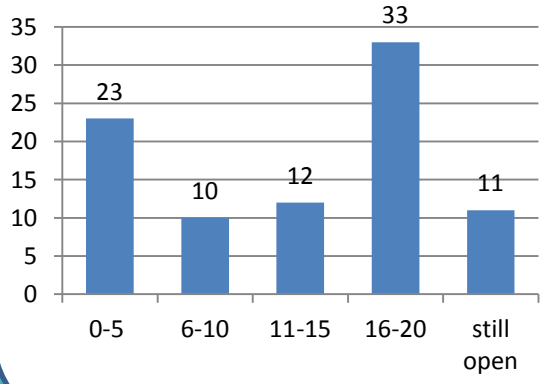
89 requests to access information under the Freedom of Information Act were processed in Qtr. 3, a decrease on the previous quarter when 97 requests were processed. Most requests were detailed and complex in nature and required significant time to collate an appropriate response working with services and support functions.

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

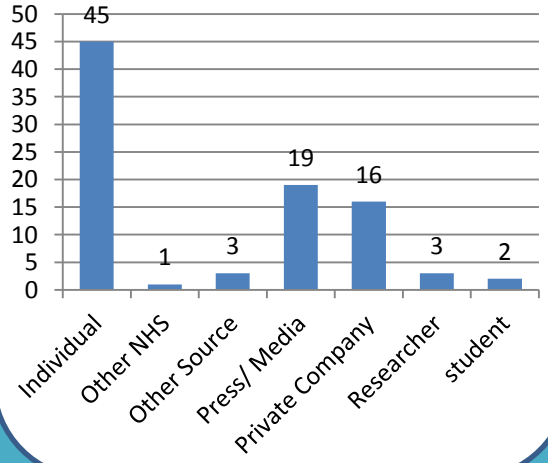
During Qtr. 3, 8 exemptions were applied:

- 1 x Exemption 21, Information already reasonably accessible.
- 2 x Exemption 31, Prejudice to law enforcement.
- 3 x Exemption 40, Personal information.
- 1 x Exemption 41, Confidentiality.
- 1 x Exemption 43, Trade secrets and prejudice to commercial interest.

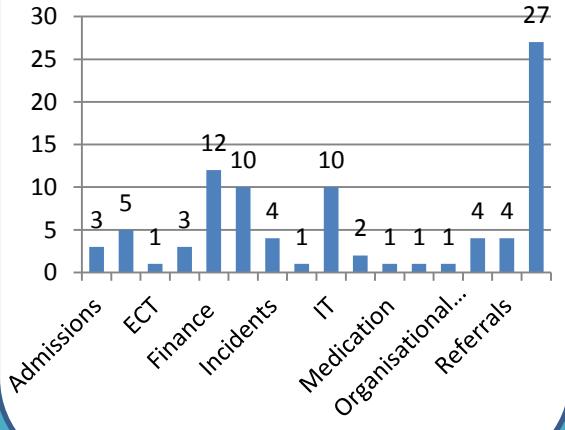
Number of days to respond



Origin of request



Types of request



Trust Board 31 January 2017
Agenda item 8.1

Title:	**Update to the Trust Constitution and Scheme of Delegation**
Paper prepared by:	Director of Corporate Development
Purpose:	Trust Board is required to approve changes to the Trust's Constitution.
Mission/values:	Robust governance arrangements are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust and to continue to meet its obligations under its Constitution.
Any background papers/ previously considered by:	The last version of the Constitution was approved by Trust Board in October 2014. The proposed amendments to the Constitution have been considered by a subgroup of the Members' Council, the Executive Management Team and the Audit Committee who support its approval. The Constitution is in line with Monitor's NHS foundation trusts: model core constitution which can be found at: https://www.gov.uk/government/publications/nhs-foundation-trusts-model-core-constitution
Executive summary:	**Background** The Trust is required to have a Constitution in place that sets out how it is accountable to local people, who can become a member and what this means, the role of the Members' Council, how Trust Board and the Members' Council are structured and how Trust Board works with the Members' Council. The Constitution also contains a set of model rules that provide the basis for elections to the Members' Council. A review of the Constitution has taken place to check the cross references with other documents and making it easier to read. The proposed amendments have been considered by a subgroup of the Members' Council, the Executive Management Team and the Audit Committee who support its approval. Amendments include: <u>Constitution (including the Standing Orders)</u> ➢ Additions to the definitions to make them clearer. ➢ Removal of duplicated text from Additional Provisions appendices ➢ Removal of the word "written" when notice is required to allow for notice can be given through various means. ➢ Inclusion of the Members' Council composition diagram with Appendix 3. ➢ Removal of the requirement to publish notice of meetings in newspapers. The details continue to be provided on the Trust's website. ➢ Notice period for urgent Trust Board meetings changed to seven days to be consistent with the notice period for urgent Members' Council meetings. ➢ Addition of "telephone" as an option for attendance (along with video or computer link) at Trust Board and Members' Council meetings where agreed. ➢ Review of Standing Orders to be conducted biannually, instead of annually, at the same time as the review of the Constitution, unless required earlier. ➢ To assist with quoracy, under the Additional Provisions – Membership,

	the quoracy for members' meetings (annual members' meeting) has been be changed to at least two Governors' from public constituencies, one staff Governor, and one appointed Governor. <u>Scheme of Delegation</u> ➢ Update to Trust branding, reference numbers, and the names of documents referenced. ➢ Inclusion of further areas from the Standing Financial Instructions approved by Trust Board in October 2016. ➢ Addition of financial approvals hierarchy. **Risk appetite** The delivery of the Trust's Constitution supports the Trust's endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to APPROVE the update to the Constitution (including the Standing Orders) and Scheme of Delegation and support its approval by the Members' Council in February 2017.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

CONSTITUTION OF

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

Version 8 draft (to be approved by Trust Board in January 2017 and Members' Council in February 2017 (effective from 3 February 2017))

Constitution of South West Yorkshire Partnership NHS Foundation Trust

TABLE OF CONTENTS

Paragraph *Page*

1. Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

Headings are for ease of reference only and are not to affect interpretation.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

"the Accounting Officer"	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
"appointed Governors"	means those Governors appointed by the appointing organisations;
"appointing organisations"	means those organisations named in this constitution who are entitled to appoint Governors;
"constitution"	means this constitution and all annexes to it;
"Director"	means a member of the Trust Board;
"elected Governors"	means those Governors elected by the Public constituencies and the classes of the Staff Constituency;
"Financial year"	means: (a) the period beginning with the date on which the Foundation Trust is authorised and ending with the next 31 March; and (b) each successive period of twelve months beginning with 1 April;
"Local Authority Governor"	means a Governor appointed by one or more local authorities whose area includes the whole or part of an area specified as a public constituency of the Foundation Trust;
"Members' Council"	means the Council of Governors'

"Monitor"	means the body corporate known as Monitor (or successor organisation), as provided by Section 61 of the 2012 Act;
"partner"	means, in relation to another person, a member of the same household living together as a family unit;
"Partnership Governor"	means a Governor appointed by a partnership organisation;
"Public Governor"	means a Governor elected by the members of one of the Public Constituencies;
"Secretary"	means the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary;
"Staff Governor"	means a Governor elected by the members of one of the classes of the Staff Constituency;
"terms of Authorisation"	means the terms of authorisation issued by Monitor under Section 35 of the 2006 Act;
"the 2006 Act"	means the National Health Service Act 2006;
"the 2012 Act"	means the Health and Social Care Act 2012;
"the Foundation Trust"	means the South West Yorkshire Partnership NHS Foundation Trust;
"Trust Board"	means the Board of Directors, as set out in 23.1;
"voluntary organisation"	means a body, other than a public or local authority, the activities of which are not carried on for profit.

2. Name

The name of the foundation trust is South West Yorkshire Partnership NHS Foundation Trust ("the Foundation Trust").

3. Principal purpose

3.1 The principal purpose of the Foundation Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Foundation Trust does not fulfil its principle purpose unless, in each financial year, its total income from the provision of goods and

services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Foundation Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

3.3.2 the promotion and protection of public health.

3.4 The Foundation Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principle purpose.

4. Powers

4.1 The powers of the Foundation Trust are set out in the 2006 Act.

4.2 All the powers of the Foundation Trust shall be exercised by the Trust Board on behalf of the Foundation Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and constituencies

The Foundation Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1 a public constituency; and

5.2 a staff constituency

Further provisions as to members' meetings are set out in Annex 9.

6. Application for membership

An individual who is eligible to become a member of the Foundation Trust may do so on application to the Foundation Trust.

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Foundation Trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the Foundation Trust under a contract of employment with the Foundation Trust may become or continue as a member of the Foundation Trust provided:

8.1.1 he/she is employed by the Foundation Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he/she has been continuously employed by the Foundation Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Foundation Trust, otherwise than under a contract of employment with the Foundation Trust may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt this does not include individuals who assist or provide services to the Foundation Trust on a voluntary basis.

8.3 Those individuals who are eligible for membership of the Foundation Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into seven descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

8.6 An individual who is:

8.6.1 a member of staff as defined in 8.1 above, and

8.6.2 is invited by the Foundation Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Foundation Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the Foundation Trust that he does not wish to do so.

8.8 An individual who:

8.8.1 exercises functions on behalf of the Trust as defined in 8.2 above, and

8.8.2 is invited by the Foundation Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall be entitled to apply to become a member of the Foundation Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency.

9. Restriction on membership

9.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

9.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

9.3 An individual must be at least 11 years old to become a member of the Trust.

9.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Foundation Trust are set out in Annex 9.

10. Annual Members' Meeting

10.1 The Foundation Trust shall hold an annual meeting of its members (Annual Members' Meeting). The Annual Members' Meeting shall be open to members of the public.

10.2 Further provisions about the Annual Members' Meeting are set out in Annex 9.

11. Members' Council – composition

11.1 The Foundation Trust is to have a Council of Governors, referred to as the Members' Council, which shall comprise both elected and appointed Governors.

11.2 The composition of the Members' Council is specified in Annex 3.

11.3 The members of the Members' Council, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

12. Members' Council – election of Governors

12.1 Elections for elected members of the Members' Council shall be conducted in accordance with the Model Election Rules using the single transferable vote method of voting.

12.2 The Model Election Rules, as published from time to time by the Department of Health, form part of this constitution. The Model Election Rules current at the date of the Trust's authorisation are attached at Annex 4.

12.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 46 of the constitution. For the avoidance of doubt, the Foundation Trust cannot amend the Model Election Rules.

12.4 An election, if contested, shall be by secret ballot.

13. Members' Council - tenure

13.1 An elected Governor shall normally hold office for a period of three calendar years.

13.2 An elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

13.3 An elected Governor shall be eligible for re-election at the end of his term.

13.4 An elected Governor may not hold office for more than nine consecutive years, and shall not be eligible for re-election if he has already held office for more than six consecutive years.

13.5 Further provisions as to tenure for appointed Governors are set out at Annex 5.

14. Members' Council – disqualification and removal

14.1 The following may not become or continue as a member of the Members' Council:

14.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

14.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

14.1.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of

imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

14.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

14.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Members' Council are set out in Annex 5.

15. Members' Council – Lead Governor

15.1 The Trust will ensure a process is in place to appoint a Lead Governor for the Members' Council (in accordance with the provisions set out in Annex 5).

16. Members' Council – duties of Governors

16.1 The general duties of the Members' Council are:

16.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board; and

16.1.2 to represent the interests of the members of the Foundation Trust as a whole and the interests of the public.

16.2 The Foundation Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Members' Council – meetings of Governors

17.1 The Chair of the Foundation Trust (i.e. the Chair of the Trust Board, appointed in accordance with the provisions of paragraph 26 or paragraph 27 below) or, in his/her absence the Deputy Chair (appointed in accordance with the provisions of paragraph 28 below) shall preside at meetings of the Members' Council. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, the Lead Governor will preside over that part of the meeting.

17.2 Meetings of the Members' Council shall be open to members of the public unless the Members' Council decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. Members of the public may be excluded from a meeting if they are interfering with or preventing the proper conduct of the meeting or for other special reasons.

17.3 For the purposes of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance), the Members' Council may require one or more of the Directors to attend a meeting.

18. Members' Council – standing orders

The standing orders for the practice and procedure of the Members' Council, as may be varied from time to time, are attached at Annex 7.

19. Members' Council – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of a Foundation Trust may refer a question as to whether the Foundation Trust has failed or is failing:

19.1.1 to act in accordance with its Constitution; or

19.1.2 to act in accordance with the provision made by or under Chapter 5 of the 2006 Act.

19.2 A governor may refer a question to the Panel only if more than half of the members of the Members' Council voting approve the referral.

20. Members' Council - conflicts of interest of Governors

20.1 A Governor shall disclose to the Members' Council any material interests (as defined below) held by a Governor, their spouse or partner, which shall be recorded in the register of interests of the Members' Council.

20.2 Subject to the exceptions below a material interest is:

20.2.1 directorships, including non-executive directorships, held in private companies or PLCs (with the exception of those of dormant companies);

20.2.2 any interest or position in any firm, company, business or organisation (including any charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the Foundation Trust;

20.2.3 any interest in an organisation providing health and social care services to the National Health Service;

20.2.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

20.2.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the

Foundation Trust including but not limited to lenders or banks.

20.3 The exceptions which shall not be treated as interests or material interests for the purposes of these provisions are as follows:

20.3.1 shares not exceeding 1% of the total shares in issue or £5,000 in value held in any company whose shares are listed on any public exchange;

20.3.2 an employment contract with the Foundation Trust held by a Staff Governor;

20.3.3 an employment contract with a local authority held by a Local Authority Governor;

20.3.4 an employment contract with a university held by a University Governor;

20.3.5 an employment contract with or other position of authority within a partnership organisation held by a Partnership Governor.

20.4 Any Governor who has an interest in a matter to be considered by the Members' Council (whether because the matter involves a firm, company, business or organisation in which the Governor or his spouse or partner has a material interest or otherwise) shall declare such interest to the Members' Council and:

20.4.1 shall withdraw from the meeting and play no part in the relevant discussion or decision; and

20.4.2 shall not vote on the issue (and if by inadvertence they do remain and vote) their vote shall not be counted).

20.5 Details of any such interest shall be recorded in the register of interests of the Members' Council.

20.6 Any Governor who fails to disclose any interest or material interest required to be disclosed under these provisions must permanently vacate their office if required to do so by a majority of the remaining Governors.

21. Members' Council – travel expenses

The Foundation Trust may pay travelling and other expenses to members of the Members' Council at rates determined by the Foundation Trust.

22. Members' Council – further provisions

Further provisions with respect to the Members' Council are set out in Annex 5.

23. Trust Board – composition

23.1 The Foundation Trust is to have a Board of Directors, referred to as the Trust Board, which shall comprise both executive and non-executive directors.

23.2 The Trust Board is to comprise:

23.2.1 a non-executive Chair

23.2.2 up to six other non-executive directors; and

23.2.3 up to six executive directors.

23.2.4 There will be at least one more non-executive director than executive directors, including the Chair of the Trust.

23.3 One of the executive directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer.

23.5 One of the executive directors shall be the finance director.

23.6 One of the executive directors is to be a registered medical practitioner.

23.7 One of the executive directors is to be a registered nurse.

24. Trust Board – general duty

The general duty of the Trust Board and of each Director individually is to act with a view to promoting the success of the Foundation Trust so as to maximise the benefits for the members of the Foundation Trust as a whole and for the public.

25. Trust Board – qualification for appointment as a non-executive director

A person may be appointed as a non-executive director only if

25.1 he/she is a member of a Public Constituency, or

25.2 where any of the Foundation Trust's hospitals includes a medical or dental school provided by a university, he/she exercises functions for the purposes of that university, and

25.3 he/she is not disqualified by virtue of paragraph 31 below or Annex 6.

26. Trust Board – appointment and removal of Chair and other non-executive directors

26.1 The Members' Council at a general meeting of the Members' Council shall appoint or remove the chair of the Foundation Trust and the other non-executive directors.

26.2 Removal of the Chair or another non-executive director shall require the approval of three-quarters of the members of the Members' Council.

26.3 The initial Chair and the initial non-executive directors are to be appointed in accordance with paragraph 27 below.

26.4 Further provisions as to the appointment and removal of the Chair and other non-executive directors are set out at Annex 6.

27. Trust Board – appointment of initial chair and initial other non-executive directors

27.1 The Chair of the applicant NHS Trust shall be appointed as the initial Chair of the Foundation Trust if he/she wishes to be appointed.

27.2 The power of the Members' Council to appoint the other non-executive directors of the Foundation Trust is to be exercised, so far as possible, by appointing as the initial non-executive directors of the Foundation Trust any of the non-executive directors of the applicant NHS Trust (other than the Chair) who wish to be appointed.

27.3 The criteria for qualification for appointment as a non-executive director set out in paragraph 25 above (other than disqualification by virtue of paragraph 31 below or Annex 6) do not apply to the appointment of the initial Chair and the initial other non-executive directors in accordance with the procedures set out in this paragraph.

27.4 An individual appointed as the initial Chair or as an initial non-executive director in accordance with the provisions of this paragraph shall be appointed for the unexpired period of his/her term of office as Chair or (as the case may be) non-executive director of the applicant NHS Trust; but if, on appointment, that period is less than 12 months, he/she shall be appointed for 12 months.

28. Trust Board – appointment of Deputy Chair

The Members' Council at a general meeting of the Members' Council shall appoint one of the non-executive directors as a Deputy Chair. If the Chair is unable to discharge his/her office as Chair of the Foundation Trust the Deputy Chair of the Trust Board shall be acting Chair of the Foundation Trust.

29. Trust Board – appointment and removal of the Chief Executive and other executive directors

29.1 The non-executive directors shall appoint or remove the Chief Executive.

29.2 The appointment of the Chief Executive shall require the approval of the Members' Council.

29.3 The initial Chief Executive is to be appointed in accordance with paragraph 30 below.

29.4 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

30. Trust Board – appointment and removal of initial Chief Executive

30.1 The chief officer of the applicant NHS Trust shall be appointed as the initial Chief Executive of the Foundation Trust if he/she wishes to be appointed.

30.2 The appointment of the chief officer of the applicant NHS trust as the initial Chief Executive of the Foundation Trust shall not require the approval of the Members' Council.

31. Trust Board – disqualification

The following may not become or continue as a member of the Trust Board:

31.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

31.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

31.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust Board are set out at Annex 6.

32. Trust Board – meetings

32.1 Meetings of the Trust Board shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

32.2 Members of the public may be excluded from a meeting if they are interfering with or preventing the proper conduct of the meeting or for other special reasons.

32.3 Before holding a meeting, the Trust Board must send a copy of the agenda of the meeting to the Members' Council. As soon as practicable after holding a meeting, the Trust Board must send a copy of the minutes of the meeting to the Members' Council.

33. Trust Board – standing orders

The standing orders for the practice and procedure of the Trust Board, as may be varied from time to time, are attached at Annex 8.

34. Trust Board – conflicts of interest of directors

34.1 The duties that a Director of the Foundation Trust has by virtue of being a Director include, in particular:

34.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust;

34.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in this capacity.

34.2 The duty referred to in paragraph 34.1.1 is not infringed if:

34.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

34.2.2 the matter has been authorised in accordance with the Constitution.

34.3 The duty referred to in paragraph 34.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

34.4 In paragraph 34.1.2, "the third party" means a person other than:

34.4.1 the Foundation Trust; or

34.4.2 a person acting on its behalf.

34.5 If a Director of the Foundation Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Foundation Trust, the Director must declare the nature and extent of that interest to the other Directors.

34.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

34.7 Any declaration required by this paragraph must be made before the Foundation Trust enters into the transaction or arrangement.

34.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

34.9 A Director need not declare an interest:

34.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

34.9.2 if, or to the extent that, the Directors are already aware of it;

34.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

34.9.3.1 by a meeting of the Board of Directors; or

34.9.3.2 by a committee of the Directors appointed for the purpose under the Constitution.

34.10 Any Director who has an interest in a matter to be considered by the Board of Directors that is required to be declared in accordance with paragraph 34 of this Constitution shall declare such interest to the Board of Directors and:

34.10.1 shall withdraw from the meeting and play no part in the relevant discussion or decision; and

34.10.2 shall not vote on the issue (and if by inadvertence they do remain and vote) their vote shall not be counted).

34.11 Details of any such interest shall be recorded in the register of interests of the Directors.

34.12 Any Director who fails to disclose any interest required to be disclosed under these provisions may be removed from office in accordance with the process for removing such a Director, as set out in this constitution.

35. Trust Board – remuneration and terms of office

35.1 The Members' Council at a general meeting of the Members' Council shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

35.2 The Foundation Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

36. Registers

The Foundation Trust shall have:

36.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

36.2 a register of members of the Members' Council;

36.3 a register of interests of Governors;

36.4 a register of directors; and

36.5 a register of interests of the directors.

37. Admission to and removal from the registers

37.1 The Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this constitution.

37.2 The Secretary is to send to Monitor a list of persons who were first elected or appointed as Governors and Directors.

38. Registers – inspection and copies

38.1 The Foundation Trust shall make the registers specified in paragraph 35 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

38.2 The Foundation Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Foundation Trust, if the member so requests.

38.3 So far as the registers are required to be made available:

38.3.1 they are to be available for inspection free of charge at all reasonable times; and

38.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

38.4 If the person requesting a copy or extract is not a member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

39. Documents available for public inspection

39.1 The Foundation Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

39.1.1 a copy of the current constitution;

39.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and

39.1.3 a copy of the latest annual report.

39.2 The Foundation Trust shall also make the following documents relating to special administration of the Foundation Trust available for inspection by members of the public free of charge at all reasonable times:

39.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

39.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

39.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;

39.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

39.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

39.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to the re-submitted final report) of the 2006 Act;

39.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

39.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act;

39.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act;

39.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

39.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy or extract.

39.4 If the person requesting a copy or extract is not a member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

40. Auditor

40.1 The Foundation Trust shall have an auditor.

40.2 The Members' Council shall appoint or remove the auditor at a general meeting of the Members' Council.

40.3 Further provisions as to the auditor are set out at Annex 10.

41. Audit committee

The Foundation Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

42. Accounts

42.1 The Foundation Trust must keep proper accounts and proper records in relation to the accounts.

42.2 Monitor may, with the approval of the Secretary of State, give directions to the Foundation Trust as to the content and form of its accounts

42.3 The accounts are to be audited by the Foundation Trust's auditor.

42.4 The Foundation Trust shall prepare in respect of each Financial Year annual accounts in such form as Monitor may, with the approval of the Secretary of State, direct.

42.5 The functions of the Foundation Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

42.6 Further provisions as to accounts are set out at Annex 10.

43. Annual report, forward plans and non-NHS work

43.1 The Foundation Trust shall prepare an Annual Report and send it to Monitor. Further provisions as to Annual Reports are set out at Annex 10.

43.2 The Foundation Trust shall give information as to its forward planning in respect of each Financial Year to Monitor.

43.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

43.4 In preparing the document, the directors shall have regard to the views of the Members' Council.

43.5 Each forward plan must include information about:

43.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Foundation Trust proposes to carry on; and

43.5.2 the income it expects to receive from doing so.

43.6 Where a forward plan contains a proposal that the Foundation Trust carries on an activity of a kind mentioned in paragraph 43.5.1, the Members' Council must:

43.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Foundation Trust of its principal purpose or the performance of its other functions; and

43.6.2 notify the Directors of the Foundation Trust of its determination.

43.7 A Foundation Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Members' Council of the Foundation Trust voting approve its implementation.

44. Presentation of the annual accounts and reports to the governors and members

44.1 The following documents are to be presented to the Members' Council at a general meeting of the Members' Council:

44.1.1 the annual accounts

44.1.2 any report of the auditor on them

44.1.3 the annual report.

44.2 The documents shall also be presented to the members of the Foundation Trust at the Annual Members' Meeting by at least one member of the Trust Board in attendance.

44.3 The Foundation Trust may combine a meeting of the Members' Council convened for the purposes of paragraph 44.1 with the Annual Members' Meeting.

45. Instruments

45.1 The Foundation Trust shall have a seal.

45.2 The seal shall not be affixed except under the authority of the Trust Board.

46. Amendment of the constitution

46.1 No amendment shall be made to this constitution (including its Annexes) unless:

46.1.1 it has been approved by more than half of the Governors present and voting at a meeting of the Members' Council duly called in accordance with this constitution.

46.1.2 it has been approved by more than half of the Directors present and voting at a meeting of the Trust Board duly called in accordance with this constitution; and

46.2 Amendments made under paragraph 46.1 take effect as soon as the conditions of that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

46.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Members' Council (or otherwise with respect to the role that the Members' Council has as part of the Foundation Trust):

46.3.1 at least one member of the Members' Council must attend the next Annual Members' Meeting and present the amendment; and

46.3.2 the Foundation Trust must give the members an opportunity to vote on whether they approve the amendment.

46.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Foundation Trust must take such steps as are necessary as a result.

46.5 Amendments by the Foundation Trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

47. Mergers, etc. and significant transactions

47.1 The Foundation Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Members' Council.

47.2 The Foundation Trust may enter into a significant transaction only if more than half of the members of the Members' Council of the Foundation Trust voting approve entering into the transaction.

47.3 The Constitution does not contain any descriptions of the terms 'significant transaction' for the purpose of section 51A of the 2006 Act (Significant Transactions). The Foundation Trust will refer to guidance issued by Monitor or the Department of Health in determining what constitutes a significant transaction.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

The Public Constituencies are:

1.1 Barnsley (the area covered by Barnsley Metropolitan Borough Council)

1.2 Calderdale (the area covered by Calderdale Metropolitan Borough Council)

1.3 Kirklees (the area covered by Kirklees Metropolitan Council)

1.4 Wakefield (the area covered by Wakefield Metropolitan District Council)

1.5 Rest of South and West Yorkshire (the area covered by Doncaster Metropolitan Borough Council, Rotherham Metropolitan Borough Council, Sheffield City Council, Bradford Metropolitan District Council and Leeds City Council)

The minimum number of members of the above Public Constituencies is to be 10.

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.4 and 8.5)

The Staff Constituency will consist of the following classes:

1.1 registered medical practitioners and registered pharmacists

1.2 registered nurses

1.3 nursing support

1.4 allied healthcare professionals

1.5 psychological therapies

1.6 social care staff working in integrated teams

1.7 non-clinical support services, including management

The minimum number of members of the above Staff Constituency is to be 4.

ANNEX 3 – COMPOSITION OF MEMBERS' COUNCIL

(Paragraphs 11.2 and 11.3)

1. The aggregate number of Public Governors is to be more than half of the total number of members of the Members' Council.

2. The Members' Council, subject to the 2006 Act, shall seek to ensure that through the composition of the Members' Council:

   2.1 the interests of the community served by the Foundation Trust are appropriately represented;

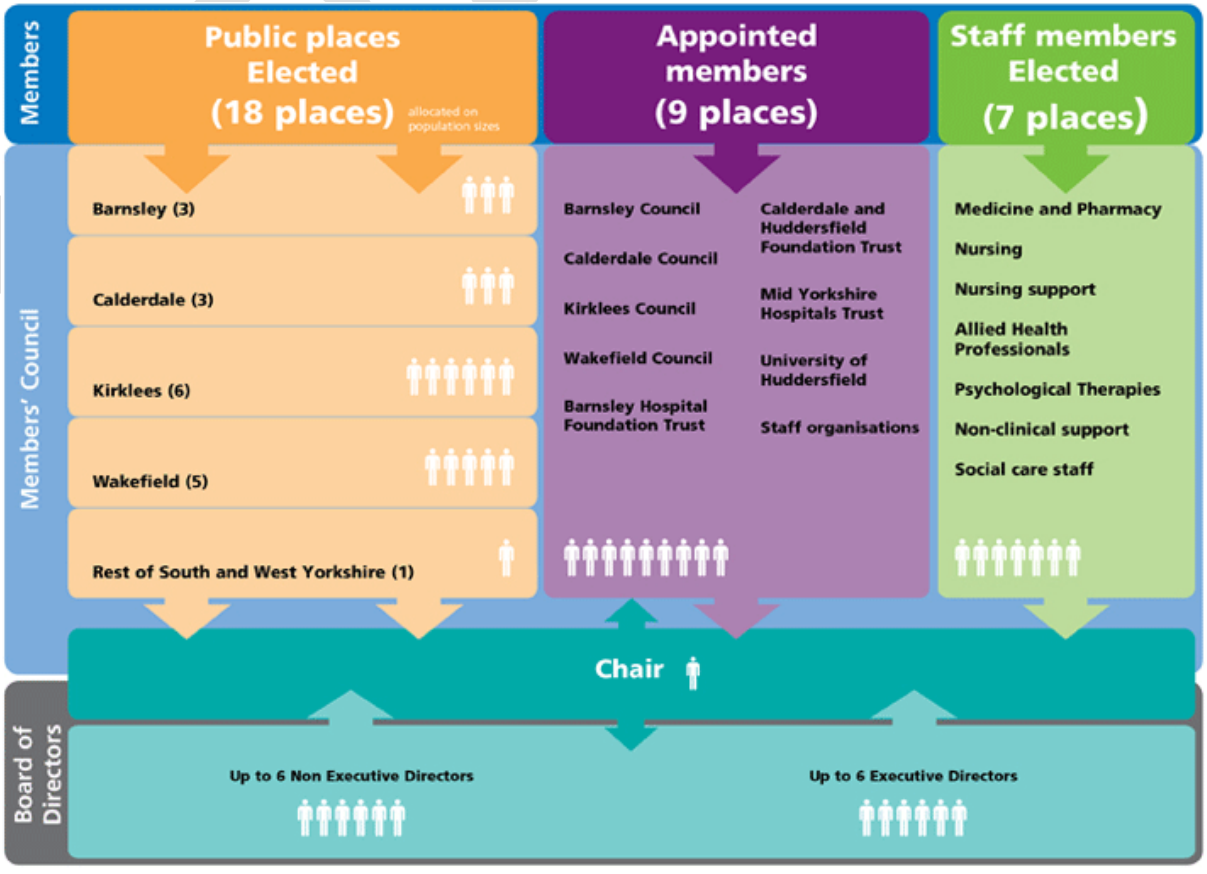
   2.2 the level of representation of the Public Constituency, the classes of the Staff Constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Foundation Trust's affairs;

   and, to this end, the Members' Council:

   2.3 shall at all times maintain a policy for the composition of the Members' Council which takes account of the membership strategy, and

   2.4 shall from time to time and not less than every three years review the policy for the composition of the Members' Council, and

   2.5 when appropriate shall propose amendments to this constitution.



3. The Members' Council of the Foundation Trust is to comprise:

3.1 Eighteen Public Governors from the Public Constituencies as follows:

3.1.1 Barnsley – three Public Governors

3.1.2 Calderdale – three Public Governors

3.1.3 Kirklees – six Public Governors

3.1.4 Wakefield – five Public Governors

3.1.5 Rest of South and West Yorkshire – one public Governor

3.2 seven Staff Governors from the following classes;

3.2.1 Registered medical practitioners and registered pharmacists – one Staff Governor

3.2.2 Registered nurses – one Staff Governor

3.2.3 Nursing support – one Staff Governor

3.2.4 Allied healthcare professionals – one Staff Governor

3.2.5 Psychological therapies – one Staff Governor

3.2.6 Social care staff working in integrated teams – one Staff Governor

3.2.7 Non-clinical support staff, including management – one Staff Governor

3.3 four Local Authority Governors to be appointed by each of Barnsley Metropolitan Borough Council, Calderdale Metropolitan Borough Council, Kirklees Metropolitan Council and Wakefield Metropolitan District Council;

3.4 five Partnership Governors to be appointed by partnership organisations.

4. The partnership organisations which are specified for the purposes of paragraph 9(7) of Schedule 7 to the 2006 Act and may appoint a Partnership Governor are:

4.1 Calderdale and Huddersfield NHS Foundation Trust;

4.2 The Mid Yorkshire Hospitals NHS Trust;

4.3 Barnsley Hospital NHS Foundation Trust

4.4 The University of Huddersfield;

4.5 Joint Committee of Staff Organisations (comprising British Medical Association, Chartered Society of Physiotherapists, Amicus, Royal College of Nursing of the United Kingdom, and UNISON (including BOAT))

ANNEX 4 –THE MODEL ELECTION RULES

(Paragraph 12.2)

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Part 1 – Interpretation

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

“*2006 Act*” means the National Health Service Act 2006;

“*corporation*” means the public benefit corporation subject to this constitution;

“*Members’ Council*” means the council of governors of the corporation;

“*declaration of identity*” has the meaning set out in rule 21.1;

“*election*” means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Members’ Council;

“*e-voting*” means voting using either the internet, telephone or text message;

“*e-voting information*” has the meaning set out in rule 24.2;

“*ID declaration form*” has the meaning set out in Rule 21.1; “internet voting record” has the meaning set out in rule 26.4(d);

“*internet voting system*” means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

“*lead governor*” means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

“*list of eligible voters*” means the list referred to in rule 22.1, containing the information in rule 22.2;

“*method of polling*” means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

“*Monitor*” means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

“*numerical voting code*” has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	**Time**
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part–4 - Stages Common to Contested and Uncontested Elections

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is

being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by

rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 – Contested elections

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting

information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from

that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule

64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID

number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an

election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

Part 6 - Counting the votes

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled

to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub-parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of

transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot

and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 – Final proceedings in contested and uncontested elections

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a

constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in

rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Part 10 – Election expenses and publicity

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or

her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the

counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – MEMBERS' COUNCIL

(Paragraphs 13.4, 13.5, 14.3, 15.1 and 22)

Elected Governors

1. A member of the Public Constituency may not vote at an election for a Public Governor unless within twenty-one days before they vote they have made a declaration in the form specified by the Secretary that they are qualified to vote as a member of the relevant Public Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

Appointed Governors

2. The Secretary, having consulted Barnsley Metropolitan Borough Council, Calderdale Metropolitan Borough Council, Kirklees Metropolitan Council and Wakefield Metropolitan District Council is to adopt a process for agreeing the appointment of Local Authority Governors with those local authorities.

3. The Partnership Governors are to be appointed by the partnership organisations, in accordance with a process agreed with the Secretary.

Appointment of Lead Governor

4. A Lead Governor is to be appointed for the Members' Council using the following procedure.

5. Publicly elected Governors will be invited to self-nominate supported by a brief written explanation of why they are putting themselves forward and evidencing how they would be able to fulfil the role.

6. The Nominations Committee will shortlist the self-nominations and invite shortlisted candidates to make a brief presentation and answer questions based on their 'application'.

7. The Nominations Committee will then make a recommendation to the full Members' Council.

Deputising arrangements for the Chair

8. The Deputy Chair of the Trust Board will chair the Members' Council in the absence of the Chair.

9. If the person chairing the meeting has a conflict of interest in relation to the business being discussed, the Lead Governor will preside over that part of the meeting.

Tenure for appointed Governors

10. An appointed Governor:

10.1 shall normally hold office for a period of three calendar years;

10.2 shall be eligible for re-appointment at the end of his term;

10.3 may not hold office for longer than nine consecutive years, and shall not be eligible for re-appointment if he has already held office for more than six consecutive years.

11. An appointed Governor shall cease to hold office if the appointing organisation which appointed him terminates the appointment.

Further provisions as to eligibility to be a Governor

12. A person may not become a Governor of the Foundation Trust, and if already holding such office will immediately cease to do so, if:

12.1 they are a Director of the Foundation Trust or a Governor or director of an NHS body (unless they are appointed by an appointing organisation which is an NHS body);

12.2 they are the spouse, partner, parent or child of a member of the Board of Directors of the Foundation Trust;

12.3 they are a member of a local authority's Scrutiny Committee covering health matters;

12.4 they have been previously removed as a Governor pursuant to paragraph 14 of this Annex 5;

12.5 being a member of one of the Public Constituencies, they refuse to sign a declaration in the form specified by the Secretary of particulars of their qualification to vote as a member of the Foundation Trust, and that they are not prevented from being a member of the Members Council;

12.6 they are subject to a sex offender order;

12.7 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body;

12.8 they are a person whose tenure of office as the Chair or as a member or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

13. A person holding office as a Governor shall immediately cease to do so if:

13.1 they resign by notice of one month in writing to the Chair of the Trust;

13.2 they fail to attend three consecutive meetings of the Members' Council, unless the other Governors are satisfied that:

13.2.1 the absences were due to reasonable causes; and

13.2.2 they will be able to start attending meetings of the Members' Council again within such a period as the other Governors consider reasonable;

13.3 they have refused without reasonable cause to undertake any training which the Members' Council requires all Governors to undertake;

13.4 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of the code of conduct for Governors;

13.5 they are removed from the Members' Council under the following provisions.

14. A Governor may be removed from the Members' Council by a resolution approved by not less than two thirds of the remaining Governors present and voting on the grounds that:

14.1 they have committed a serious breach of the code of conduct; or

14.2 they have acted in a manner detrimental to the interests of the Foundation Trust; and

14.3 the Members' Council consider that it is not in the best interests of the Foundation Trust for them to continue as a Governor.

Vacancies amongst Governors

15. Where a vacancy arises on the Members' Council for any reason other than expiry of term of office, the following provisions will apply.

16. Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

17. Where the vacancy arises amongst the elected Governors, the Members' Council shall be at liberty either:

17.1 to call an election within three months to fill the seat for the remainder of that term of office; or

17.2 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office; or

17.3 if the unexpired period of the term of office is less than 9 months, to leave the seat vacant until the next elections are held.

ANNEX 6 – ADDITIONAL PROVISIONS – TRUST BOARD

(Paragraphs 25.3, 26.4, 27.3 and 31)

Appointment and Removal of Chair and other Non-Executive directors

1. Non-Executive Directors are to be appointed by the Members' Council using the following procedure.

   1.1 The Members' Council will maintain a policy for the composition of the Non-Executive Directors which takes account of the membership strategy, and which they shall review from time to time and not less than every three years.

   1.2 The Trust Board may work with an external organisation recognised as expert at appointments to identify candidates with appropriate skills and experience required for Non-Executive Directors vacancies.

   1.3 (An) appropriate candidate(s) will be identified by a Nominations Committee through a process of open competition, which takes account of the policy maintained by the Members' Council and the skills and experience required.

   1.4 The Nominations Committee will comprise the Chair of the Foundation Trust (or, when a Chair is being appointed, another non-executive Director), the Chief Executive and at least two Governors selected by the Members' Council. The Nominations Committee will have the power to co-opt external persons to act as independent assessors to the Nominations Committee.

2. The removal of the Chairman or another Non-Executive Director shall be in accordance with the following procedures.

   2.1 Any proposal for removal must be proposed by a Governor and seconded by not less than three-quarters of the Members' Council of whom at least two must be elected Governors and two must be appointed Governors.

   2.2 Written reasons for the proposal shall be provided to the Non-Executive Director in question, who shall be given the opportunity to respond to such reasons.

   2.3 In making any decision to remove a Non-Executive Director, the Members' Council shall take into account the annual appraisal carried out by the Chair.

   2.4 If any proposal to remove a Non-Executive Director is not approved at a meeting of the Members' Council, no further proposal can be put forward to remove such Non-Executive Director based upon the same reasons within 12 months of the meeting.

Further provisions as to disqualification of Directors

3. A person may not become or continue as a Director of the Foundation Trust if:

   3.1 they are a member of the Members' Council or, except with the permission of the Trust Board, a governor or director of an NHS body;

   3.2 they are the spouse, partner, parent or child of a member of the Trust Board of the Foundation Trust;

   3.3 they are a member of a local authority's Scrutiny Committee covering health matters;

   3.4 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

   3.5 they are a person whose tenure of office as a Chair or as a member or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of the health service, for non attendance at meetings, or for non-disclosure of a pecuniary interest;

   3.6 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body;

   3.7 in the case of a Non-Executive Director they have refused without reasonable cause to fulfil any training requirement established by the Trust Board; or

   3.8 they have refused to sign and deliver to the Secretary a statement in the form required by the Trust Board confirming acceptance of the code of conduct for Directors.

Expenses

4. The Foundation Trust may reimburse Executive Directors travelling and other costs and expenses incurred in carrying out their duties at such rates as the remuneration committee of Non-Executive Directors decides. These are to be disclosed in the annual report.

5. The remuneration, allowances and other terms of office of the Non-Executive Directors are determined by the Members' Council as set out in paragraph 35.1 of the constitution.

6. The remuneration and allowances for Directors are to be disclosed in bands in the annual report.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE MEMBERS' COUNCIL

(Paragraph 18)

1. Calling Meetings

1.1 The Members' Council is to meet at least four times in each financial year (excluding the Annual Members' Meeting) at such times and places as the Council may determine.

1.2 Meetings of the Members' Council may be called by the Secretary, or by the Chair, or by ten Governors including at least two elected Governors and two appointed Governors who give written notice to the Secretary specifying the business to be carried out.

2. Admission of the Public

2.1 All meetings of the Members' Council are to be General Meetings open to members of the public unless the Members' Council decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chair may exclude any member of the public from a meeting of the Members' Council if they are interfering with or preventing the proper conduct of the meeting.

3. Notice of Meetings

3.1 Save in the case of emergencies or the need to conduct urgent business, the Secretary will give at least seven days notice of the date and place of every meeting of the Members' Council to all Governors. Notice will also be published on the Trust's website.

3.2 After the receipt of a request to call a meeting the Secretary shall send notice to all Governors, specifying the business to be carried out, as soon as possible after the receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chair or ten Governors, whichever is the case, shall call such a meeting.

3.3 The notice of the meeting specifying the business proposed to be transacted at it shall be delivered to every Governor, so as to be available to him/her at least five clear days before the meeting.

3.4 Lack of service of the notice shall not affect the validity of a meeting.

3.5 In the case of a meeting called by the Chair or the Governors in default of the Secretary, the Chair or those Governors shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

3.6 In such a case, failure to serve such a notice on more than 20 Governors will invalidate the meeting.

4. Setting the Agenda

4.1 The Foundation Trust may determine that certain matters shall appear on every agenda for a meeting of the Council and shall be addressed prior to any other business being conducted.

4.2 In accordance with the Constitution every agenda for meetings of the Members' Council will draw to the attention of Governors the declaration they are required to make in clause 9.1 stating that they are qualified to vote as a member of the Trust and that they are not prevented from being a member of the Members' Council. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Members' Council.

4.3 Any Governor wishing to submit an agenda item must notify the Secretary in writing at least ten clear days prior to the meeting at which it is to be considered. Requests made less than ten clear days before a meeting may be included on the agenda at the discretion of the Chair.

5. Chair of the Meeting

5.1 The Chair of the Trust or, in their absence, the Deputy Chair is to preside at meetings of the Members' Council.

5.2 If the Chair has a conflict of interest in relation to the business being discussed, the Deputy Chair will chair that part of the meeting.

5.3 If the person chairing the meeting has a conflict of interest in relation to the business being discussed, the Lead Governor will preside over that part of the meeting

5.4 If a vote concerns matters relating to the Chair and/or Non Executive Directors, neither the Chair of the Trust nor any other Non Executive Director should preside over the meeting. In this instance the Lead Governor should preside over that part of the meeting and have the casting vote.

6. Annual Members' Meeting

6.1 The Foundation Trust will publicise and hold an Annual Members' Meeting in accordance with the Constitution.

7. Motions

7.1 Motions may only be submitted by a Governor and must be received by the Secretary in writing at least one week prior to the meeting at which they are to be considered.

7.2 Emergency motions may only be submitted by a Governor and must be received by the Secretary before the commencement of the meeting. Acceptance of such motions for inclusion on the Agenda will be at the discretion of the Chair.

7.3 Any other business should be notified to the Chair at the commencement of the meeting. Acceptance of such items of business for inclusion on the agenda will be at the discretion of the Chair.

7.4 Notice of a motion to rescind a previous Minute must be received by the Secretary at least 21 days before the meeting and must be signed by a majority of members. Such a motion should not be taken until at least 30 minutes after the start of the meeting.

7.5 An amendment that does not directly negate a resolution may be moved by any member. No further amendments may be moved until the first amendment is disposed of. If an amendment is passed it shall become part of the substantive motion and subject to further amendment.

8. Chair's Ruling

8.1 Statements of Governors made at meetings of the Members' Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

9. Voting

9.1 An elected Governor may not vote at a meeting of the Members' Council unless, before attending the meeting, they have made a declaration in the form specified by the Members' Council of particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Members' Council. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Members' Council, and every agenda for meetings of the Members' Council will draw this to the attention of elected Governors.

9.2 Subject to the Constitution questions arising at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

9.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

9.4 In accordance with the Constitution the appointment of the Chair and any Non Executive Director of the Trust is subject to the approval of a majority of the votes of the Governors present.

9.5 In accordance with the Constitution the removal of the Chair and any Non Executive Director of the Trust is subject to a three-quarters majority of all the members of the Council of Members, voting at the meeting, of which at least two must be elected and two appointed.

9.6 In accordance with the Constitution the appointment of the Chief Executive is subject to the approval of a majority of the members of the Council of Members present and voting at a meeting.

9.7 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

9.8 Subject to the Constitution, and subject to clause 9.5, questions arising at a meeting of the Members' Council shall be decided by a majority of votes.

9.9 No resolution of the Members' Council shall be passed if all the Public Governors present unanimously oppose it.

9.10 All decisions taken in good faith at a meeting of the Members' Council or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

10. Attendance

10.1 Governors who are unable to attend the Members' Council meeting should advise the Secretary in advance of the meeting so that their apologies may be submitted.

10.2 The Members' Council may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute the presence of the person at the meeting.

10.3 The Members' Council may invite the Chief Executive or any other member or members of the Trust Board, or a representative of the Trust's auditors or other advisors to attend a meeting of the Members' Council.

11. Minutes

11.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting. The person presiding at that meeting will sign them.

11.2 No discussion shall take place upon the Minutes except upon their accuracy or where the Chairman considers discussion appropriate (for example, consideration of matters arising). Any amendment to the Minutes shall be agreed and recorded at the next meeting.

11.3 Minutes shall be circulated in accordance with the Governors' wishes. Where

providing a record of a public meeting the Minutes shall be made available to the public.

12. Record of Attendance

12.1 The names of the Governors present at the meeting shall be recorded in the minutes.

13. Suspension of Standing Orders

13.1 Except where this would contravene the Constitution or any statutory provision ,any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council are present, and that a majority of those present vote in favour of suspension.

13.2 A decision to suspend Standing Orders shall be recorded in the minutes of the Meeting.

13.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Governors.

13.4 No formal business may be transacted while Standing Orders are suspended.

14. Variation and Amendment of Standing Orders

14.1 These Standing Orders may only be amended in accordance with paragraph 46 of this constitution. A motion to change the Standing Orders must be submitted to the Secretary in writing at least 21 day before the meeting.

15. Quorum

15.1 The quorum for the Members' Council will be one-third of the membership of the Council provided that a minimum of half of this one-third are publicly elected Governors.

15.2 Any Governor who has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

15.3 In accordance with the Constitution if at any meeting there is no quorum within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for seven days and upon reconvening, those present shall constitute a quorum.

16. Committees

16.1 The Members' Council may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors, and other persons to assist the Members' Council in carrying out its functions. The Members' Council may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE TRUST BOARD

(Paragraph 33)

To be read in conjunction with the Standing Financial Instructions, Reservation of Powers to the Board and Scheme of Delegation

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the National Health Service Act 2006, the Health and Social Care Act 2012 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

"Accounting Officer" refers to the Chief Executive who is responsible and accountable to Parliament for ensuring the proper stewardship of public funds and assets.

"Trust" means the South West Yorkshire Partnership NHS Foundation Trust.

"Trust Board" means the Chair, executive and non-executive directors of the Trust collectively as a body.

"Constitution" means the Constitution of the Trust and all annexes to it.

"Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Budget holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

"Chair of the Board (or Trust)" is the person appointed by the Members' Council to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief officer of the Trust, who is also the Accounting Officer.

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services within available resources.

"Committee" means a committee or sub-committee created and appointed by the Trust.

"Committee members" means persons formally appointed by the Board to sit on or to chair specific committees.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"Governor" means a person elected or appointed to serve on the Members' Council.

"Deputy Chair" means the non-executive director appointed by the Members' Council to take on the Chair's duties if the Chair is absent for any reason.

"Director of Finance" means the Chief Financial Officer of the Trust.

"Executive Director" means a director of the Trust who is an employee of the Trust.

"Funds held on trust" shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

"Members' Council" is the body established according to the constitution to represent the interests of stakeholders.

"Monitor" (or successor organisation) is the Regulator appointed under the National Health Service Act 2006.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non Executive Director" means a director of the Trust who is not an employee of the Trust.

"Officer" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

"Secretary" means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and guidance issued by the Department of Health and Monitor.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

"Trust Board member" means an executive or non-executive director of the Board as the context permits.

2. INTRODUCTION

2.1 Statutory Framework

South West Yorkshire Partnership NHS Foundation Trust is a public benefit corporation established in accordance with the provisions of the National Health Service Act 2006 and was authorised on 1 May 2009. The Standing Orders of the Trust are designed to facilitate effective working of the Trust Board and to reflect the standards for business conduct and probity that are set out in the Monitor Code of Governance.

2.1.1 The Trust provides services to the population of Barnsley, Calderdale, Kirklees and Wakefield and the principal places of business are within the boundaries of these local authority areas. The Trust also operates regional forensic psychiatric services for the population of Yorkshire and the Humber. The headquarters of the Trust is Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP.

2.1.2 NHS Foundation Trusts are governed mainly by the National Health Service Act 2006 and the Health and Social Care Act 2012, and are subject to regulation by Monitor.

2.1.3 The functions of the Trust are conferred by this legislation.

2.1.4 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

The Trust is required to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals. The Trust is additionally required to draw up a schedule of decisions that are reserved for the Board and to ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The documents setting out the Reservation of Powers to the Board and Scheme of Delegation, and the Standing Financial Instructions have effect as if incorporated into the Standing Orders.

The Trust is also bound by such other statutes and legal provisions which govern the conduct of its affairs. In addition to the statutory requirements, the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

2.2 Dissemination of the Trust Board standing orders

The Chief Executive is responsible for ensuring all existing directors and staff and all new appointees to the Trust Board are notified of and understand their responsibilities within Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

2.3 Changes to Standing Orders

Changes to the Standing Orders are subject to the following conditions.

- A notice of motion under SO 4.4 has been given.
- The amendment has been approved in accordance with paragraph 45 of the constitution.

2.4 Review of standing orders

These standing orders will be reviewed biannually by the Trust Board or when required. This review will include all documents having the effect as if incorporated into Standing Orders.

3. THE TRUST BOARD: COMPOSITION AND THE ROLE AND TERMS OF OFFICE OF DIRECTORS

3.1 Role of Directors

The Board will function as a unitary board. Executive and Non-Executive Directors will be full and equal members of the Board which will act as the corporate decision body. Their role as members of the Trust Board will be to consider the key strategic, risk and governance issues facing the Trust in carrying out its statutory and other functions.

3.2 Chair

The Chair shall be responsible for the operation of the Trust Board and chair all meetings of the Trust Board and the Members' Council when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

The Chair will meet at least four times per year with the Non-Executives without the Executive Directors present.

3.3 Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

3.4 Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

3.5 Chief Executive

The Chief Executive is the Accounting Officer for the Trust and is responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for NHS Foundation Trust Chief Executives.

3.6 Director of Finance

The Director of Finance is responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

3.7 Composition of the Trust Board

In accordance with the constitution the composition of the Trust Board shall be:

(1) the Chair of the Trust (appointed by the Members' Council);

(2) up to six non-executive directors (appointed by the Members' Council);

(3) up to six executive directors including:

- the Chief Executive who is the accounting officer;
- the Director of Finance
- a registered medical practitioner
- a registered nurse

There will be at least one more non-executive director than executive directors, including the Chair of the Trust.

3.8 Appointment of Chair and Non-Executive Directors of the Trust

Provisions covering the appointment and removal of the Chair and Non-Executive Directors of the Trust Board are set out in paragraphs 26 and 27 of the constitution and Annex 6 of the constitution: Additional Provisions. The Chair and Non-Executive Directors will be appointed by the Members' Council for an initial period of three years or as determined by the Nominations Committee. The Chair may be re-appointed for a further three years (up to a maximum of nine years) subject to the approval of the members' Council. Appointment of Non-Executive directors may be re-appointed for a further three years (up to a maximum of nine years), subject to approval by the Members' Council following confirmation by the Chair that they have performed effectively and remain committed to the role. Appointments beyond six years will be subject to annual review.

On appointment the Chair must meet the 'independence' criteria set out in the Monitor Code of Governance.

The Members' Council will be responsible for agreeing the remuneration of the Chair and Non-Executive Directors.

The senior independent director will meet annually with the Non-Executive Directors to review the Chair's performance. Any further arrangements for appraisal of the chair will be agreed with the Members' Council.

3.9 Appointment of Chief Executive and Executive Directors

The Chief Executive will be appointed by a Committee of the Trust Board, consisting of the Chair, other Non-Executive Directors, and a representative from the Members' Council. The Committee shall be advised by an independent assessor, who will have no formal role in making an appointment. Appointment of the Chief Executive will be subject to approval by the Members' Council at the first general meeting after appointment.

Executive Directors of the Trust Board will be appointed by a Committee of the Trust Board consisting of Chair, the Chief Executive and other non-executive directors.

3.10 Appointment and Powers of Deputy Chair

The Members' Council will appoint a Non-Executive Director to be the Deputy Chair for period of three years or for the remainder of their term as a member of the Trust Board (if less than three years) or for any other period determined by the Members' Council.

Any member so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. The Members' Council may thereupon appoint another member as Deputy Chair.

Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

3.11 Appointment of a Senior Independent Director

The Trust Board shall appoint one of the independent non-executive directors to act as the Senior Independent Director. This will be done in consultation with the Members' Council. The Senior Independent Director may be, but need not necessarily be, the Deputy Chair.

The Senior Independent Director will be available to directors and Governors if they have concerns which they cannot resolve with the Chair, Chief Executive or Director of Finance.

3.12 Company secretary

The Trust Board shall appoint a senior member of staff to carry out the functions of a Company Secretary to provide advice on corporate governance issues to the Chair, the Trust Board and the Members' Council and monitor the Trust's compliance with these standing orders, the Constitution, the terms of authorisation, statutory provisions and guidance and directions given by Monitor. The Secretary will ensure good information flows between the Trust Board, its committees and the Members' Council.

3.13 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

3.14 Schedule of Matters reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

3.15 Lead Roles for Board Members

The Chair will ensure that the designation of lead roles or appointments of Board members as required by commissioners or as set out in any statutory or other relevant guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3.16 Indemnity for Directors

Directors may, at the Trust's expense, seek external advice or appoint an external advisor on any material matter of concern provided the decision to do so is a collective decision by the majority of directors.

A director who acts honestly and in good faith will not have to meet out of his/her personal resources any personal civil liability incurred in the execution of the functions of the Trust Board, save where he has acted recklessly. Any costs arising from a director acting honestly and in good faith will be met by the Trust. The Board of Directors may make any arrangements it considers appropriate for the provision of indemnity insurance to meet any liabilities which are properly the liability of the trust.

4. MEETINGS OF THE TRUST

4.1 Calling meetings

4.1.1 Ordinary meetings of the Board shall be held sufficiently regularly to enable the Board to discharge its duties effectively at such times and places as the

Board may determine subject to the conditions set out in Annex 6 of the constitution (Additional provisions for the Trust Board).

4.1.2 The Chair of the Trust may call a meeting of the Board at any time.

4.1.3 Meetings of the Trust Board may be called by the Secretary or the Chairman or by four directors who give notice to the secretary specifying the business to be carried out. The secretary will send notice to all directors as soon as possible after receipt of such a request. The secretary will call a meeting at least fourteen days but not more than 28 days after receipt of such a notice to discuss the specified business. If the secretary fails to do so, then the chairman or the directors may call such a meeting.

4.2 Notice of Meetings and the Business to be transacted

4.2.1 At least 14 days notice of the date, time and place of meetings will be given except in an emergency.

4.2.2 In the case of a meeting called by directors in default of the Chair calling the meeting, the notice shall be signed by those directors.

4.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 4.5.

4.2.4 A director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

4.2.5 Before each public meeting of the Board notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least three clear days before the meeting

4.3 Agenda and Supporting Papers

The Agenda will be sent to Trust Board directors at least six clear days before the meeting and supporting papers, whenever possible, will accompany the agenda, unless there are exceptional circumstances and the Chair and Secretary have agreed to one or more papers being circulated later. Failure to serve such a notice on any director shall not affect the validity of a meeting.

4.4 Notice of Motion

4.4.1 Subject to the provision of Standing Orders 4.6 'Motions: Procedure at and during a meeting' and 4.7 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Secretary who will ensure that it is brought to the immediate attention of the Chair.

4.4.2 The notice shall be delivered at least 10 clear days before the meeting. The Secretary shall include in the agenda for the meeting all notices so received

that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

4.5 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 4.6 'Motions: Procedure at and during a meeting', a director of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

4.6 Motions: Procedure at and during a meeting

4.6.1 **Who may propose?**

A motion may be proposed by the Chair of the meeting or any director present. It must also be seconded by another director.

4.6.2 **Contents of motions**

The Chair may exclude from the debate at their discretion any motion not included in the notice summoning the meeting except motions relating to:

- the receipt of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

4.6.3 **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

4.6.4 **Rights of reply to motions**

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The director who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

4.6.5 **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

4.6.6 **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- referral of the matter to a committee of the Trust Board;
- that a director be not further heard;
- a motion resolving to exclude the public (see Standing Order 4.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a director of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote. No resolution will be passed if it is opposed by all of the Non-Executive Directors or all of the Executive Directors.

4.7 Motion to Rescind a Resolution

4.7.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director who gives it and also the signature of three other directors, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

4.7.2 When any such motion has been dealt with by the Trust Board it shall not be competent for any director other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

4.8 Chair of meeting

At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair, if present, shall preside.

4.9 Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their

interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

4.10 Quorum

4.10.1 One third of the whole number of directors, including not less than one executive director (one of whom must be the Chief Executive or another executive director nominated by the Chief Executive) and not less than two non-executive directors (one of whom must be the Chair or deputy Chair of the Trust Board) shall form a quorum.

The Trust Board may agree that it's members can participate in its meeting by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

If the Chair or director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.8) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.11 Voting

4.11.1 The following Directors are entitled to vote as per the composition of the Trust Board:

- a non-executive ~~the~~ Chair;
- up to six other ~~all~~ non-executive directors; and
- up to six executive directors; including:
  - one of the executive directors shall be the Chief Executive.
  - one of the executive directors shall be the finance director.
  - one of the executive directors is to be a registered medical practitioner.
  - one of the executive directors is to be a registered nurse.
- there will be at least one more non-executive director than executive directors, including the Chair of the Trust.

4.11.2 Except for the provisions made in Standing Orders 4.13 - Suspension of Standing Orders and 4.14 - Variation and Amendment of Standing Orders), every question put to a vote at a meeting shall be determined by a majority of the votes of directors present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting) shall have the casting vote.

4.11.3 At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair

directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

4.11.4 If at least one third of the directors present so request, the voting on any question may be recorded so as to show how each director present voted or did not vote (except when conducted by paper ballot).

4.11.5 If a director so requests, their vote shall be recorded by name.

4.11.6 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

4.11.7 A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Director.

4.11.8 A manager attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. The status of people when attending a meeting will be recorded in the minutes.

4.11.9 Where the office of a director of the Board is shared jointly by more than one person, either or both of those persons may attend or take part in meetings of the Board:

- if both are present at a meeting they should cast one vote if they agree;
- in the case of disagreements no vote should be cast;
- the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 4.10 - Quorum.

4.11.10 No resolution of the Trust Board shall be passed if it is opposed by all of the Non-Executive Directors present or by all of the Executive Directors present.

4.12 Disputes

Where directors have issues that cannot be resolved about the running of the NHS Foundation Trust or a proposed action, this should be recorded in the minutes. The Chief Executive, as Accounting Officer, should follow the procedure set out by Monitor in the Accounting Officer's memorandum for advising the Trust Board and Members' Council and for recording and submitting objections to decisions on matters of propriety or regularity or on the wider responsibilities of the Accounting Officer

4.13 Suspension of Standing Orders

4.13.1 Except where this would contravene any statutory provision or the rules relating to the Quorum (SO 4.10), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the directors of the Board are present (including at least

one director who is a Non-Executive Director and one of whom is an Executive Director of the Trust) and that at least two-thirds of those directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

4.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and directors of the Trust.

4.13.3 No formal business may be transacted while Standing Orders are suspended.

4.13.4 The Audit Committee shall review every decision to suspend Standing Orders.

4.14 Variation and amendment of Standing Orders

No amendment shall be made to these Standing Orders unless:

- notice of motion has been given in accordance with Standing Order 4.4;
- the amendment has been approved in accordance with paragraph 46 of the constitution.

4.15 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded. Where a director arrives late or leaves before the end of the meeting, this will be reflected in the minutes. A record of each director's attendance at meetings of the trust Board and Committees of the Board will be kept and reported to the Members' Council on request.

4.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendments to the minutes will be agreed and recorded prior to being signed as a true record.

Minutes will be circulated in accordance with the wishes of the Chair and, where the minutes provide a record of a public meeting, will be made available to the public as required by the Code of Practice on Openness in the NHS, the Freedom of Information Act and the Monitor Code of Governance.

4.17 Admission of public and the press

4.17.1 **Admission and exclusion on grounds of confidentiality of business to be transacted**

Meetings of the Trust Board shall be open to members of the public. Members of the public may be excluded from a meeting of the Trust Board

for special reasons, which shall include, but not be limited to, the following reasons.

- Discussion of matter which contains confidential personally identifiable information relating to a member of staff or a service user or carer.
- Discussion of any matter which contains commercially sensitive information relating to the Trust or a third party.
- In the interests of public order, in accordance with Standing Order 4.17.2 below.

4.17.2 **General disturbances**

The Chair or the person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

- "That, in the interests of public order, the meeting adjourns for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public".

4.17.3 **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in 4.17.1 and 4.17.2 above, shall be confidential to the members of the Board.

Directors and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

4.17.4 **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

4.18 Observers at Trust meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

5. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

5.1 Appointment of Committees

Subject to the constitution, Terms of Authorisation, statutory provision and directions given by Monitor (or successor organisation), the Trust Board may appoint committees of the Trust made up of Directors of the Trust.

The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

Committees of the Board may appoint sub-committees consisting wholly or partly of members of the committee, whether or not they include directors, or wholly of persons who are not members of the committee, whether or not they include Directors.

Each committee or sub-committee will have terms of reference and powers approved by the Trust Board, which will have the effect of being incorporated into the Standing Orders.

5.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chair” applies to the Chair of the committee, and the term “member” is to be read as a reference to a member of the committee. There is no requirement to hold meetings of committees established by the Trust in public.

5.4 Terms of Reference

Each committee will have terms of reference and powers and will be subject to conditions, such as a requirement to report to the Trust Board, which will be determined by the Trust Board. The terms of reference will have effect as if incorporated into the Standing Orders.

5.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

5.6 Approval of Appointments to Committees

The Trust Board will approve the appointments to each of the committees which it has formally constituted. The Board will define the powers of such appointees and will agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.7 Appointments for Statutory functions

Where the Trust Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to

operate independently of the Board such appointment shall be made in accordance with the regulations and/or directions made by Monitor.

5.8 Committees established by the Trust Board

Without prejudicing the formation of other committees or sub-committees as are considered necessary by the trust, the major committees are:

5.8.1 **Audit Committee**

The Audit Committee provides the Trust Board with an independent and objective view on its systems of control, including the adequacy of the governance arrangements and the systems for financial control and financial reporting. At least one of the Non-Executive directors on the Audit Committee must have relevant financial experience. The purpose of the committee is defined in its terms of reference.

5.8.2 **The Clinical Governance and Clinical Safety Committee**

The Clinical Governance and Clinical Safety Committee provides assurance to the Trust Board on matters of service quality and the effectiveness of clinical risk management, practice effectiveness and standards of clinical and professional practice. The purpose of the committee is defined in its terms of reference.

5.8.3 **The Mental Health Act Committee**

The Mental Health Act Committee is responsible for ensuring the organisation operates within the legal requirements of the Mental Health Act and Mental Capacity Act. The purpose of the committee is defined in its terms of reference.

5.8.4 **Remuneration and Terms of Service Committee**

The Remuneration and Terms of Service Committee will be made up at least three Non-Executive Directors, all of whom must meet the independence criteria set out in the Monitor Code of Governance. The purpose of the committee is defined in its terms of reference.

5.8.5 **Nominations Committee**

The Nominations Committee is responsible for overseeing the appointment of Non-Executive Directors. Its membership will include the Chair of the Trust Board, the Chief Executive and at least two members of the Members' Council. The purpose of the committee is defined in its terms of reference.

5.8.6 **Charitable Funds Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board has established a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or directions set out by the Charity Commission. The purpose of the committee is defined in its terms of reference.

5.8.7 **Other Committees**

The Trust Board may also establish such other committees or sub committees as required to discharge the Trust's responsibilities. The Trust Board will determine those duties that can be delegated to committees or sub-committees.

6. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

6.1 Delegation of Functions to Committees and Officers or other bodies

6.1.1 Subject to paragraph 3 of the constitution, the Board may make arrangements for any of its functions to be carried out on its behalf by a committee, Executive Team or Executive Director, subject to approval by the Trust Board and to restrictions and conditions which will be agreed by the Board.

6.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 3.14) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

6.3 Delegation to Committees

6.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

6.4 Delegation to Executive Directors

6.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

6.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying decision making rights and accountability. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

6.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability of the Director of Finance to the Trust Board to provide information and advise the Board in accordance with statutory duties. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

6.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

6.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

6.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action (which may include disciplinary action) or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6.7 Confidentiality

A member of a committee will not disclose a matter dealt with by or brought before the committee without its permission until the committee has reported to the Board or has otherwise concluded on the matter.

A Director of the Trust or a member of a committee will not disclose any matter reported to the Trust Board or otherwise dealt with by the committee, whether or not it has been reported to the Trust Board, if the Trust Board or the Committee resolve that it should remain confidential.

7. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

7.1 Policy statements: general principles

The Trust Board will from time to time agree and approve Policy statements which will apply to all or specific groups of staff employed by South West Yorkshire Partnership NHS Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

7.2 Specific Policy statements

Notwithstanding the application of SO 7.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct in Public Service Policy (including Declarations of Interests) for South West Yorkshire Partnership NHS FT staff;

- the staff disciplinary and appeals procedures adopted by the Trust

7.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

7.4 Specific guidance

Notwithstanding the application of SO 7.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

8. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

8.1 Declaration of Interests

Trust Board directors are required to comply with the provisions set out in paragraph 34 of the constitution.

Directors should declare any interests required to be declared by paragraph 34 of the constitution in writing to the Secretary as soon as practicable. Declarations of interest should be made on appointment to the Trust Board or as soon as the Director becomes aware of the interest.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

Declared interests of Board members' should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

8.2 Register of Interests

The Chief Executive will ensure that a Register of Interests of the Directors is established to record formally declarations of interests of Board members. The Register will include details of any directorships held by any of the Directors and any interests declared pursuant to paragraph 34 of the constitution by any Executive Director or Non-Executive Director of the Trust Board. The Register will be available to the public.

8.3 Standards of Business Conduct

All Trust staff and members of the Trust Board must comply with the Trust's Standards of Business Conduct in Public Service Policy and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff'.

8.3.1 **Interest of Officers in Contracts**

i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Company Secretary as soon as practicable. In the case of spouses or persons cohabiting as partners, the interest of one spouse or partner shall, if known to the other, be deemed to be also the interest of the other.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

8.3.2 **Canvassing of and Recommendations by Directors in Relation to Appointments**

i) Canvassing of directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Directors of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.3.3 **Relatives of Directors or Officers**

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chair and every director and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that director or officer is aware. It is the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether

they are related to any other member or holder of any office under the Trust.

iii) Where the relationship to a director of the Trust is disclosed, that director will have no part in the appointment process.

9. RESOLUTION OF DISPUTES WITH THE MEMBERS' COUNCIL

In the event of a dispute between the Trust Board and the Members' Council which cannot be resolved by the Chair, the Chair may at his/her discretion seek to bring in independent facilitation or mediation.

On satisfactory completion of the disputes process, the Board of Directors will implement the agreed changes.
On unsatisfactory completion of the process, the view of the Board of Directors will prevail.

The Members' Council will not be prevented from informing Monitor that the Board of Directors has not responded constructively to the concerns of the Members' Council or reporting a failure of the Trust to meet the terms of its Authorisation.

10. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

10.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

10.2 Sealing of Documents

The Seal of the Trust will not be fixed to any documents unless the sealing has been authorised by a resolution of the Trust Board or a committee of the Board or where the Trust Board has delegated its powers.

Where it is necessary that a document be sealed, the seal shall be affixed in the presence of the Chair of the Trust or Deputy Chair of the Trust and the Chief Executive (or his/her nominated deputy). Before any building, engineering, property or capital document is sealed, it must be approved and signed by the Director of Finance or an officer nominated by him and authorised and countersigned by the Chief Executive or an officer nominated by him, who will not be from the originating directorate.

The form of attestation of documents will be 'The Common Seal of South West Yorkshire Partnership NHS Partnership Foundation Trust was hereto affixed in the presence of….'.

10.3 Register of Sealing

An entry of every sealing will be made and numbered consecutively in a register provided for that purpose and will be signed by the person who approved and authorised the document and those who attested the seal. A report of each sealing will be made quarterly to the Trust Board.

10.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

The Chief Executive or nominated officers will be authorised by resolution of the Trust Board to sign on behalf of the Trust any agreement or other document not required to be executed as a deed, the subject matter of which has been approved by the Trust Board or committee or sub-committee to which the Trust Board has delegated authority.

ANNEX 9 – ADDITIONAL PROVISIONS – MEMBERSHIP

(Paragraphs 5.2, 7.4 and 10.2)

1. DISQUALIFICATION FROM MEMBERSHIP

1.1 An individual may not become a member of the Foundation Trust if:

1.1.1 they are under 11 years of age; or

1.1.2 within the last five years they have been involved as a perpetrator in a serious incident of violence at any of the Foundation Trust's hospitals or facilities or against any of the Foundation Trust's employees or other persons who exercise functions for the purposes of the Foundation Trust, or against any registered volunteer.

2. TERMINATION OF MEMBERSHIP

2.1 A member shall cease to be a member if:

2.1.1 they resign by notice to the Secretary;

2.1.2 they die;

2.1.3 they are expelled from membership under this constitution;

2.1.4 they cease to be entitled under this constitution to be a member of the Public Constituency or of any of the classes of the Staff Constituency;

2.1.5 it appears to the Secretary that they no longer wish to be a member of the Foundation Trust, and after enquiries made in accordance with a process approved by the Members' Council, they fail to demonstrate that they wish to continue to be a member of the Foundation Trust;

2.1.6 they behave in a way that is incompatible with the Code of Conduct for members.

2.2 A member may be expelled by a resolution approved by not less than two-thirds of the Governors present and voting at a General Meeting. The following procedure is to be adopted.

2.2.1 Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the Foundation Trust.

2.2.2 If a complaint is made, the Members' Council may itself consider the complaint having taken such steps as it

considers appropriate to ensure that each member's point of view is heard and may either:

2.2.2.1 dismiss the complaint and take no further action; or

2.2.2.2 for a period not exceeding twelve months suspend the rights of the member complained of to attend members meetings and vote under this constitution;

2.2.2.3 arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Members' Council.

2.2.3 If a resolution to expel a member is to be considered at a General Meeting of the Members' Council, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

2.2.4 At the meeting the Members' Council will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

2.2.5 If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

2.3 A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

2.4 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the Members' Council present and voting at a General Meeting.

3. MEMBERS' MEETINGS

3.1 The Foundation Trust shall hold its Annual Members' Meeting within nine months of the end of each financial year.

3.2 All members' meetings, other than Annual Members' Meeting, are called special members' meetings.

3.3 The Annual Members' Meeting is open to the public, all members of the Foundation Trust, Governors and Directors, and representatives of the auditor.

3.4 Special Members' Meetings are open to all members of the Foundation Trust, Governors and Directors, but not to members of the public unless the Trust Board decides otherwise.

3.5 The Trust Board may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Foundation Trust to attend a Members' Meeting whether Annual or Special.

3.6 All members' meetings are to be convened by the Secretary by order of the Trust Board.

3.7 The Trust Board may decide where a members' meeting is to be held and may also for the benefit of members:

3.7.1 arrange for the annual members' meeting to be held in different venues each year:

3.7.2 make provisions for a members' meeting to be held at different venues simultaneously or at different times. In making such provision the Trust Board shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

3.8 At the annual members' meeting:

3.8.1 the Trust Board shall present to the members:

3.8.1.1 the annual accounts;

3.8.1.2 any report of the auditor;

3.8.1.3 a copy of the annual report

and

3.8.1.4 forward planning information for the next Financial Year

3.8.2 the Members' Council shall present to the members a report on:

3.8.2.1 steps taken to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership;

3.8.2.2 the progress of the membership strategy; and

3.8.2.3 any proposed changes to the policy for the composition of the Members' Council and of the non-executive Directors

3.9 Notice of a members meeting is to be given:

3.9.1 by notice to all members;

3.9.2 by notice prominently displayed at the head office and at all of the Foundation Trust's places of business; and

3.9.3 by notice on the Foundation Trust's website

at least 14 clear days before the date of the meeting. The notice must:

3.9.4 be given to the Members' Council and the Trust Board, and to the auditor;

3.9.5 state whether the meeting is an annual or special members' meeting;

3.9.6 give the time, date and place of the meeting; and

3.9.7 indicate the business to be dealt with at the meeting.

3.10 Before a members' meeting can do business there must be a quorum present. A quorum is at least two Governors' present from the Foundation Trust's public constituencies, and one staff Governor, and one appointed Governor.

3.11 The Foundation Trust may make arrangements for members to vote by post, or by using electronic communications.

3.12 It is the responsibility of the Trust Board, the Chair of the meeting and the Secretary to ensure that at any members' meeting:

3.12.1 the issues to be decided are clearly explained;

3.12.2 sufficient information is provided to members to enable rational discussion to take place.

3.13 The Chair of the Foundation Trust, or, in their absence, the Deputy Chair of the Trust Board, shall act as chair at all members' meetings of the Foundation Trust. If neither the Chair nor the Deputy Chair of the Trust Board is present, the members of the Members' Council present shall elect one of their number to be Chair and if there is only one Governor present and willing to act they shall be Chair.

3.14 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Trust Board determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

3.15 A resolution put to the vote at a members' meeting shall be decided upon by a show of hands unless a poll is requested by the Chair of the meeting.

3.16 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chair of the meeting is to have a second and casting vote.

3.17 The result of any vote will be declared by the Chair and recorded in the minutes.

ANNEX 10 – FURTHER PROVISIONS

(Paragraphs 40.3, 42.6 and 43.1)

1. **COMMITMENTS**

1.1 The Foundation Trust shall exercise its functions effectively, efficiently and economically.

Representative membership

1.2 The Foundation Trust shall at all times strive to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end:

1.2.1 the Foundation Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Members' Council, and shall be reviewed by them from time to time, and at least every three years,

1.2.2 the Members' Council shall present to each annual members' meeting a report on:

1.2.2.1 steps taken to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership;

1.2.2.2 the progress of the membership strategy;

1.2.2.3 any changes to the membership strategy.

Co-operation with NHS bodies and local authorities

1.3 In exercising its functions the Foundation Trust shall co-operate with NHS bodies and local authorities.

Openness

1.4 In conducting its affairs, the Foundation Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

Prohibiting distribution

1.5 The profits or surpluses of the Foundation Trust are not to be distributed either directly or indirectly in any way at all among members of the Foundation Trust.

2. FRAMEWORK

2.1 The affairs of the Foundation Trust are to be conducted by the Board of Directors, the Members' Council and the members in accordance with this constitution and the Foundation Trust's authorisation. The members, the Members' Council and the Trust Board are to have the roles and responsibilities set out in this constitution.

Members

2.2 Members may attend and participate at members' meetings, vote in elections to, and stand for election to, the Members' Council, and take such other part in the affairs of the Foundation Trust as is provided in this constitution.

Members' Council

2.3 The roles and responsibilities of the Members' Council, which are to be carried out in accordance with this constitution and the Foundation Trust's terms of Authorisation, are:

2.3.1 at a General Meeting:

2.3.1.1 to appoint or remove the Chair and the other non-executive Directors;

2.3.1.2 to approve an appointment (by the non-executive Directors) of the Chief Executive;

2.3.1.3 to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive Directors;

2.3.1.4 to appoint or remove the Foundation Trust's auditor;

2.3.1.5 to be presented with the annual accounts, any report of the auditor on them and the annual report;

2.3.2 to provide their views to the Trust Board when the Trust Board is preparing the document containing information about the Foundation Trust's forward planning;

2.3.3 to respond as appropriate when consulted by the Trust Board in accordance with this constitution;

2.3.4 to undertake such functions as the Trust Board shall from time to time request;

2.3.5 to prepare and from time to time review the Foundation Trust's membership strategy and its policy for the

composition of the Members' Council and of the non-executive Directors and when appropriate to make recommendations for the revision of this constitution.

Board of Directors

2.4 The business of the Foundation Trust is to be managed by the Trust Board, who shall exercise all the powers of the Foundation Trust, subject to any contrary provisions of the 2006 Act as given effect by this constitution.

3. SECRETARY

3.1 The Foundation Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary's functions shall include:

3.1.1 acting as Secretary to the Members' Council and the Trust Board, and any committees;

3.1.2 summoning and attending all members' meetings, meetings of the Members' Council and the Trust Board, and keeping the minutes of those meetings;

3.1.3 keeping the register of members and other registers and books required by this constitution to be kept;

3.1.4 having charge of the Foundation Trust's seal;

3.1.5 publishing to members in an appropriate form information which they should have about the Foundation Trust's affairs;

3.1.6 preparing and sending to Monitor and any other statutory body all returns which are required to be made.

3.2 Minutes of every members' meeting, of every meeting of the Members' Council and of every meeting of the Trust Board are to be kept. Minutes of meetings will be read at the next meeting and signed by the Chair of that meeting. The signed minutes will be conclusive evidence of the events of the meeting.

3.3 The Secretary is to be appointed and removed by the Trust Board, in consultation with the Members' Council.

3.4 The Board of Directors of the applicant NHS Trust shall appoint the first Secretary of the Foundation Trust.

4. FURTHER PROVISIONS AS TO AUDITOR

4.1 A person may only be appointed as the auditor if they (or in the case of a firm each of its members) are a member of one or more of the bodies referred to in paragraph 23 (4) of Schedule 7 to the 2006 Act.

4.2 The auditor is to carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by Monitor and/or the Department of Health on behalf of the Secretary of State on standards, procedures and techniques to be adopted.

5. FURTHER PROVISIONS AS TO ACCOUNTS

5.1 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

5.1.1 the accounts;

5.1.2 any records relating to them; and

5.1.3 any report of the auditor on them.

5.2 In preparing its annual accounts, the Accounting Officer shall cause the Foundation Trust to comply with any directions given by Monitor and/or the Department of Health on behalf of the Secretary of State with the approval of the Treasury as to:

5.2.1 the methods and principles according to which the accounts are to be prepared;

5.2.2 the information to be given in the accounts;

and shall be responsible for the functions of the Foundation Trust as set out in paragraph 25 of Schedule 7 to the 2006 Act.

5.3 The Accounting Officer shall cause the Foundation Trust to:

5.3.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

5.3.2 once it has done so, send copies of those documents to Monitor or the Secretary of State (as required by the 2006 Act, from time to time) within such period as Monitor may direct.

6. FURTHER PROVISIONS AS TO ANNUAL REPORTS

6.1 The annual reports are to give:

6.1.1 information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff

Constituency is representative of those eligible for such membership; and

6.1.2 any other information Monitor and/or the Department of Health requires.

6.2 The Foundation Trust is to comply with any decision Monitor and/or the Department of Health makes as to:

6.2.1 the form of the reports;

6.2.2 when the reports are to be sent to it;

6.2.3 the periods to which the reports are to relate.

7. INDEMNITY

Members of the Members' Council and the Trust Board and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Foundation Trust. The Foundation Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Members' Council and the Trust Board and the Secretary.

8. DISPUTE RESOLUTION PROCEDURES

8.1 Every unresolved dispute which arises out of this constitution between the Foundation Trust and:

8.1.1 a member; or

8.1.2 any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or

8.1.3 any person bringing a claim under this constitution; or

8.1.4 an office-holder of the Foundation Trust

will be determined by the Chair of the Trust, whose decision will be final and binding except in the case of manifest error. If a dispute is brought by or against the Chair of the Trust, the dispute will be determined by the Trust Board (excluding the Chair) whose decision will be final and binding except in the case of manifest error. In the event that the dispute is referred to the Chair (or the Trust Board if it is by or against the Chair) and the Chair considers that he/she has a perceived or real interest in the outcome of the dispute (or the Trust Board considers it has a perceived or real interest in the outcome of the dispute) and/or that the dispute would be better resolved externally, then the Chair may refer the dispute for resolution under the Rules of the Chartered Institute for Arbitrators.

8.2 Any person bringing a dispute must, if required to do so, deposit with the Foundation Trust a reasonable sum (not exceeding £250) to be determined by the Members' Council and approved by the Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.

9. DISSOLUTION

The Foundation Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2006 Act.

10. HEAD OFFICE

The Foundation Trust's head office is at Fieldhead, Ouchthorpe Lane, Wakefield, WF1 3SP or such other place as the Trust Board shall decide.

11. NOTICES

11.1 Any notice required by this constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. "Address" in relation to electronic communications includes any number or address used for the purposes of such communications.

11.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

South West Yorkshire Partnership NHS Foundation Trust

Reservation of Powers to Trust Board and Delegation of Powers

Standing Order 3.14 provides that subject to directions given by the Secretary of State for Health or NHS Improvement, Trust Board may make arrangements for any of its functions to be carried out on its behalf by a Committee or sub-committee or by the Chair or by a director or any officer of the Trust, in each case subject to restrictions and conditions determined by Trust Board.

The purpose of this document is to describe those powers that are reserved to Trust Board (generally those matters for which the Trust is accountable to the Secretary of State or to NHS Improvement) whilst at the same time delegating the detailed application of Trust policies and procedures to the appropriate level. Trust Board remains accountable for all its functions, even those delegated to the Chair, individual directors or officers, and will put in place arrangements to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

- Part 1 – Reservation of powers to the Trust Board and scheme of delegation general provisions
- Part 2 – Decisions/duties delegated by the Trust Board to Committees
- Part 3 – Scheme of delegation derived from the Accounting Officers Memorandum
- Part 4 – Delegation of duties relating to Corporate Governance
- Part 5 – Scheme of delegation from the Trust's Constitution Standing Orders
- Part 5 – Scheme of delegation from the Trust's Standing Financial Instructions

Role of the Chief Executive

All powers of the Trust that have not been retained by Trust Board or delegated to a Committee will be exercised on behalf of Trust Board by the Chief Executive. The Chief Executive will prepare a scheme of delegation identifying the functions he/she will perform personally and those which will be delegated to other directors or officers. All powers delegated by the Chief Executive can be reassumed by him/her at any time. The Chief executive is the Accounting Officer for the Trust and is accountable to Parliament for the efficient and effective use of the Trust's resources.

Caution over the use of delegated powers

Powers are delegated to directors and officers on the understanding that they be exercised responsibly.

Directors' ability to delegate their own delegated powers

The Scheme of Delegation shows the delegation from Trust Board to Committees and Executive Directors. The Scheme should be used in conjunction with the system of budgetary control and other established procedures within the Trust (Standing Financial Instructions) and any further scheme of delegation developed to support arrangements within Business Delivery Units and to support Service Line Management.

Absence of directors to whom powers have been delegated

In the absence of a director or officer to whom powers have been delegated those powers will be exercised by the director or officer's designated deputy unless alternative arrangements have been approved by Trust Board.

Matters reserved for Trust Board and those matters that are delegated by Trust Board to Committees or Executive Directors are detailed in the attached Scheme of Delegation schedule.

RESERVATION OF POWERS TO THE TRUST BOARD AND SCHEME OF DELEGATION GENERAL PROVISIONS

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
	Trust Board	**General Enabling Provision** Trust Board may make decisions on any matter for which it has delegated or statutory authority, in full session within its statutory powers.
	Trust Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Scheme of Delegation and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive. 5. Approve a scheme of delegation of powers from Trust Board to committees. (Decisions taken by Committees within their delegated powers will be regarded as having been taken by Trust Board). 6. Establish terms of reference and reporting arrangements of all Committees and sub-committees that are established by Trust Board. 7. Grant delegated authority to the Chair or other directors to approve actions on its behalf, subject to ratification at a future meeting of Trust Board. 8. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications to them. 9. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 10. Require and receive the declaration of interests for staff that may conflict with those of the Trust. 11. Approve arrangements for dealing with complaints. 12. Authorise use of the seal. 13. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 6.6. 14. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 15. Receive reports from Committees including those that the Trust is required to establish and to take appropriate action on.

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
		16. Confirm the recommendations of the Trust's Committees where the Committees do not have executive powers. 17. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 18. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.
	Trust Board	**Appointments/dismissals** 1. Appoint the Deputy Chair of the Board. 2. Appoint the senior independent director. 3. Appoint and dismiss Committees (and individual directors) that are directly accountable to Trust Board. 4. Approve proposals regarding the Chief Executive, directors, senior employees and those of staff not covered by the Remuneration and Terms of Service Committee. 5. Appoint, discipline and dismiss Executive Directors (subject to SO 3.9). 6. Confirm appointment of members of any Committee of the Trust as representatives on outside bodies where they are a voting member. 7. Appoint, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders).
	Trust Board	**Strategy, Plans and Budgets** 1. Define and set the Trust's strategy, the strategic aims and objectives. 2. Approve the five year Integrated Business Plan or equivalent as required by NHS Improvement. 3. Receive and approve the Trust's Annual Report and Annual Accounts. 4. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 5. Approve the Trust's Risk Management Strategy. 6. Approve an annual plan for each Committee of Trust Board. 7. Approve outline and final Business Cases for capital investment above £500,000 or a series of projects for which the combined value would exceed £1 million. 8. Approve the Trust's annual budget. 9. Approve the Trust's organisational development strategy. 10. Ratify proposals for acquisition, disposal or change of use of land and/or buildings above £500,000 or a series of acquisitions or disposals for which the combined value would exceed £1 million.

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
		11. Approve PFI proposals. 12. Approve the opening of bank accounts. 13. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 over a 3 year period or the period of the contract if longer. 14. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board. 15. Approve individual compensation payments not covered by the NHS LA risk pooling scheme above £5,000. 16. Approve arrangements for agreeing action on litigation against or on behalf of the Trust. 17. Review use of NHSLA risk pooling schemes. 18. Agree the Trust's Procurement strategy.
	Trust Board	**Policy Determination** 1. Approve management which incorporate the arrangements for the appointment, removal and remuneration of staff. 2. Approve the Treasury Management Policy. 3. Approve policies relating to people's detention under the Mental Health Act. 4. Approve policies relating to statutory compliance. 5. Approve the policy and procedure for dealing with serious untoward incidents. 6. Agree the process for approval of all other policies.
	Trust Board	**Audit** 1. Receive the ISA260 (or equivalent) received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
	Trust Board	**Annual Reports and Accounts** 1. Receive and approve the Trust's Annual Report and Annual Accounts. 2. Receive and approve the Annual Report and Accounts for charitable funds held on trust.

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
NA	Trust Board	**Monitoring** 1. Receive such reports as Trust Board sees fit from Committees in respect of their exercise of delegated powers, including an annual report of activities undertaken by the Committee. 2. Continuous appraisal of the affairs of the Trust by means of the provision to Trust Board as Trust Board may require from directors, Committees, and officers of the Trust as set out in management policy statements. 3. Receive performance reports on performance against annual and five year plans (or equivalent) and key performance indicators as agreed by Trust Board. 4. Receive reports on compliance with the NHS Improvement Single Oversight Framework (or equivalent) and the terms of the Trust's Licence. 5. Receive reports on actual and forecast income from contracts. 6. Approve key compliance reports, including reports to NHS Improvement and the Care Quality Commission.

DECISIONS/DUTIES DELEGATED BY THE TRUST BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
Standing Order (SO) 5.8.1 Standing Financial Instructions (SFI) 4.1	Audit Committee	The terms of reference of the Audit Committee describe the functions that have been delegated to the Committee by Trust Board. These include: 1. Advise Trust Board on any key issues raised by both internal and external audit services; 2. Review the effectiveness of systems to support integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives, including the Assurance Framework; 3. Monitor compliance with Standing Orders, Standing Financial Instructions and the Scheme of Delegation; 4. Review schedules of losses and compensations and making recommendations to Trust Board; 5. Approve ISA260 (or equivalent), Annual Governance Statement, and Head of Audit Opinion prior to submission to Trust Board.
SO 5.8.4	Remuneration and Terms of Service Committee	The terms of reference of the Remuneration and Terms of Service Committee describe the functions that have been delegated to the Committee by Trust Board. These include: 1. Determine the remuneration and terms of service for the Chief Executive; 2. Determine the remuneration arrangements for executive directors and senior executives and to agree individual salary levels for executive directors and senior executives; 3. Determine any annual uplift (such as cost of living) for the chief executive, executive directors and senior management posts (Band 8d and 9); 4. Approve any annual uplifts in pay structures and performance related pay arrangements for senior posts; 5. Approve any termination payments for the Chief executive, Executive Directors and senior executives and ensure they are properly calculated and reasonable with regard to probity and value for money; 6. Receive a report from the Chief Executive of any proposed termination payments to senior managers.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SO 5.8.2	Clinical Governance and Clinical Safety Committee	The terms of reference of the Clinical Governance and Clinical Safety Committee describe the functions that have been delegated to the Committee by Trust Board. These include: 1. Approve strategies and policies relating to the management of clinical risk and clinical safety on behalf of Trust Board; 2. Monitor the implementation of significant strategic developments relevant to clinical governance, care delivery and practice effectiveness; 3. Monitor complaints and serious untoward incidents and implementation of agreed action; 4. Monitor the implementation of actions agreed in response to independent inquiries; 5. Monitor the Trust's compliance with national requirements relating to clinical governance and clinical safety.
SO 5.8.3	Mental Health Act Committee	The terms of reference of the Mental Health Act Committee describe the functions that have been delegated to the Committee by Trust Board. These include: 1. Monitoring compliance with current mental health legislation including the mental Health Act 2007 and the Mental Capacity Act 2005; 2. Monitor trends in relation to the application of the Act and make recommendations; 3. Receive reports from the Care Quality Commission and agree follow up action; 4. Approve policies relating to the Mental Health Act and Mental Capacity Act.
SO 5.8.6 SFI 21	Charitable Funds Committee	The terms of reference of the Charitable Funds Committee describe the functions that have been delegated to the Committee by Trust Board. These include: 1. Management of the Trust's charitable funds in accordance with statutory requirements; 2. Ensure expenditure is in line with the objects of those funds and with the Charity Commission requirements; 3. Establish suitable arrangements for delegated responsibility for management of funds.
SO 5.8.5	Nominations Committee	The terms of reference of the Nominations Committee describe the functions that have been delegated to the Committee by Trust Board. These include: 1. Appointment of the Chair and Non-Executive Directors of the Trust;

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		2. Ratification of the appointment of the Chief Executive of the Trust.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER'S MEMORANDUM

(Accounting Officer's Memorandum: https://www.gov.uk/government/publications/nhs-foundation-trusts-accounting-officers-responsibilities)

REF	DELEGATED TO	ACCOUNTING OFFICER'S MEMORANDUM DUTIES DELEGATED
Accounting Officer's Memorandum (AOM) 12	Chair	Implement requirements of corporate governance, including the NHS Improvement Code of Governance.
AOM 7	Chief Executive (CE)	Accountable as the Accounting Officer to Parliament for stewardship of Trust resources.
AOM 9	CE and Director of Finance (DoF)	Ensure the accounts of the Trust are prepared under principles and in a format directed by NHS Improvement. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of Trust Board.
AOM 10	CE	Sign a statement in the accounts outlining responsibilities as the Accounting Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control, which must be presented to the Trust Board annually for review.
AOM 12 & 13	CE	Ensure effective management systems that safeguard public funds and assist the Chair to implement requirements of corporate governance including ensuring managers: • "have a clear view of their objectives and the means to assess achievements in relation to those objectives; • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
AOM 13	CE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO).

REF	DELEGATED TO	ACCOUNTING OFFICER'S MEMORANDUM DUTIES DELEGATED
AOM 15	DoF	Operational responsibility for effective and sound financial management and information.
AOM 15	CE	Primary duty to see that DoF discharges this function.
AOM 16	CE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
AOM 18	CE and DoF	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to Trust Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
AOM 19	CE	If CE considers Trust Board or the Chair is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chair and Trust Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and, if necessary, refer to NHS Improvement.
AOM 21	CE	If Trust Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of Trust Board. Exceptionally, the CE should inform NHS Improvement. In such cases, and in those described in paragraph 24, the CE should, as a member of Trust Board, vote against the course of action rather than merely abstain from voting.

DELEGATION OF DUTIES RELATING TO CORPORATE GOVERNANCE

(Code of Governance: https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance)

REF	DELEGATED TO	GOVERNANCE AUTHORITIES/DUTIES DELEGATED
	Trust Board	Ensure the organisation is compliant with the Terms of Authorisation and is financially viable, legally constituted, well governed and that the organisation complies with the constitution, mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations.
Code of Governance	Trust Board	Subscribe to Code of Conduct.
Code of Governance	Trust Board	Board members share corporate responsibility for all decisions of the Board.
Code of Governance	Trust Board	The Trust Board is accountable for the following key functions: 1. effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint and remunerate senior executives; 4. to agree the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community through the Members' Council and the membership on its plans and performance and that these are responsive to the community's needs.
Code of Governance	BOARD	It is the Board's duty to: 1. provide active leadership to the NHS FT within a framework of prudent and effective controls; 2. act within statutory financial and other constraints; 3. ensure the quality and safety of clinical services provided by the organisation;

REF	DELEGATED TO	GOVERNANCE AUTHORITIES/DUTIES DELEGATED
		4. be clear what decisions and information are appropriate to Trust Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these; 5. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 6. establish performance and quality measures that maintain the effective use of resources and provide value for money; 7. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 8. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.
Code of Governance	Chair	It is the Chair's role to: 1. provide leadership to Trust Board and the Members' Council; 2. enable all Board members to make a full contribution to Trust Board's affairs and ensure that Trust Board acts as a team; 3. ensure that key and appropriate issues are discussed by Trust Board in a timely manner; 4. ensure Trust Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. ensure the Members' Council is informed of the affairs and activities of the Trust and that the views of the Members' Council are communicated to Trust Board.
Code of Governance	Chief Executive (CE)	The Chief Executive is accountable to the Chair and Non-Executive members of Trust Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of Trust Board.

REF	DELEGATED TO	GOVERNANCE AUTHORITIES/DUTIES DELEGATED
		The other duties of the Chief Executive as Accounting Officer are laid out in the Accounting Officer's Memorandum.
	All directors	Constructively challenge the decisions of Trust Board, monitor the performance of the organisation and make decisions objectively in the interests of the Trust.
	Non-Executive Directors	Non-Executive Directors are appointed by the Members' Council to bring independent judgement to bear on issues of strategy and performance.
SO 8.3	Trust Board	Approve the Standards of Business Conduct in Public Service Policy.
	Trust Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
SO 8	Chair and Directors	Declaration of conflict of interests.
	Trust Board	Trust Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf, and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.
Code of Governance	Trust Board	Trust Board must notify the Members' Council and NHS Improvement (and to the attention of the public if considered to be in the public interest) any major new developments that could affect the financial well being, performance or reputation of the Trust.
Code of Governance	Trust Board	To present a balanced and understandable assessment of the Trust's position and prospects and must notify the Members' Council and NHS Improvement any relevant information regarding the Trust's financial condition, performance or expectations that are likely to affect the financial well being, performance or reputation of the Trust.

SCHEME OF DELEGATION FROM SOUTH WEST YORKSHIRE PARTNERSHIPS NHS FOUNDATION TRUST CONSTITUTION STANDING ORDERS

REF	DELEGATED TO	STANDING ORDERS AUTHORITIES/DUTIES DELEGATED
Standing Order (SO) 4.9	Chair	Final authority in interpretation of Standing Orders (SOs).
SO 3.10	~~Board~~ Members' Council	Appointment of Deputy Chair.
SO 4.1.2	Chair	Call meetings.
SO 3.2	Chair	Chair all Board meetings and all meetings of the Members' Council.
SO 4.9	Chair	Give final ruling in questions of order, relevancy and regularity of meetings.
SO 4.11.2	Chair	Having a second or casting vote.
SO 4.13	Trust Board	Suspension of Standing Orders.
SO 4.13.4	Audit Committee	Audit Committee will review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board).
SO 4.14	Trust Board	Variation or amendment of Standing Orders.
SO 5	Trust Board	Formal delegation of powers to sub committees or joint committees and approval of their terms of reference.
SO 6.2	Chair & Chief Executive (CE)	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.

REF	DELEGATED TO	STANDING ORDERS AUTHORITIES/DUTIES DELEGATED
SO 6.4.2	CE	The Chief Executive shall prepare a Scheme of Delegation identifying decision making rights and accountability.
SO 6.6	All	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
SO 8.1	Trust Board	Declare relevant and material interests.
SO 8.2	CE	Maintain Register(s) of Interests.
SO 8.3	All staff	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”.
SO 8.3.3	All	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
SO 10	CE	Keep seal in safe place and maintain a register of sealing.
SO 10.4	CE / Executive Directors	Approve and sign all documents which will be necessary in legal proceedings unless any enactment other requires or authorises.

SCHEME OF DELEGATION FROM SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST STANDING FINANCIAL INSTRUCTIONS

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
Standing Financial Instructions (SFI) 1	Director of Finance (DoF)	Advice on interpretation or application of SFIs.
SFI 1	All members of the Trust Board and employees	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
SFI 3.2	Chief Executive (CE)	Responsible as the Accounting Officer to ensure the effective and efficient use of resources and for the overall for the System of Internal Control, which must be reviewed annually.
SFI 3.2	CE & DoF	Accountable for financial control and for putting in place appropriate arrangements for delegation of financial management.
SFI 3.2	CE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
SFI 3.3	DoF	Responsible for: a) implementing the Trust's financial policies and coordinating corrective action; b) maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) design and supervision of systems of internal financial control; d) ensuring that sufficient records are maintained to explain Trust's transactions and financial position; e) providing financial advice to members of Board and staff; f) preparation and maintenance of accounts, certificates etc as are required for the Trust to carry out its statutory duties;

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
		g) lead the development of the Trust's financial strategy
SFI 3.4	All members of the Trust Board and employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
SFI 3.4	CE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
SFI 4.1	Audit Committee	Provide independent and objective view on internal control and probity.
SFI 4.1	Chair of Audit Committee	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
SFI 4.2	DoF	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. This will be after discussion with NHS Protect where appropriate. In cases of fraud and corruption DoF must inform the relevant LCFS and CFSMS Regional Team in line with SoS directions.
SFI 4.2	DoF	Notify CFSMS and External Audit of all frauds.
SFI 4.4	DoF	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
SFI 4.3	DoF	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
SFI 4.5	Internal Auditor	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
SFI 4.6	Audit Committee	Ensure the External Auditors' work presents value for money.
SFI 4.2	CE & DoF	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 5.1	CE	Compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
SFI 5.1	DoF	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
SFI 5.1	DoF	Ensure adequate training is delivered on an on going basis to budget holders.
SFI 5.2	CE	Delegate budget to budget holders.
SFI 5.2	CE & Budget Holders	Must not exceed the budgetary total or virement limits set by the Board.
SFI 5.3	DoF	Devise and maintain systems of budgetary control.
SFI 5.3	CE or nominated officers	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources
SFI 5.3	CE	Identify and implement cost improvements and income generation activities in line with the Annual Plan
SFI 6	DoF	Preparation of annual accounts and reports.
SFI 7	DoF	Managing the banking arrangements, which have been approved by Trust Board, including: a) bank accounts and Government Banking Service (GBS) accounts; b) establishing separate bank accounts for the Trust's non-exchequer funds; c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 8	DoF	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
SFI 8.2	All employees	Duty to inform DoF of money due from transactions which they initiate/deal with.
SFI 8.2	Trust Board	Approval of income generating activities attracting an income of £500,000 or above.
SFI 9	CE	Negotiating contracts for the provision of healthcare services in accordance with the business plan, and for establishing the arrangements for extra-contractual services.
SFI 10.1	Trust Board	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
SFI 10.4	Director of HR	Payroll: specifying timetables for submission of properly authorised time records and other notifications; final determination of pay and allowances; making payments on agreed dates; agreeing method of payment; issuing instructions
SFI 10.4	Director of HR	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
SFI 10.5	Director of HR	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation and deal with variations to, or termination of, contracts of employment.
SFI 11.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 11.1	Trust Board	Agreeing the Trust's the Procurement Strategy.
SFI 11.2	Trust Board	Approve any procurement arrangement that commits the Trust to expenditure above £500,000 over three or less years.
	DoF	To mange procurement of goods and services in accordance with the strategy and policies approved by Trust Board
SFI 11.2	DoF	Responsible for the prompt payment of accounts and claims.
SFI 11.2	Appropriate Executive Director	Make a written case to support the need for a prepayment.
SFI 11.2	DoF	Approve proposed prepayment arrangements.
SFI 11.2	DoF	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
SFI 12	DoF	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. b) Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds. c) Be responsible for the prompt payment of all properly authorised accounts and claims. d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment. f) Instructions to employees regarding the handling and payment of accounts within the Finance Department. g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 12	CE	Tendering and contract procedure.
SFI 12.5	DoF	Responsible for the receipt, endorsement and safe custody of tenders received.
SFI 12.5	DoF	Shall maintain a register to show each set of competitive tender invitations despatched.
SFI 12.5	CE and DoF	Where one tender is received will assess for value for money and fair price.
SFI 12.7	CE of DoF	Waive formal tendering procedures.
SFI 12.7	DoF	Report waivers of tendering procedures to the next formal meeting of the Audit Committee.
SFI 12.7	DoF	Where a supplier is chosen that is not on the approved list the reason ~~shall~~ should be recorded in writing to the CE.
SFI 12.11	Trust Board	Approval of partnerships for the delivery of services or for obtaining goods and services where there is no exchange of monies or where the terms and conditions are negotiated by another body, and the value of the goods or services exceeds £250,000, including setting the timescale for its review and renewal.
SFI 13.1	DoF	The DoF will advise the Board on the Trust's ability to pay interest and repay and will report, periodically, any external borrowing
SFI 13.1	DoF	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
SFI 14	Trust Board	Approve treasury management policy
SFI 14	DoF	Prepare detailed procedural instructions on the operation of investments held.
SFI 15	DoF	Ensure that the Trust Board are aware of the prevailing instructions and guidance of the Independent Regulatory, and any statutory or regulatory requirements, regarding the financial management and financial duties of the Trust.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 16.1	Trust Board	Approval of all decisions relating to capital investment above £500,000.
SFI 16.1	CE	a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans; b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and c) shall ensure that the capital investment is not undertaken without full consideration of the impact on the Trust's cash and working capital position and Risk Rating.
SFI 16.1	DoF	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
SFI 16.1	~~DoF~~ CE	Issue procedures for management of contracts involving stage payments.
SFI 16.1	DoF	Issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
SFI 16.1	CE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
SFI 16.1	DoF	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
SFI 16.2	CE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
SFI 16.2	Trust Board	The Trust Board will approve all PFI proposals or proposals to enter into a contract that commits the Foundation trust to long term (15 years or more) arrangements for capital assets with a lifetime value in excess of £500,000.
SFI 16.2	Trust Board	Any individual capital development that forms part of an arrangement under PFI or a partnership

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
		described above.
	CE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
	CE	Must ensure the Trust enters into suitable contracts with commissioners for the provision of NHS services
	CE	Ensure that regular reports are provided to the Board detailing actual and forecast income from contracts
SFI 16.2	DoF	Demonstrate that the use of private finance is fully assessed against alternative routes and follows with prevailing guidance.
SFI 16.3	CE	Overall responsibility for fixed assets and maintenance of asset registers (on advice from DoF).
SFI 16.3	DoF	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
SFI 17.1	CE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
SFI 18.1	DoF	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
SFI 18.1	Trust Board	Approval of disposal of assets with a Net Book Value in excess of £50,000.
SFI 18.2	DoF	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
SFI 18.2	DoF	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 18.2	DoF	Consider whether any insurance claim can be made.
SFI 18.2	DoF	Maintain losses and special payments register.
SFI 18.2	Audit Committee	Approve write off of losses (within limits delegated by the Department of Health).
SFI 19	DoF	Responsible for accuracy and security of computerised financial data.
SFI 19	DoF	Satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.
SFI 19	DoF	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
SFI 19	DoF	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
SFI 20	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
SFI 20	DoF	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 21	DoF	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
SFI 22	CE	Retention of document procedures in accordance with the Trust Non-Clinical Records Management Policy
SFI 23	CE	Implementation of the Risk management strategy
SFI 23	Trust Board	Approve and monitor risk management strategy
SFI 23	Trust Board	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
SFI 23	DoF	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
SFI 23	DoF	Ensure documented procedures cover management of claims and payments below the deductible amount.

Financial approvals hierarchy

The following limits are applied for both requisitioning and approving of invoices.

DELEGATED TO	LIMIT
2 Directors (normally the relevant Director and Director of Finance)	Greater than £75,000
Director	£75,000
Deputy Director	40,000
Service Line Manager	£10,000
Team Leader	£5,000
Mid Level Manager	£1,000
Requestioner	£200

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 January 2017
Agenda item 8.2

Title:	**Update to the Treasury Management Policy**
Paper prepared by:	Director of Finance
Purpose:	As part of its governance arrangements, the Trust is required to formally outline its approach to treasury management.
Mission/values:	The Strategy and Policy link to the mission and values by ensuring that the Trust adheres to governance requirements, makes the best use of its resources and supports financial probity, reporting and transparency
Any background papers/ previously considered by:	Minor revisions to the policy were reviewed by the Executive Management Team on 12 January 2017 and the Audit Committee on 24 January 2017. The Audit Committee recommends approval to Trust Board.
Executive summary:	There is significant focus on cash management within the NHS and access to borrowings is becoming increasingly restricted and difficult. As such the Trust needs to maintain strong focus on working capital and cash management and this Treasury Management Policy is a key component of clarifying how the Trust will maintain strong control over how it safely makes best use of its cash resources. Written in conjunction with the guidance contained within 'Managing Operating Cash in NHS Foundation Trusts' (December 2005) issued by Monitor. In 2016 NHS Improvement became the operating name for Monitor and NHS Trust Development Authority, within this document Monitor is referred to as NHS Improvement unless it relates to a document published by Monitor pre 2016. This document describes guidelines that are intended to ensure adequate safety (i.e. manageable risk profile) and liquidity (i.e. accessibility of funds at short notice), of such investments, while generating a competitive return. This policy puts in place formal and comprehensive objectives, policies and practices, strategies and reporting arrangements for the effective management and control of their Treasury Management activities. "Under Section 17 of the Health and Social Care (Community Health and Standards) Act 2003, NHS Foundation Trusts have a wide discretion to invest money (other than money held by them as Trustee) for the purposes of, or in connection with, their functions. Whilst this freedom offers greater opportunity to improve patient care, it should be managed carefully to avoid financial and/or reputational risks" (Monitor-Managing Operating Cash in NHS Foundation Trusts). The Trust's Treasury Management Strategy is to hold appropriate levels of short-term liquid investments whilst maintaining a competitive rate of interest for the Trust. The Trust will pursue best value in Treasury Management and through the use of suitable performance measures ensure that the Trust works within the context of effective risk management. The purpose of the policy is to provide a clearly defined risk management framework for those responsible for treasury operations. The approach and policy are reviewed annually. There are no significant changes to the policy; however minor changes have been made include updating references to NHS Improvement and the addition of an Equality Impact Assessment. **Risk Appetite** Financial or commercial risks within the Trust's Risk Appetite statement are

	those which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income. This policy supports the risk appetite statement "Risk of breakdown in financial controls, loss of assets with significant financial value" which has an appetite level of avoid/none and a target score of nil.
Recommendation:	**Trust Board is asked to APPROVE the Policy to support the overall financial strategy.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Document name:	Treasury Management Strategy & Policy
Document type:	Policy
What does this policy replace?	Update of existing policy
Staff group to whom it applies:	All staff within the Trust who can action transfers within Trust bank accounts
Distribution:	Executive Management Team & Finance Department
How to access:	Intranet
Issue date:	November 2009 First revision June 2010 Second Revision December 2013 Third Revision December 2014 Fourth Revision December 2015 Fifth Revision December 2016
Next review:	December 2017
Approved by:	Original – Trust Board 29 June 2010 Reviewed – Trust Board December 2013 Audit Committee 2 February 2016
Developed by:	Deputy Director of Finance
Director leads:	Director of Finance
Contact for advice:	Deputy Director of Finance

Contents

1 SCOPE OF THIS STRATEGY & POLICY

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

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

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

2 TREASURY OBJECTIVES

2.1 Introduction

There is significant focus on cash management within the NHS and access to borrowings is becoming increasingly restricted and difficult. As such the Trust needs to maintain strong focus on working capital and cash management and this Treasury Management Policy is a key component of clarifying how the Trust will maintain strong control over how it safely makes best use of its cash resources.

Written in conjunction with the guidance contained within 'Managing Operating Cash in NHS Foundation Trusts' (December 2005) issued by Monitor. In 2016 NHS Improvement became the operating name for Monitor and NHS Trust Development Authority, within this document Monitor is referred to as NHS Improvement unless it relates to a document published by Monitor pre 2016. This document describes guidelines that are intended to ensure adequate safety (i.e. manageable risk profile) and liquidity (i.e. accessibility of funds at short notice), of such investments, while generating a competitive return. This policy puts in place formal and comprehensive objectives, policies and practices, strategies and reporting arrangements for the effective management and control of their Treasury Management activities.

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

2.2 Treasury Management Strategy

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

2.3 Scope of the Treasury Function

This Trust defines its Treasury Management activities as:

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

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

- ensuring a competitive rate of return on surplus funds with a minimal risk profile;
- ensuring the availability of cash to meet operational requirements; and

- ensuring the availability of flexible, competitively priced funding at all times.

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

2.4 Approved Activities of the Treasury Management Operation
The Treasury Management operation will encompass all of the following techniques and procedures.

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

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

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

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

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

The key components of the overall treasury-operating environment include
- clearly defined roles and responsibilities, as laid out in section 4;
- regular reporting of treasury activities;
- controls on who can operate bank accounts and authorisation limits; and
- segregation of duties across the treasury function.

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

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

3 ATTITUDES TO RISK

3.1 Funding

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

The Trust will conduct a monthly review on the best approach to ensuring a competitive return on surplus funds while maintaining a minimal risk profile.

The outcome of this review will be either:

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

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

The National Loans Fund (NLF) is part of HM Treasury and is a permitted institution for deposits by NHS Improvement and can be used in the calculation to offset PDC interest payable. The minimum deposit is £1m for a period of 7 days to 6 months.

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

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

The Trust Board has approved a risk appetite statement. With regard to cash it best fits under the risk of breakdown in financial controls, loss of assets with significant financial value. The identified risk appetite it avoid/none as such there is a target risk score of nil.

3.2 Safe Harbour Investments

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

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

Monitor's guidance defines a safe harbour as follows:

"Securities that are considered sufficiently safe and liquid to be in the safe harbour meet all of the following criteria:

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

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

Term	Advice
Recognised Rating Agency	Only the following are recognised rating agencies • Standard & Poors; • Moodys; and • FitchRatings.
Permitted Rating Requirement	The short term rating should be at least • A-1 Standard & Poors rating; or • P-1 Moodys rating; or • F1 Fitch Ratings *See note**
Permitted Institutions	Permitted institutions include: Institutions that have been granted permission, or any European institution that has been granted a passport, by the Financial Services Authority, to do business with UK institutions provided it has an investment grade credit rating of A1/A+ issued by a recognised rating agency; and The UK Government, or an executive agency of the UK Government, that is legally and constitutionally part of any department of the UK Government, including the UK Debt Management Agency Deposit Facility. No change is currently recommended to these permitted institutions. The impact of the UK exiting the European Union will need to be considered at the appropriate time with regard to if this affects the permitted institutions.
Maximum Maturity Date	• The maximum maturity date for all investments should be 95 days • The maturity date for any investment should be

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

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

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

Investments will be in sterling accounts only and with UK domiciled institutions.

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

The Trust can invest upto one month's working capital with any one institution.

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

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

3.4 Foreign Exchange Management
The Trust's current policy is not to cover any foreign exchange risk. This is due to the low volume and value of the Trust's foreign exchange exposure, and will be re-evaluated if foreign trading transactions become more significant.

3.5 Bank Relationships
The Trust's approach is to develop long-term relationships with a core group of quality banks. A transactional approach, without the development of relationships, may result in the Foundation Trust being unable to rely on the support of banks in any unforeseen

circumstances that may arise, such as a crisis in the banking market, or a sudden decrease in surplus funds.

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

4 SUMMARY OF KEY RESPONSIBILITIES

4.1 Trust Board

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

4.2 Audit Committee

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

4.3 Director of Finance

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

4.4 Deputy Director of Finance / Head of Financial Accounting

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

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

5 BANK RELATIONSHIPS AND CASH MANAGEMENT

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

5.1 Objectives

- To ensure the cost paid for banking services is competitive;

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

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

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

6 TREASURY REPORTING

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

6.1 Bi-Weekly Movement Reports
This report is completed bi-weekly by the Financial Accountant for review by the Head of Financial Accounting. This details all payments to / receipts from the operational accounts (Paymaster General and the Trust nominated clearing bank) as well as the forecast closing positions.

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

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

6.2 Monthly Reports
Monthly Reconciliation

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

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

Monthly Board Report
Included in the monthly Board Report is a forecast of the Trust's cash balances for the current financial year, together with the Balance Sheet which incorporates the month's closing cash balance. This is based on the current Trust Annual Plan as submitted to NHS Improvement.

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

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

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

7 TREASURY PERFORMANCE MANAGEMENT

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

7.1 Quarterly Performance Reports

Quarterly Reports submitted to NHS Improvement
Reports are required by NHS Improvement to assess the financial risk of each Foundation Trust as part of the compliance framework. The report consists of a Balance Sheet, Income and Expenditure Account and Cash Flow Statement detailing planned, actual and variance figures. A commentary is also required to explain any significant variances from plan.

Financial Risk Ratings (are included to ensure the Trust is maintaining its minimal risk approach and remains a going concern.

The quarterly performance reports required by NHS Improvement will be produced by the Deputy Director of Finance. The reports will be checked and signed off by the Director of Finance.

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

The report will detail:

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

*Libor = London Interbank Offered Rate

8 TREASURY CONTROLS

8.1 Summary

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

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

8.2 Operational Procedures

Undertaking Transactions – External Deposits

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

Verification of Transactions

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

9. Equality Impact Assessment Tool

Date of Assessment: _____

	Equality Impact Assessment Questions:		**Evidence based Answers & Actions:**
1	**Name of the document that you are Equality Impact Assessing**		Treasury Management Strategy & Policy
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		To provide clear guidance on the Trust Treasury Management Strategy and procedures in cash management. All staff involved in Treasury Management
3	**Who is the overall lead for this assessment?**		Director of Finance
4	**Who else was involved in conducting this assessment?**		Deputy Director of Finance
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		N/A N/A
6	**What equality data have you used to inform this equality impact assessment?**		N/A
7	**What does this data say?**		N/A
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**Yes/No**	**Evidence based Answers & Actions. Where Negative impact has been identified please explain what action you will take to remove or mitigate this impact.**
8.1	**Race**	No	N/A
8.2	**Disability**	No	N/A
8.3	**Gender**	No	N/A
8.4	**Age**	No	N/A

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.5	**Sexual Orientation**	No	N/A
8.6	**Religion or Belief**	No	N/A
8.7	**Transgender**	No	N/A
8.8	**Maternity & Pregnancy**	No	N/A
8.9	**Marriage & Civil partnerships**	No	N/A
8.10	**Carers*Our Trust requirement***	No	N/A
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		N/A
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		
9c	**Promotes good relations between different equality groups;**		
9d	**Public Sector Equality Duty – "Due Regard"**		
10	**Have you developed an Action Plan arising from this assessment?**		No
11	**Assessment/Action Plan approved by**		**Signed:** Mark Brooks **Date:** **Title:** Director of Finance
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Inclusion Team:*** inclusion@swyt.nhs.uk **Please note that the EIA is a public document and will be published on**		

	Equality Impact Assessment Questions:	Evidence based Answers & Actions:
	the web. **Failing to complete an EIA could expose the Trust to future legal challenge.**	

If you have identified a potential discriminatory impact of this policy, please refer it to the Director of Corporate Development or Head of Involvement and Inclusion together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Corporate Development or Head of Involvement and Inclusion.

10. Dissemination and implementation arrangements

Once approved this policy will be available on the intranet and circulated to the Finance department. Any staff members who require training will be given this on a one to one basis.

11. Process for monitoring compliance and effectiveness

Compliance to the policy will be monitored on a quarterly basis as part of the Treasury Management update given to the Trust's Audit Committee.

12. Review and revision arrangements

This policy will be reviewed on an annual basis or earlier if guidance changes.

13. References

Managing Operating Cash in NHS Foundation Trusts

APPENDIX 1 - Ratings Guide

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

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

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

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

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

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

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

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 January 2017
Agenda item 8.3

Title:	**Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)**
Paper prepared by:	Director of Corporate Development
Purpose:	To enable Trust Board to approve the Policy on Policies, a core policy for the Trust and reserved for Trust Board consideration and approval.
Mission/values:	Policies and procedures covering core Trust systems and processes are a key part of the Trust's governance arrangements, supporting the Trust to achieve its mission and adhere to its values.
Any background papers/ previously considered by:	The policy was approved by Trust Board in July 2011, October 2012 (as part of the changes recommended to achieve NHS LARMS level I) and July 2014. Clinical leads, Human Resources and the Trade Union were consulted in the development of the policy. The revised policy has been reviewed and supported by the Executive Management Team for approval by Trust Board.
Executive summary:	**Background** The purpose of the Policy on Policies is: ➢ to describe the approach to development and approval of policies and procedural documents; ➢ to provide a standard template for policy documents; ➢ to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure; ➢ to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance; ➢ to describe the process for version control to ensure people have access and are operating to the most current version; and ➢ to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements. **Review December 2016/January 2017** The Director of Corporate Development has reviewed the Policy on Policies for relevance and compliance with guidance and minor amendments have been made to ensure that it remains fit for purpose. The Executive Management Team have reviewed the updated policy and support its approval. Trust Board is, therefore, asked to approve the current policy for a further two years to January 2019. **Risk Appetite** The Policy on Policies supports the Trust in its endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to APPROVE the update to the policy.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Document name:	Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)
Document type:	Policy
What does this policy replace?	Update of previous policy
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	July 2011 (V5) October 2012 (V6) Revised equality impact assessment added 3 October 2013 (approved by lead Director) (V7) July 2014 (V8) January 2017 (V9)
Next review:	January 2019
Approved by:	Trust Board 31 January 2017
Developed by:	Director of Corporate Development
Director leads:	Director of Corporate Development
Contact for advice:	Integrated Governance Manager

Policy for the development, approval and dissemination of policy and procedural documents

1. Introduction

Policies and procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust.

A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that policies and procedures in use are current and reflect an organisational approach.

2. Purpose

The purpose of this document is:

- to describe the approach to development and approval of policies and procedural documents;
- to provide a standard format and content for policy and procedure documents;
- to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure;
- to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance;
- to describe the process for version control to ensure people have access to – and are operating to - the most current version; and
- to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements.

3. Definitions

3.1 A **POLICY** is a high level statement. Each policy should specify its purpose and may also include a procedure setting out how the policy will be achieved. A policy enables management and staff to make correct decisions, deal effectively and comply with legislation, Trust processes and good working practices.

3.2 A **PROCEDURE** is often incorporated into a policy or can be a 'stand alone' document. Procedures are the practical way in which a policy is translated into action. They explicitly outline how to accomplish a task or activity, giving detailed instructions. A procedure often allocates specific roles that specific individual must undertake.

4. Duties

It is the policy of the Trust that all policy documents and procedure documents will:

- have an identified director lead;
- have a designated contact for advice; and
- identify who is responsible for taking what action.

The following duties apply to this policy.

4.1 Trust Board

Trust Board is responsible for approving the policy for the approval, dissemination and implementation of policies and procedures as outlined in this document.

Policies that require Trust Board approval are outlined in the scheme of delegation. These include policies which are likely to be of major strategic or political significance, such as those relating to the appointment, remuneration and dismissal of staff, policies relating to the management of financial or clinical risk and policies for management of complaints and claims. Approval may also be delegated by the Trust Board for approval by a Committee through their terms of reference and the scheme of delegation. The policies that require Trust Board approval are specifically:

- this policy;
- arrangements for dealing with complaints;
- policies and procedures for dealing with serious untoward incidents;
- HR policies relating to the arrangements for the appointment, removal and remuneration of staff not covered by the Remuneration and Terms of Service Committee;
- the Standards of Business Conduct in Public Service policy;
- the Treasury Management policy;
- procurement policies, including tendering and quotation procedures that form part of the Standing Financial Instructions.
- policies relating to statutory compliance;
- policies relating to people's detention under the Mental Health Act (delegated to the Mental Health Act Committee); and
- policies relating to the management of clinical risk and clinical safety (delegated to the Clinical Governance and Clinical Safety Committee).

4.2 Executive Management Team (EMT)

The Executive Management Team will approve all other policies (however, see 4.3 below). The EMT will be responsible for ensuring the policy document has been developed according to this policy.

4.3 Directors

Each policy will have an appointed lead director. The lead director lead is responsible for the development of new policies and timely review of policies in accordance with this policy.

The lead director will be responsible for engaging relevant stakeholders in the development of the policy and ensuring appropriate arrangements are in place for managing any resource implications, including dissemination and training and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation.

It is the responsibility of the lead director for a policy to ensure that the document is appropriately consulted on during the development process by key stakeholders (see section 6.2) and to agree the most appropriate way to undertake such consultation.

Multi agency policies will have a lead director who will be responsible for ensuring the policy has gone through the necessary approval process.

In the case of policies relating to medicines management, with the exception of the overarching medicines management policy and the medicines code, approval is delegated to the Drugs and Therapeutics sub-committee of the Clinical Governance and Clinical Safety Committee and it is the responsibility of the lead director to ensure that these policies adhere to this policy.

Other policies that are specific or relevant to local clinical arrangements can be approved locally by appropriate mechanisms within Business Delivery Units; however, where there are implications across the Trust or a policy will have an impact on resources, staffing, Trust strategy, reputation, etc., approval remains reserved for the Executive Management Team. Directors should seek the advice of the Director of Corporate Development or the Integrated Governance Manager if in doubt.

Procedures and guidance notes may be developed and issued by the lead director using the principles included in this document. The lead director is responsible for engaging relevant stakeholders in developing the procedure or guidance note, communicating the procedure and ensuring its implementation.

4.4 Director of Corporate Development

The Director of Corporate Development will, on behalf of Trust Board, ensure this Policy is implemented and that documents are controlled in accordance with non-clinical records management requirements.

4.5 Business Delivery Units (BDUs) and Trust Action Groups (TAGs)

Directors may engage BDUs (including the Operational Management Group) and TAGs in developing and implementing policies or procedural documents. TAGs have no authority to approve policy.

4.6 Specialist staff

Specialist staff have a role in developing and implementing policies and procedures but have no authority to approve policies or procedures. Specialist staff include areas such as Safeguarding and Infection Prevention and Control.

4.7 Service managers

Service managers have a role in developing and implementing policies and procedures but have no authority to approve policies or procedures.

4.8 Staff

All staff need to be aware of policies and how they impact on their practice. All new policies approved by Trust Board, its Committees and/or EMT are communicated through the staff briefing and via the intranet. Staff have an individual responsibility to seek out this information.

4.9. Duties for this policy

The Trust Board is responsible for approving this policy.

The lead director is the Director of Corporate Development.

All staff who write policies need to be aware of this policy.

The Integrated Governance Manager (this title denotes the person who acts as Secretary to Trust Board and the Executive Management Team) is responsible for overseeing the administration of this policy. This includes ensuring policies for approval are included in the relevant Board or EMT agenda in a timely way, maintaining a corporate record of all current and past policy and procedure documents, and notifying lead directors when a policy or procedure is due for review.

5. Style and format

All policies and procedures should be written in a style that is clear, concise and unambiguous. Titles should be kept simple to assist easy identification of the document.

Policy and procedural documents should follow Trust Branding Guidance. The standard font is Arial 12 point. Uppercase and underlining should be avoided except in headings. Page numbers should be used.

The structure and sections to be included are provided in appendix A.

5.1 An explanation of any terms use in documents developed

Acronyms and technical language should be explained or a glossary included.

5. 2 Contents

A checklist is provided at Appendix C. This should be completed and submitted to the Executive Management Team, committee or Trust Board at the time of final approval.

6. Development process

6.1 Identification of need

The need for a new policy or procedure may be prompted by a change in national legislation, policy or guidance or it may be identified within the Trust either as a result of learning from experience, such as complaints or incidents, or as a result of a risk being identified by a specialist advisor or TAG. New policies may also be required as a result of the development of a new service or new way of working.

The first step should be to establish whether a new policy or procedure is required or whether the requirement can be met by amending an existing policy or procedure.

The aim should be to keep the number of policies to a minimum. The lead director should be able to provide a clear justification for the development of any new policy.

This policy has been developed to minimise risks associated with policies and procedures being written without appropriate authority or consideration of the impact of the policy and to prevent inconsistent application of policies as a result of failure to effectively communicate or disseminate a policy or procedure. No other document already in existence in the Trust covers this subject.

6.2 Stakeholder involvement

Consultation with relevant stakeholders secures 'buy in' and provides an opportunity to identify and eliminate potential barriers to implementation.

The lead director is responsible for ensuring relevant stakeholders have been consulted during the development of the policy. The following identifies some of the individuals or groups who might be consulted with. This is not an exhaustive list.

Stakeholder	Level of involvement
Executive Management Team (EMT)	Approval – (may also be involved at the outset in confirming the requirement for a new policy or agreeing the development process)
Directors	Initiation, lead, development, receipt, circulation
Business Delivery Units (BDUs) (including the Operational Management Group)	Development, consultation, dissemination, implementation, monitoring
Specialist advisors	Development, consultation, dissemination, implementation
Service user and carers	Development, consultation
Professional groups and leaders	Development, consultation, dissemination, implementation
Trust Action Groups	Development, consultation, dissemination, implementation
Staff side	Development, consultation, dissemination
Trust learning networks	Consultation
Local Authorities	Development, consultation
Police	Development, consultation
Other NHS Trusts	Development, consultation
University	Consultation

For this document, the Clinical Governance Support Team and the Executive Management Team were consulted. The Trust Board agreed when developing the Scheme of Delegation that responsibility for determining policy approval arrangements should be a decision reserved to the Board.

6.3 Equality Impact Assessment

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer. All new policies and procedures should be subject to an Equality Impact Assessment (EIA). For revised policies an update of the EIA needs to be undertaken. A tool to support this process is included at appendix B to this document.

If any negative impact is identified, the policy should be amended or (if this is not possible) an action plan to mitigate the negative impact must be included.

7. Approval and ratification process

Procedures and guidance notes may be approved and issued by the lead director.

Policies for approval that have not been identified as requiring Trust Board approval should be submitted by the lead director to the EMT. The checklist at appendix C should be completed by the lead director.

Policies where authority to approve is reserved to the Board should be submitted to the Trust Board by the lead director after they have been discussed by the EMT.

8. Process for review

At the time of approval, all policies should have a clearly defined review date. This may be brought forward if earlier review is required, for example because of an identified risk or change in national policy.

The Integrated Governance Manager will notify the lead director three months before the policy is due for review.

The lead director will check the policy. If no amendment is required, this should be reported to the Executive Management Team or Trust Board for ratification by the review date and the policy will be reissued.

If the policy requires minor amendments, the revised policy should be presented to the EMT or Trust Board.

If significant amendment is required, the process described in section 5 should be followed.

An equality impact assessment (EIA) must be completed for all policies that have not previously been subject to EIA. For revised policies an update of the EIA needs to be undertaken.

It should be noted that, for services that came to the Trust as part of the Transforming Community Services agenda, there will be a number of policies that, over time, will need to be aligned. Existing policies will continue to be followed until this work takes place. Each appointed lead Director for a policy will need to ensure that reviews include all existing policies that have been produced by previous organisations and that new/updated polices are clear which policies they replace.

9. References

Documents referred to in the development of the policy and documents that should be read in conjunction with the policy should be listed.

10. Version control

All policies and procedures must have the version number, date of issue and the review date clearly marked on the front cover and as a footnote.

Draft policies should be marked v1 draft, v2 draft etc during the consultation phase. Once approved the document becomes Version 1. Each time the policy or procedure is updated the version number must be changed.

The introduction to the Policy should make it clear whether a document replaces or supersedes a previous document, including the title(s) of any superseded or replaced documents.

11. Dissemination

Once approved, the integrated governance manager will be responsible for ensuring the updated version is added to the document store on the intranet and is included in the staff brief.

The Integrated Governance Manager is responsible for ensuring the document being replaced is removed from the document store and that an electronic copy, clearly marked with version details, is retained as a corporate record.

Directors are responsible for ensuring that staff within their area of responsibility are aware of mew or amended policies and procedures related to their work.

If local teams down load and keep a paper version of procedural documents, the responsible manager must identify someone within the team who is responsible for updating the paper version when a policy change is communicated via the staff brief.

12. Implementation

All policies and procedures must identify the arrangements for implementation, including:

- any training requirements, including which staff groups this affects and the arrangements and timescale for delivering training;
- any resource requirements, including staff, and how these will be met;
- support available to assist implementation;
- arrangements for ensuring the policy or procedure is being followed; and
- monitoring and audit arrangements.

13. Document control and archiving

13.1 Current policies and procedures

Current policies and procedures will be available on the intranet in read only format.

13.2 Historic policies and procedures

A central electronic read only version will be kept in a designated shared folder to which all staff can request access.

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

14. Monitoring compliance with the policy

All policies and procedure must identify the arrangements that are in place for ensuring and monitoring compliance. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission standards, NHSLA Risk Management Standards and Monitor (or successor organisation) compliance.

Methods may include:

- monitoring and analysis of incidents, performance reports and training records;
- audit;
- checklists; and
- monitoring of delivery of actions plans through TAGS or BDUs.

The document should identify the methods that will be used to ensure timely and efficient implementation.

For this policy implementation:

- is the responsibility of the Director lead for individual policies to ensure that this policy is followed in the development and presentation of individual policies;
- is monitored through presentation to EMT and/or Trust Board, evidenced by the minutes of meetings where policies are approved, or the appropriate ratifying body, again evidenced by the minutes of meetings where policies are approved;
- is monitored by the ratifying body through the policies checklist; and
- is assured through occasional audit by the Trust's internal auditors.

15. Associated documents and supporting references

This document has been developed in line with guidance issued by the NHS Litigation Authority and with reference to model documents used in other trusts. It should be read in conjunction with

- the Trust Branding Policy; and
- the Records Management Strategy, Non-Clinical Records management policy and non-clinical records retention and disposal schedule.

Appendix A

Style and format template for policies and procedural documents

Each policy and procedure should have a cover sheet (as set out on the cover of this policy), which includes the Trust's branding. Each page of the document should be numbered at the bottom in a footer.

Policies and procedural documents should include the following sections.

1. Introduction
This section should include a brief explanation of the reason for the policy.

2. Purpose and scope of the policy
This section will include why the policy needed, the rationale for development, what will it cover and an outline of the objectives and intended outcomes.

3. Definitions
This section will include a list and/or description of the meaning of terms used in the context of the policy or procedure.

4. Duties
- who is responsible for developing and implementing the policy
- who in the organisation is required to do what
- who is responsible for communicating the policy
- who is responsible for consultation with stakeholders
- who is responsible for approving the policy/procedure

5. Principles
The fundamental action points of the policy or procedure to be adopted.

6. Equality Impact Assessment
New or updated Equality Impact Assessment to be completed.

7. Dissemination and implementation arrangements (including training)

8. Process for monitoring compliance and effectiveness
This section will include arrangements for compliance and effectiveness, responsibility for conducting any audit, review or monitoring, the methodology to be used for audit, review or monitoring, its frequency, the process for reviewing the results and monitoring of key performance indicators.

9. Review and revision arrangements (including archiving)

10. References

11. Associated documents

12. Appendices

All policies should include completed versions of the following:

- Equality Impact Assessment (see appendix B);
- Checklist for the Review and Approval of Procedural Document (see appendix C);
- Version control sheet (see appendix D).

Appendix B - Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

Date of Assessment: 3 January 2017

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

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.4	**Age**	No	N/A
8.5	**Sexual orientation**	No	N/A
8.6	**Religion or belief**	No	N/A
8.7	**Transgender**	No	N/A
8.8	**Maternity & Pregnancy**	No	N/A
8.9	**Marriage & Civil partnerships**	No	N/A
8.10	**Carers*Our Trust requirement***	No	N/A
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		This policy aims to standardise the approach to policy development, approval and dissemination and requires adoption of the Equality Impact Assessment throughout the organisation.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		As above.
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		As above.
9c	**Promotes good relations between different equality groups;**		As above.
9d	**Public Sector Equality Duty – "Due Regard"**		As above.
10	**Have you developed an Action Plan arising from this assessment?**		N/A
11	**Assessment/Action Plan approved by**		**Signed:** Dawn Stephenson **Date:** 3 January 2017 **Title:** Director of Corporate Development
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the partnerships team:*** partnerships@swyt.nhs.uk **Please note that the EIA is a public**		

	Equality Impact Assessment Questions:	Evidence based Answers & Actions:
	document and will be published on the web. **Failing to complete an EIA could expose the Trust to future legal challenge.**	

If you have identified a potential discriminatory impact of this policy, please refer it to the Director of Corporate Development or Equality and Engagement Development Managers together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Corporate or Equality and Engagement Development Managers.

Appendix C - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	EMT	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent)	YES	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

Appendix D - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	June 2008	Director of Corporate Development	Final	Final version approved by Trust Board
2	March 2009	Director of Corporate Development		Changes made to ensure clarity on superseded or replaced documents and to reflect change in guidance for 2009/10
3	March 2010	Integrated Governance Manager	Final draft	Changes made following review and subsequent recommendations made during NHS LARMS review
4	Decemb er 2010	Integrated Governance Manager	Final	Inclusion of Equality Impact Assessment
5	July 2011	Integrated Governance Manager	Final	Changes made to accommodate comments made during NHS LARMS review and transfer of services from NHS Barnsley
6	October 2012	Integrated Governance Manager	Final draft	Changes made to meet requirements of NHS LARMS
7	October 2013	Integrated Governance Manager	Final	Revised equality impact assessment added (approved by lead Director 3 October 2013)
8	July 2014	Integrated Governance Manager	Final	Review by Lead Director; agreed no changes required. Approval of review date extension for further two years
9	January 2017	Integrated Governance Manager	Final	Review by Lead Director with minor amendments.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 January 2017
Agenda item 8.4

Title:	**Update to the Customer Services Policy: management of complaints, concerns, comments and compliments**
Paper prepared by:	Director of Corporate Development
Purpose:	For Trust Board to note that the policy that provides the framework for responding to enquiries and learning lessons from feedback through complaints, concerns, comments and compliments has been reviewed and updated taking account of the information shown in the executive summary below.
Mission/values:	The Customer Services Policy links to all the Trust's values in supporting an improved service user experience through being open honest and transparent, respectful, putting the person first and in the centre, to improve and be outstanding, be relevant today and ready for tomorrow and demonstrating that families and carers matter.
Any background papers/ previously considered by:	None
Executive summary:	The Trust has an established Customer Services function, which works with Business Delivery Units (BDUs) to support a response to all enquiries. This includes a response to issues raised under the NHS Complaints procedures. The policy provides the framework for responding to these enquiries and takes account of relevant legislation and best practice, most recently: • Feedback from the CQC inspection and Customer Services Excellence Accreditation in 2016. • The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England's joint report – My Expectations (for raising concerns and complaints). • NHS England's Assurance of Good Complaints Handing for Acute and Community Care – which sets out evidence commissioners' should be seeking as part of their regular quality assurance processes with providers. • The Care Quality Commission report – Complaints Matter. Procedures in relation to the management of complaints have been reinforced in light of the above. Alerts have been added to ensure any professional issues are highlighted to medical and nursing specialists to support an effective response. Service directors now review responses to complaints before sign off by the Chief Executive to ensure ownership of the response by the service, quality assurance of the response in terms of addressing the root causes and that learning is consistent and applied across services and in the system. Enhanced reporting is available to BDUs and delivery on action plans arising from complaints is monitored through BDU governance processes. **Risk Appetite** The Customer Services Policy supports the Trust in its endeavours to provide high quality and equitable services, which value and respond to feedback,

	improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to APPROVE the Customer Service policy updated as outlined above**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Document name:	Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
Document type:	Policy and Procedure
What does this policy replace?	Update of previous policy
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet and internet
Issue date:	December 2013 (V1) December 2014 (V2) January 2016 (V3) January 2017 (V4)
Next review:	January 2018
Approved by:	Trust Board 31 January 2017
Developed by:	Deputy Director of Corporate Development
Director leads:	Director of Corporate Development
Contact for advice:	Customer Services

1. Introduction

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

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

The Customer Services policy incorporates the obligations in the NHS Constitution and the Health and Social Care Act. This current version takes account of feedback from the Care Quality Commission inspection and the Customer Services Excellence Accreditation in 2016. It also takes account of national reports, in particular:

- The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England's joint report – My Expectations (for raising concerns and complaints).
- NHS England's Assurance of Good Complaints Handing for Acute and Community Care – which sets out evidence commissioners should be seeking as part of their regular quality assurance processes with providers.

Ensuring that people have opportunity to feedback their views and experiences of care is essential to delivering the Trust values and is part of how we ensure people have a say in public services. Making the process easy is also essential; the Trust recognises that complaints might only arise as a culmination of a number of experiences, so actively encouraging feedback and apologising for negative experience is important.

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

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

The Care Quality Commission's (CQC) expectations mirror the Trust's high standards in terms of listening to and acting on people's concerns. The CQC makes complaints central to its inspection regime and include a lead inspector for complaints (and staff concerns) in large inspection teams. The CQC use the 'My Expectations' outcomes framework in inspections. This is a five-step framework developed by people who use NHS and social care services and describes what a

good complaints handling service experience should look like (more information below).

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

2. Purpose and scope

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

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

NHS complaints legislation requires a single approach for the handling of complaints across health and social care. The Trust has adopted a person centred approach to ensure that issues are dealt with in a way that people are empowered and able to make choices about how their concerns are dealt with. This approach has been further strengthened through the adoption of the framework which sets out best practice in five steps which is reflected in this policy:

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

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

The commitment to learning from people's experience includes:

- Staff empowered to support service users, their relatives and carers in giving feedback and to resolve issues promptly and locally wherever possible.

- The use of insight gained from complaints, concerns, comments and compliments, and other forms of feedback to improve the care provided to service users and carers.
- Thorough and timely investigation of complaints and concerns, and an open and conciliatory response.
- Fair treatment for people who make complaints, and assurance that care will not be compromised in any way.
- Feedback used as essential element of the Trust's approach to Governance.

3. Definitions

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

3.1 Compliments

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

3.2 Comments

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

3.3 Concerns

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

3.4 Complaints

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

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

4. Other forms of feedback

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

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

4.1 Who can give feedback?

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

4.2 Receiving feedback

The Trust encourages and expects staff to seek feedback and to know how to signpost to Customer Services if that is the person's preference. Customer Services leaflets and posters will be displayed in all service areas.

The Customer Services team can be contacted by telephone, email, via web link, text, in writing or by referral from a member of staff. Corporate social media accounts and external websites (NHS Choices, Patient opinion. Healthwatch) are also monitored to ensure feedback is captured and responded to if possible.

4.3 Acting on Feedback

4.3.1 Compliments

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

4.3.2 Comments

- Each BDU is responsible for ensuring comments received are reviewed and actioned appropriately, including responding to the person offering the comment.
- BDUs must ensure that service areas log all comments received and that monitoring forms are submitted to Customer Services on a monthly basis.
- Customer Services will respond to comments received directly in liaison with the relevant team.

4.3.3 Concerns and Complaints

4.3.3a Verbal

- Services should invite and welcome feedback.
- Response to concerns and complaints should be *on the spot* wherever possible and a concern report form completed.
- If it is not possible to resolve the concern or complaint straight away, assistance should be sought from line management. If the concern or complaint is raised verbally, and can be resolved within one working day, the response does not need to be in writing. The issue should be documented using the monitoring form.

- Customer Services will assist as required, offering a named point of contact.

4.3.3b In Writing

- Concerns and complaints received in writing will be reviewed by the Customer Services manager and allocated to a named officer.
- Customer services staff will agree a handling plan with the person raising the issue.
- People will be supported to resolve their concerns either directly with the service or to receive a written response from the Chief Executive.
- Written complaints will always require a formal investigation and written response.

The procedure for complaints handling is detailed in Appendix A.

4.4 NHS Complaint Regulations

The NHS Complaints Procedure covers the following:

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

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

- Requests for access to records or an amendment to the clinical record (refer to Access to Records procedure).
- Requests for a change to care plan or medication (refer to clinical team).
- Challenges to policy decisions by the Trust Board (refer to Trust Board chair).
- Complaints made by a member of staff about their employment or about another member of staff. (refer to HR policies).
- Complaints made about volunteer activity (refer to Partnerships Team).
- Complaints about involvement activity (refer to Partnerships Team).
- Commissioning decisions (refer to appropriate Clinical Commissioning Group).

- Complaints about services delivered by an independent provider, on behalf of the Trust, are not covered by the NHS Complaints regulations. However, the Trust must satisfy itself about the quality of service and that the independent provider has its own robust complaints procedure.
- Complaints about superannuation (refer to payroll/HR department).
- Staff who wish to voice concerns or grievances. These should be raised through appropriate line management processes in line with Human Resources policy.
- Complaints which have already been investigated and concluded using the NHS procedure (refer to the section of this policy covering Parliamentary and Health Service Ombudsman).

5. Duties

The customer services process is supported by:-

5.1 The Customer Services Team

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

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

- Ensure that the complainant is contacted by an allocated team member to explain the process and discuss the handling of the concern/complaint.
- Ensure the complainant is at the centre of the process, and that a complaint management plan is developed, taking account of the complainant's expectations for resolution and negotiated timescale for investigation.
- Alert directors as appropriate to concerns / complaints that suggest quality of care is compromised or other risk assessment is required.
- Ensure written acknowledgement is sent to the complainant within 3 working days.
- Ensure the assigned team member liaises with the relevant clinical lead, manager, or other organisations, to facilitate a response within the agreed timescale.
- Ensure the lead investigator keeps Customer Services updated with the progression of the complaint at all times and at least weekly.
- Receive information from the lead investigator to enable a response to be produced for director review prior to Chief Executive sign-off.

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

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

5.2 Director of Corporate Development

The Director of Corporate Development is the lead director for customer services, including complaints management. The Director of Corporate Development will ensure appropriate arrangements are in place to respond to issues raised, in ways that support people to live well in their communities, and that maintain and enhance the Trust's reputation for putting people who use services at the heart of service delivery. The Director of Corporate Development will ensure that Customer Services information is reported appropriately to BDUs, in integrated performance reports and in quarterly and annual reports to Trust Board.

5.3 The Chief Executive

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

5.4 Medical Director and Director of Nursing, Clinical Governance and Safety

The Medical Director and Director of Nursing and Quality will support risk assessment of complaints and provide objective clinical advice to support the investigation of complaints, either directly, or through clinical leads and practice governance coaches. The Trust's Medical Director will assign investigators where a complaint relates to medical staff. The Nursing Director will ensure appropriate support where complaints highlight professional issues for nursing or allied health professions, or where input from specialist advisors is required.

5.5 District directors / Deputy district directors

District directors (supported by deputies) will ensure appropriate systems are in place to:

- Respond to feedback, investigate concerns and complaints
- Review complaint responses to ensure:
    - Ownership of the response by the service
    - Quality assurance of the response in terms of addressing the root causes
    - Actions are consistently learned and applied across services and in the system.
- Monitor delivery of complaint action plans through BDUs governance processes.
- Provide updates to Customer Services to incorporate in quarterly reports to Trust Board.

5.6 Clinical leads / general managers / practice governance coaches

Working with Customer Services as appropriate:

- Ensure objective and thorough investigations in accordance with the procedure, either by investigating the issues in person or by appointing a suitably skilled member of staff to conduct the investigation.
- Ensure all relevant information to respond to a complaint is collated and provided to the lead investigator, who will complete the complaints toolkit.
- Meet agreed timescales in relations to complaints investigation and management.
- Advise the deputy district director about complaints, and support review of issues and learning through BDU governance processes.
- Ensure any learning for the wider Trust is shared.

5.7 Reporting Feedback

The Customer Services Team and Director of Corporate Development will monitor compliance with this policy and procedure.

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

The Customer Services Team will provide quarterly reports to Trust Board and to BDUs, covering the number of issues raised, a breakdown of complaints, concerns, comments and compliments, identification of themes and evidence to demonstrate that lessons have been learned as a result of service user feedback. Reports will also include issues referred to the Parliamentary and Health Service Ombudsman, including any financial redress. The quarterly report will be shared with the Mental Health Act Committee to alert to complaints relating to application of the Mental Health Act, and with the Members' Council Quality Group for review and information.

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

District Directors will be responsible for ensuring systems are in place to investigate complaints and concerns, that feedback received is reviewed and acted upon, with learning evidenced through governance processes. Insight will be used alongside other sources of feedback to improve services.

The Executive Management Team will monitor key performance indicators (KPIs) in relation to complaints through monthly business intelligence dashboard reporting. The Executive Management Team will also review any action plans arising from complaints upheld or partially upheld by the Parliamentary and Health Service Ombudsman.

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

6. Process for monitoring compliance with this policy

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

- The ongoing monitoring role of the Customer Services team.
- The Customer Services team make data and reports available within the Trust as described above.
- Routine contact with services and investigators regarding the ongoing process for complaints investigation.
- Feedback from Commissioners.
- Contact, as appropriate, with partner organisations, the Parliamentary and Health Service Ombudsmen, the CQC, the Information Commissioner and NHSI.

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

7. Associated documentation

Supporting procedural documents include:

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

8. Equality Impact Assessment

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

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

9. Dissemination and implementation

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

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

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

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

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

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

10. Review and Revision arrangements

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

11. Document control and archiving

This policy will be accessible via the Trust's intranet and website in read only format and managed in accordance with the requirements for retention of non-clinical records. See Appendix D.

Appendix A

Complaints Procedure (Local Resolution)

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

- Every effort must be made to support people who wish to make a complaint. This could include language support, support in documenting the issues, signposting to advocacy services or providing mediation.
- Written complaints received by the Chief Executive's office will be notified to Customer Services. Written complaints will be stamped indicating the date received. Written complaints received in other Trust locations should be forwarded to Customer Services in a timely manner (using nhs.net or safehaven fax)
- Complaints will be managed and coordinated by Customer Services in conjunction with the lead investigator. The Customer Services Team will agree the desired outcome with the complainant, contact arrangements and likely timescales.
- Complaints that span two or more organisations will be managed and coordinated by the organisation that has the majority of issues, or the highest risk issues. The lead organisation will coordinate a single comprehensive investigation and response to the complainant. Local working arrangements are in place to support this.
- Complaints received electronically will be coordinated by Customer Services. Contact will be made to obtain the complainants official mailing address and telephone number and an explanation provided that, due to issues of confidentially, the final response to the complaint will be sent in hard copy via the postal system.
- All complaints will be coded and logged on Datix web. Customer Services will maintain up to date Datix web records at all times, recording all activity. Demographic data will also be captured on Datix web, including address and standard equality data.
- All records relating to complaints should be stored confidentially by the Customer Services team, and should be readily accessible via the team if required. No other files relating to complaints should be held by the organisation and complaints correspondence should not be part of the clinical record. Clinical staff must be appraised of actions taken to resolve complaints to promote learning.
- If the complainant requires access to medical records/patient information, Customer Services will provide appropriate contact information in accordance with the Data Protection Act / Access to Health Records Act.
- If the complaint includes a request for information under the Freedom of Information (FOI) Act, the request must be referred to the Customer Services Manager or Deputy Director of Corporate Development to action.
- If a complaint makes reference to a claim for compensation, this will not automatically exclude the issues from being investigated through the complaint process, subject to prejudice to any legal proceedings. Customer Services will work with Legal Services in such cases.

- Complaints will be acknowledged by letter within three working days. Complaints made by third parties will require written consent from the service user before confidential information is released. However, investigation into the issues can commence pending receipt of consent to ensure a prompt response can be offered when appropriate.
- The Customer Services Coordinator will record the progress of the complaint investigation onto Datix web, which will include copies of all correspondence to the complainant, staff, details of telephone calls, face-to-face conversations and electronic correspondence.
- Complaints progression must be maintained in real time by Customer Services staff.
- All records relating to complaint investigation are confidential and must be kept in one master complaint file separate from any medical records. Care should be taken with accuracy, legibility and language used. In accordance with the Data Protection Act (1998), a complainant has the right to access all correspondence contained within the file.
- All complaint records must be kept by the Trust in a secure environment for 10 years.
- Customer Services must maintain contact with the complainant regarding progress and must renegotiate timescales as necessary.
- Consideration must be given to the following:
    - If a complaint involves clinical issues that require urgent attention or raises issues that could potentially compromise public or service user safety, the appropriate district director must be informed immediately.
    - Complaints that could fall into the Serious Untoward Incident category (SUI) must be referred for advice to the Patient Safety Support Team. Every effort must be made to minimise distress or confusion to the complainant.
    - Where a complainant indicates they intend to take legal action, the matter must also be referred to the Head of Legal Services. The Trust will take legal advice and in some, but not all, circumstances it may be appropriate to cease action under the complaints procedure. This is consistent with national guidance.
    - Complaints / concerns highlighting professional practice issues must be referred to the medical or nursing directorate as appropriate.
    - Complaints about members of staff that involve accusation of misconduct must be referred to Human Resources. Staff have the right to be dealt with fairly in such cases, and complainants do not have the right to information about specific action taken against staff members.
    - Issues that could potentially attract media attention must be referred to the Communications Team.
    - Issues relating to child protection must be referred to the Trust's Named Nurse for Child Protection, and dealt with under joint agency protocols for child protection.
    - Issues relating to Vulnerable Adults must be referred to the Trust's Vulnerable Adults Specialist Advisor, and dealt with under joint agency protocols for vulnerable adults.
    - Where a complaint alleges a criminal offence, the complainant will be advised of their right to report the matter to the police, and will be supported to do so. If the complainant chooses not to report a serious

matter which may be criminal, the Trust may choose to notify the police. Advice should be sought from the Caldicott Guardian where such action might be in breach of a person's confidentiality.
    - Investigators should always alert Customer Services at an early stage if a complaint is proving particularly complex or difficult to resolve. Revising the approach may prevent a complaint escalating to Ombudsman Review.

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

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

Customer Services will prepare a response to the complainant based on the information provided in the toolkit. Responses will be reviewed in Corporate Development and checked by the relevant director before sign-off by the Chief Executive.

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

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

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

Parliamentary and Health Service Ombudsman Review

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

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

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

The PHSO review will seek to demonstrate that the Trust has acted appropriately when assessing the complaint to identify if there is evidence of maladministration or service failure. The PHSO will request the Trust to provide a copy of the complaint file and health care records. After undertaking the review, the PHSO will inform the Trust whether it can close the case without investigation, or whether it intends to progress to formal investigation. Over the past year, the Ombudsman lowered the threshold for investigation and expanded the number of cases considered.

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

Any action plans arising from complaints upheld or partially upheld by the PHSO will be reviewed by the Executive Management Team with delivery monitored by the appropriate service director.

The PHSO produces an annual review of complaints handling in the NHS and undertakes specialist reviews. The PHSO shares all investigation reports with the relevant commissioning body and NHS England. Learning from these reviews will be shared in the organisation via Customer Services reporting processes.

Unreasonable or persistent complaints

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

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

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

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

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

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

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

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

Appendix B

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

Date of Assessment: December 2016

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		To provide a framework for ensuring feedback is valued and responded to appropriately. To support effective complaints management processes, consistently applied across all services. People who use services, carers, staff
3	**Who is the overall lead for this assessment?**		Bronwyn Gill
4	**Who else was involved in conducting this assessment?**		Corporate Development - Customer Services Team
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		Customer services processes and procedures are subject to constant evaluation with service users and carers (following their contact with the team) and with staff following involvement in complaints handling or report review. Information used to inform policy
6	**What equality data have you used to inform this equality impact assessment?**		Protected characteristics data collected via the function.
7	**What does this data say?**		
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**No**	It is not anticipated that this Policy will have any negative impact on any of the equality groups. The potential for people having difficulty giving feedback or raising complaints and concerns is mitigated by promoting an allocated caseworker to provide individual support, access to advocacy and / or interpreting services and taking account of information requirements (which will be further enhanced through compliance with the Accessible Information Standard.
8.1	**Race**	**No**	Other mixed } Chinese } Mixed white / Caribbean } White other } 5% Indian } White Irish } Other white background }

			Pakistani – 1% White British – 42% Prefers not to disclose – 53%
8.2	**Disability**	**No**	Sensory impairment – 1% Cognitive impairment – 0% Long standing illness – 4% Learning disability / difficulty – 4% Physical impairment – 5% Mental illness – 20% No disability – 14% Prefers not to disclose – 52%
8.3	**Gender**	**No**	Average % access 57% female 26% male 17% prefer not to disclose
8.4	**Age**	**No**	under 21 – 4% 22 - 31 – 10% 32 – 41– 15% 42 – 51 15% 52 – 61 11% Over 62 – 10% Not disclosed 35%
8.5	**Sexual Orientation**	**No**	Gay – 0% Heterosexual – 13% Lesbian – 1% Bisexual – 0% Unknown/ prefers not to disclose – 86%
8.6	**Religion or Belief**	**No**	No information available
8.7	**Transgender**	**No**	0%
8.8	**Maternity & Pregnancy**	**No**	No information available in the Trust's monitoring data.
8.9	**Marriage & Civil partnerships**	**No**	No information available in the Trust's monitoring data.
8.10	**Carers*** **Our Trust requirement***	**No**	It is not anticipated there will be any negative impact on service users or their carers, feedback is captured through service evaluation.
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		The Policy is subject to annual review.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		The policy promotes equality of opportunity as it provides for a supportive, fair and non-discriminatory approach to customer services and complaints management
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		The Trust is committed to eliminating discrimination in all its forms, including those with protected characteristics
9c	**Promotes good relations between different equality groups;**		The Trust's approach to equality promotes good relations including with those from different equality groups.
10	**Have you developed an Action Plan arising from this assessment?**		No

11	**Assessment/Action Plan approved by (Director Lead)**	**Sign: Dawn Stephenson Date: 23 January 2017** **Title: Director of Corporate Services**
12	**Please note that the EIA is a public document and will be published on the web.**	

Appendix C - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	EMT	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent)	YES	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

Appendix D - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	Dec 2013	Head of Communications and Customer Services	Final	Approved by Trust Board Included updates in line with Francis Report, Patient's Association Report on Complaints and the Rt Hon Ann Clwyd review of NHS Complaints Management.
2	Dec 2014	Head of Communications and Customer Services	Final	Approved by Trust Board Included updates in line with the Francis Report, The Government's response, 'Hard Truths' and the Duty of Candour.
3	January 2016	Deputy Director of Corporate Development	Final	Approved by Trust Board Included updates in line with CQC Essential Standards and PHSO report 'My Expectations'
4	January 2017	Deputy Director of Corporate Development	Final	Approved by Trust Board Includes update in line with: • CQC inspection 2016 • CSE Accreditation 2016 • PHSO report 'My Expectations' • NHSE Assurance of Good Complaints Handling • CQC report 'Complaints Matter'

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31January 2017
Agenda item 8.5

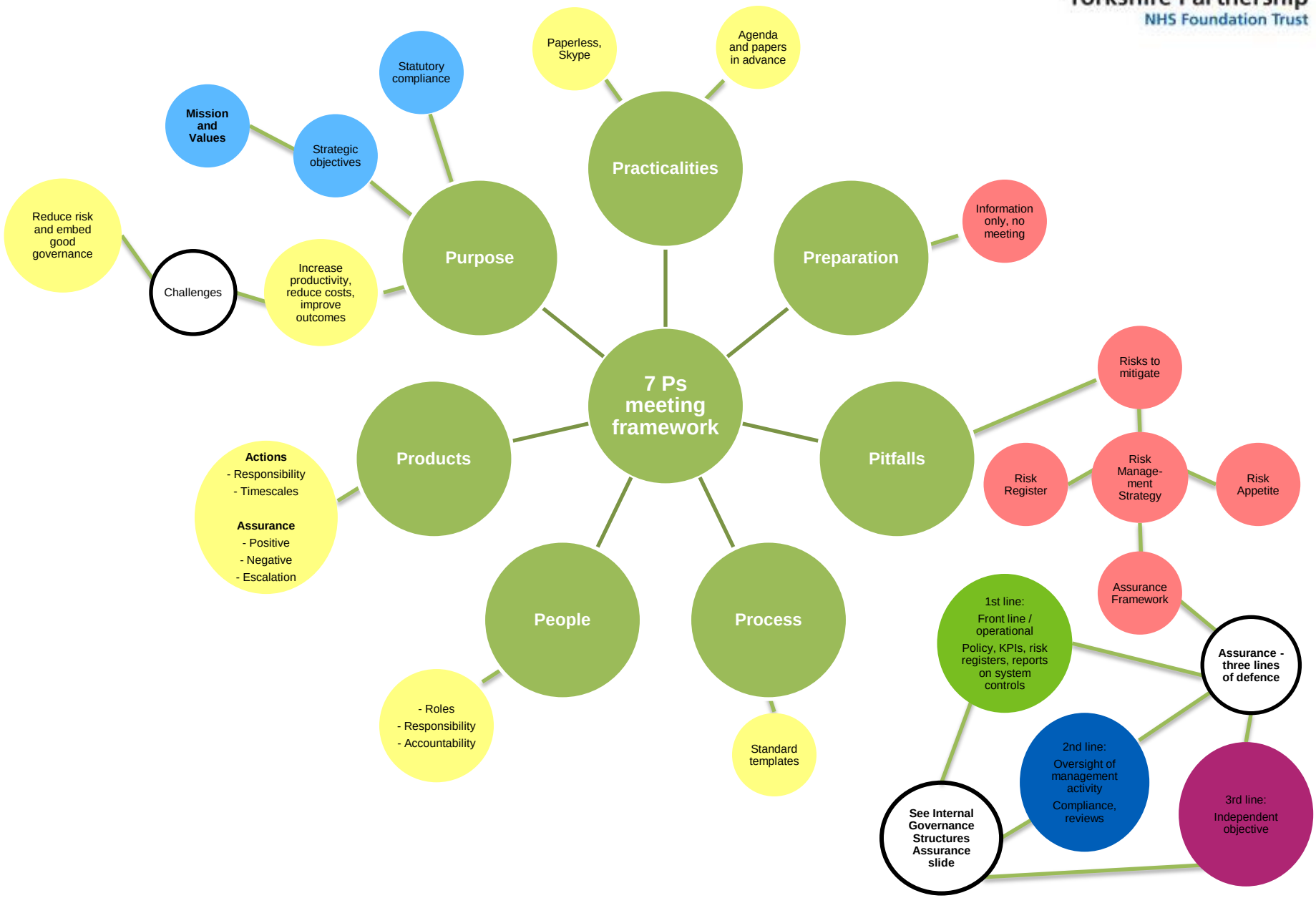
Title:	**Internal Meeting Governance Framework**
Paper prepared by:	Director of Corporate Development
Purpose:	To review the Trusts internal meeting governance structures to ensure they support the delivery of the Trusts Mission and Values, strategic objectives and legal requirements and provide the Board and sub-committees of the Board with the required levels of assurance.
Mission/values:	Good Internal Meeting Governance provides a framework for the continuous development of systems and processes to support assurance, compliance and risk management in support of the delivery of the Trusts mission and strategic objectives.
Any background papers/ previously considered by:	Draft papers have been considered by the Executive Management Team and comments included as applicable.

Executive summary:	Trust meeting structures should enable the Board to:
	• Meet its statutory duties
	• Aid good decision making
	• Ensure timely escalation of issues
	• Sharing of learning
	• Provide assurance on delivery and compliance with legislation
	
	Through the Executive Management Committee (EMT) a review of formal internal meetings has been undertaken, to ensure we have clarity of purpose and outputs from the range of committees/meetings we currently have in place. This can consume a great deal of management and clinical time with sometimes, few tangible outcomes.
	• Agreement was reached, on those meetings that lead Directors could safely/legitimately cease, merge or reduce the frequency of, in order to:
	  ○ Improve accountability
	  ○ Minimise bureaucracy
	  ○ Make best use of resources
	• EMT agreed to put further on-going challenge into the system around the value added of meetings re outputs, membership, frequency and consistency.
	• EMT agreed that all current meetings identified as task and finish are to be “finished” by March 2017 or by a date agreed with EMT.
	• EMT supported the development/introduction of standard meeting templates including a gateway process for the introduction of formal delivery and task and finish groups.
	• To improve and support the efficiency and effectiveness of the Trusts “meeting” governance, ensuring alignment to delivery, risk mitigation and provision of assurance, EMT supported the adoption of the 7P’s meeting framework (Schematic attached as an appendix) covering:
	  ○ Purpose: what will the outcomes be i.e. increased productivity, reduced costs, safer services, compliance with legislation.
	  ○ Products: ensure actions recorded with responsibilities and time scales and assurance provided or issues escalated.
	  ○ People: are the right people members re roles, responsibilities and accountabilities?
	  ○ Process: development of standard templates to support consistency of governance processes.
	  ○ Pitfalls: What are the risks we need to mitigate in line with the Trusts

	Risk Management Strategy and Risk Appetite Statement? o Preparation: Have we the right information to take decisions. o Practicalities: Logistics i.e. timing of papers, use of skype. • EMT supported a review of external meeting governance. The review also highlighted inconsistencies in reporting of committees and how they supported the assurance structures of the organisation. EMT supported a rationalisation of 1st and 2nd line assurance reporting into the formal sub-committees of the Board with a report into Trust Board January 2017. Attached as an appendix is a draft Internal Governance Structure showing the 3 lines of assurance for a number of key committees, providing clarity around reporting lines and accountability. **Risk Appetite** The delivery of the proposed Internal Meetings Governance Framework supports the Trust in providing safe, high quality and equitable services within available resources through an integrated approach to delivery, management of risk and the provision of assurance at the right level. Improving the Trust's efficiency and effectiveness in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to support and APPROVE the proposed Internal Meetings Governance Framework, adopting the "7P's", the rationalisation of meetings and formalisation of 1st and 2nd line assurance reporting. Subject to the above, Trust Board is asked to support the further work required to review committee terms of reference and alignment with the proposed internal meetings Governance Framework.**
Private session:	Not applicable

Internal meetings governance framework (inc. 7Ps)

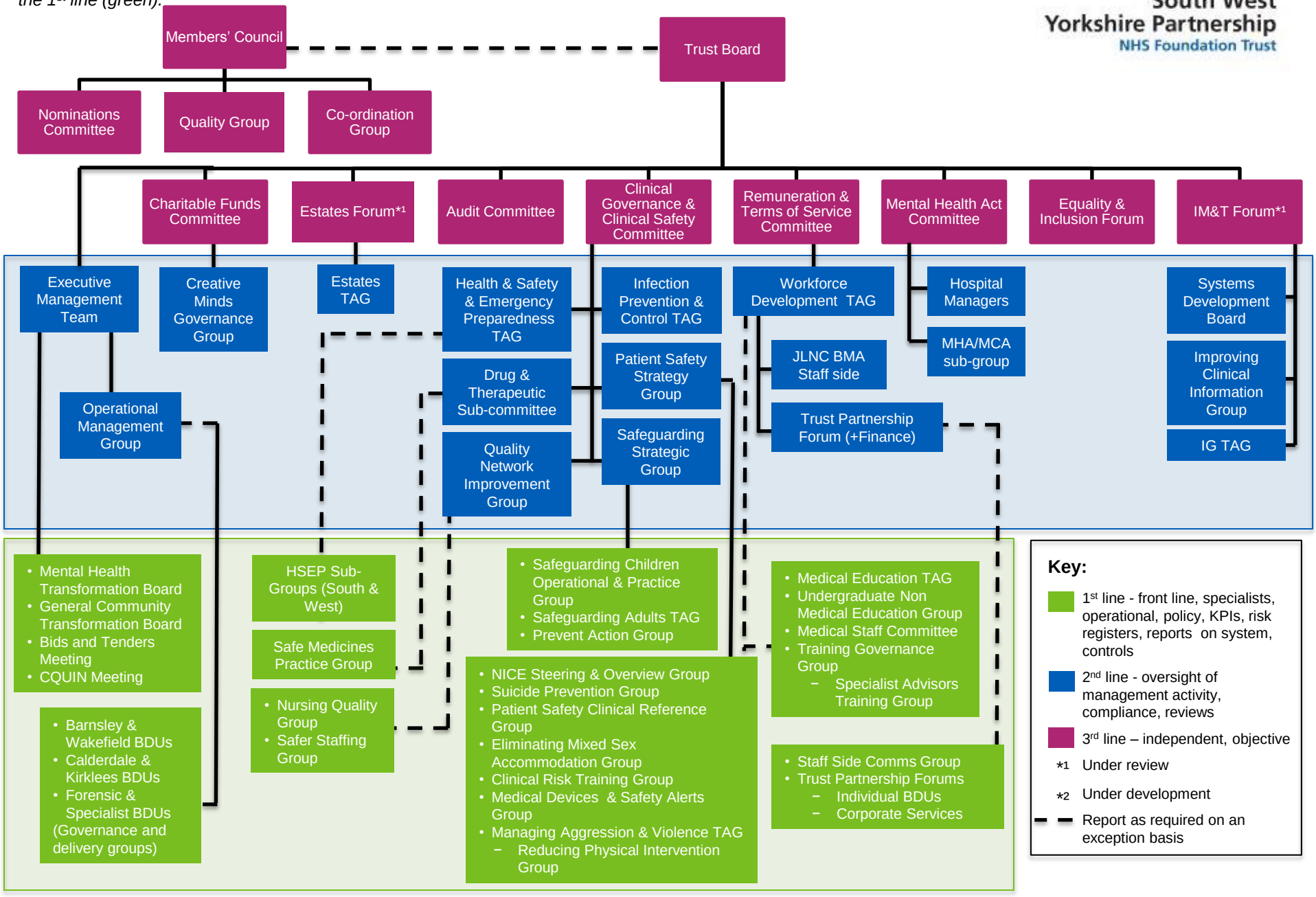
The 7 P's Meeting Framework describes the way we meetings are constructed in a clear way and how we manage risk



Internal governance structures – 3 lines of assurance

Board are required to ensure appropriate risk management processes are in place.
Executive Management Team are responsible for the delivery of the strategy and plans within the organisation which are managed through the 1st line (green).

South West Yorkshire Partnership NHS Foundation Trust



South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31January 2017
Agenda item 8.6

Title:	**Guidance for the use of off-payroll arrangements for substantive and interim NHS office holders**
Paper prepared by:	Director of Corporate Development
Purpose:	This report clarifies the off-payroll arrangements for substantive and interim NHS office holders. It supplements previous guidance to NHS trusts and foundation trusts.
Mission/values:	Supports the good governance of the organisation in support of the delivery of the Trusts mission and strategic objectives.
Any background papers/ previously considered by:	Previous papers to Remuneration and Services Committee around off payroll guidance and processes in place to ensure compliance. Draft paper considered by the Executive Management Team and comments included as applicable. The full guidance is available from the NHS Improvement website: https://improvement.nhs.uk/resources/very-senior-manager-vsm-staff-guidance-payroll-interims/

Executive summary:	• DH letter 23.05.2015 to NHS trusts and foundation trusts states that in accordance with HMT guidance the most senior staff must be on the payroll, unless there are exceptional temporary circumstances which will require Accountable Officer sign-off and cannot last longer than 6 months.
	• Recent advice from HMRC to NHS Improvement (NHS I) goes further than the guidance above. HMRC has confirmed that all appointments to NHS posts defined as “office holders” should be on payroll regardless of the expected duration of the appointment. The only provisional circumstance that HMRC may consider an off-payroll engagement is where an individual is appointed to cover an office holder who is temporarily unable to perform duties (i.e. because of illness) but who retains “office” whilst not working.
	• In the context of NHS foundation trusts, NHS I considers “office holders” to be Trust Board members as determined within the Trusts Constitution.
	• NHS foundation trusts (where appropriate- see below) should bring this guidance to the attention of their board of directors, their remuneration committee and governors.
	• **NHS foundation trusts should make no new off-payroll office holder appointments from the date of this publication HMRC expects foundation trusts to review all existing office holder off-payroll appointments for compliance with this guidance. The Trust can confirm we currently have no off-payroll office holders in post.**
	• Foundation trusts should also seek the views of DH and HMT ministers for any future on-payroll office holder appointments if the proposed salary is £142,500 pa or above, or pay rises are proposed for very senior managers earning salaries of £142,500 pa or above.
	• These rules only apply to:
	  ○ NHS trusts
	  ○ NHS foundation trusts receiving interim support from DH.
	  ○ NHS foundation trusts in breach of their licence for financial reasons.
	  ○ Whilst the Trust does not currently fall within the above

	categories, foundation trusts are strongly encouraged to comply with this process. **Risk Appetite** The adoption of this guidance supports the Trusts governance processes, improving the Trust's efficiency and effectiveness in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to NOTE we currently have no off-payroll office holders in post and SUPPORT the adoption and implementation of the guidance, including bringing the guidance to the attention of the next meeting of the Members Council and to provide an update on off-payroll arrangements, to the next meeting of the Remuneration and Terms of Service Committee.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 January 2017

Agenda item 8.7 – Receipt of minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	6 December 2016
Member	Rob Webster/Sean Rayner
Items discussed	➢ Sustainability and Transformation Plan ➢ Place Based Local Plan ➢ Joint Strategic Needs Assessment ➢ Healthwatch Annual Report ➢ Safer Barnsley Partnership Plan ➢ SEND Strategy ➢ Travel Assistance Policy ➢ Police and Crime Commissioners and Health and Wellbeing Boards
Minutes	The papers and draft minutes of the meeting are available at: http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Wakefield Health and Wellbeing Board

Date	24 November 2016
Member	Rob Webster/Sean Rayner
Items discussed	➢ Sustainability and Transformation Plan - West Yorkshire. ➢ Sustainability and Transformation Plan - Wakefield. ➢ New Models of Care - Overview. ➢ End of Life Strategy - Update. ➢ Frailty Blue Print. ➢ Healthwatch Public Voice Report - Annual Update. ➢ Connecting Care Executive - Summary and Minutes. ➢ Working Together - how health, social care and fire and rescue services can increase their reach, scale and impact through joint working. ➢ Cancer Costs - the financial impact of treatment on young cancer patients and their families.
Minutes	The papers and draft minutes of the meeting are available at: http://www.wakefield.gov.uk/residents/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 31 January 2017
Agenda item 9

Title:	**Assurance framework and organisational risk register Q3 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 Board in the formulation of the Board agenda and in the management of risk and by the Chief Executive to support his 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.

Overview of current assurance level:

Principle strategic objective	Principle strategic risk (abbreviated)	Assurance level Q1	Assurance level Q2	Assurance level Q3
1. Improve the health of the people we serve and reduce health inequities	1.1 Inequalities across the Trust footprint	**A/G**	**A/G**	**A/G**
	1.2 Inability to create person centred delivery	**A/G**	**A/G**	**A/G**
	1.3 Health and safety compliance issues	**G**	**G**	**G**
	1.4 Variation in clinical practice	**A/G**	**A/G**	**A/G**
2. Improve the quality and experience of the care we provide	2.1 Poor clinical information	**A/G**	**A/G**	**A/G**
	2.2 Inability to recruit and retain staff	**A/G**	**A/G**	**A/G**
	2.3 Failure to crease learning environment	**A/G**	**A/G**	**A/G**
	2.4 Failure to embed Trust mission, vision, values	**G**	**G**	**G**
3. Improve our use of resources	3.1 Failure to manage costs to deliver capital programme	**A/G**	**A/G**	**A/G**
	3.2 Failure to develop commissioner support leading to loss of contracts/income	**A/G**	**A/G**	**A/G**
	3.3 Failure to delivery efficiency improvements/CIPs	**A/R**	**A/R**	**A/R**
	3.4 Failure to meet strategic objective due to capacity and resources	**A/G**	**A/G**	**A/G**

Organisational risk register

The organisational risk register records high level risks in the organisation and the controls in place to manage and mitigate the risks. The risk register is reviewed by the Executive Management Team (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 register 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 contains the following risks.

- No. 275 impact on the demand for services as a result of continued reduction in Local Authority funding (LA as a provider).
- No. 695(a) impact on clinical services if the Trust is unable to achieve the transitions identified in the Trusts 5 year plan.
- No. 695(b) financial unsustainability if the Trust is unable to achieve the

	transitions identified in the Trusts 5 year plan. ➢ No. 772 impact on level of financial resources to commission services as a result of continued reduction in Local Authority budgets (LA as Commissioner. ➢ No. 812 impact of commissioning intentions from CCGs and NHS England due to the impact of funding restrictions, other system pressures and the creation of local place based solutions. ➢ No. 850 impact of RiO 7 upgrade on clinical services. ➢ No. 1076 risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support. ➢ No. 1077 risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective. ➢ No. 1078 risks that the long waiting lists to access CAMHS treatment and ASD diagnosis and treatment could lead to a delay in young people starting treatment, potentially causing further deterioration in their mental health and a breakdown of their support networks. ➢ No. 1079 risk of not securing medication wholesale supply and pharmacy computer system from 1 April 2017. ➢ No. 1080 risk that the Trust's information systems could be the target of cyber crime leading to theft of personal data. A possible new risk has been identified in relation to the following and this will be reviewed in the next iteration of the organisational risk register. ➢ Risk in continuity of the clinical records management system. <u>Risk Appetite</u> The Board Assurance Framework and organisational risk register supports the Trust in providing safe, high quality services within available resources, in line with the Trust's Risk Appetite Statement. Over the next quarter, further work will be undertaken through EMT to review Directorate risk registers where risks have not been escalated to the organisational risk register (not considered 15 and above), but may fall outside the Trust Risk Appetite Framework.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the controls and assurances against corporate objectives for Q3 2016/17; and** ➢ **NOTE the key risks for the organisation subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**
Private session:	Not applicable.

ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

South West Yorkshire Partnership NHS Foundation Trust

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 3

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. **RAG Rating Principles**: **Green:** On-target to deliver actions within agreed timeframes; **Amber Green:** Off trajectory but ability/confident can deliver actions within agreed time frames: **Amber Red:** Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame: **Red:** Actions/targets will not be delivered.

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	A/G	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/R
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)	Budget and draft operational plan approved by Trust Board March 2016. External review of plan undertaken by Deloitte undertaken March 2016 (reporting to April 2016 Trust Board). Through 2016/17, supported by monthly financial reporting to Trust Board and Monitor and quarterly exception reports. Operational plan for 2017/18-2018 approved by Trust Board December 2017.
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)	Audit Committee April 2016 and Trust Board April 2016.
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)	Quarterly exception reporting and self-certification to Trust Board. Quarterly review meeting with Monitor supported by Monitor's formal letter in response to quarterly submission. Note: With the introduction of the Single Oversight Framework in October 2016, NHS Improvement have not requested a Governance in year return. Areas are reported to NHS Improvement when needed.
A.4	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks (BDU)	Bi-monthly meetings of EMT (general) provide focus for the Trust's transformation plans. Transformation update also provided to Trust Board on a quarterly basis.
A.5	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems (CEO)	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
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)	Bids and tenders report (standing item delivery EMT) May 2016
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)	Monthly integrated performance and finance reporting to EMT and Trust Board.
A.8	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested (DFPI)	Monthly integrated performance and finance reporting to EMT and Trust Board.
A.9	Independent PLACE audits undertaken and results and actions to be taken reported to EMT, Members' Council and Trust Board (DHR)	Update provided to Clinical Governance and Clinical Safety Committee April 2016
A.10	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events (DHR DCD DMECD)	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Communication, Engagement and Involvement Strategy approved by Trust Board in October 2016.
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)	Quarterly strategy sessions in place
A.13	Service user survey results reported annually to Trust Board and action plans produced as applicable (DCD)	2016 NHS Community Mental Health Service User Survey Results reported to Trust Board in December 2016.
A.14	CQC registration in place and assurance provided that Trust complies with its registration (DNCGS)	Trust is registered with the CQC and assurance process in place through the Director of Nursing to ensure continued compliance.
A.15	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board (DNCGS)	Unannounced and planned visits programme in place.
A.16	Strategic overview and analysis of partnerships in line with Trust vision and objectives through EMT (CRM system) (DMECD)	Bi-monthly meetings of EMT (general) include an assessment and analysis of Trust relationship and partnership with its stakeholders. This includes an analysis of risk and mitigation.
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)	Quarterly reports to Trust Board. Triangulation of risk, performance and governance presented to each Committee
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)	Remuneration and Terms of Service Committee July 2016

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	Quarter 4
- ORR no. 695(a) –Impact on clinical services unable to achieve the transitions identified in the 5 Year Plan	Quarter 4
- ORR no. 812 – commissioning intentions, being mitigated through action plans as set out in the ORR	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.	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.
- 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.
- Trust involved in local Vanguards and STP's.
- Chair has key role in NHS Providers.
- Involved in development of Accountable Care Organisation in Barnsley and MCP in Wakefield.
- Loss of smoking cessation service in Kirklees and impact on our more vulnerable groups.

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	A/G	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/G
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)	Quarterly exception reporting and self-certification to Trust Board Note: With the introduction of the Single Oversight Framework in October 2016, NHS Improvement have not requested a Governance in year return. Areas are reported to NHS Improvement when needed.
A.2	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems (CEO)	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
A.3	Monthly review and monitoring of performance reports through EMT deviations identified and remedial plans requested (DFPI)	Monthly integrated performance and finance reporting to EMT and Trust Board.
A.4	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives (CE)	Quarterly strategy sessions in place
A.5	CQC registration in place and assurance provided that Trust complies with its registration (DN)	Trust is registered with the CQC and assurance process in place through the Director of Nursing to ensure continued compliance.
A.6	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans (DN)	Unannounced and planned visits programme in place.
A.7	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken (DCD)	Quarterly reports to Trust Board
A.8	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place (DCD)	Triangulation of risk, performance and governance presented to each Committee
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)	April 2016 – implantation of smoke-free environment, national audit of schizophrenia, implementation of twelve hour shifts June 2016 - Barnsley 0-19 services, national audit of schizophrenia action plan September 2016 – independent review of Horizon, implementation of smoke-free environment progress report, patient safety strategy progress report Standing items – Quality Accounts, child and adolescent mental health services
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)	Quarterly quality performance reporting to EMT and Trust Board with supporting, more detailed compliance report
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)	Trust Board report April 2016
A.12	Nursing and Medical staff revalidation in place evidenced through report to Trust Board	Independent desk-top review of revalidation process during 2015/16 Q3, which found the process in place is robust, comprehensive and fit for purpose. Annual report to Trust Board June 2015. Appraisers' Forum held three times/year. Exception report to Trust Board September 2016.
A.13	Data quality improvement plan monitored through EMT deviations identified and remedial plans requested (DFPI)	Included in monthly integrated performance reporting to EMT and Trust Board. Regular reports to CG&CS Committee
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)	Process in place with outcome reported through quarterly serious incident reporting to EMT, Clinical Governance and Clinical Safety Committee and Trust Board. Learning lessons report presented quarterly to Trust Board.
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).	Monthly integrated performance reports to EMT and Trust Board.
A.16	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board (DN)	Unannounced and planned visits programme in place.
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)	

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.20	Independent CQC reports to Mental Health Act Committee provided assurance on compliance with Mental Health Act (DN)	Standing item at Mental Health Act Committee
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	Quarter 3
- ORR no. 850 – RiO upgrade implementation, being mitigated through action plans as set out in the ORR	Quarter 2
- ORR no. 852 – information governance incidents, being mitigated through action plans as set out in the ORR	July 2016
- ORR no. 1080 - 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	July 2017
- ORR no. 1078 - 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 .	January 2017
- Internal audit report – patient property partial assurance with improvement requirements being addressed through BDUs.	Quarter 3
- 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.	Quarter 4
- Further updates to CG&CS and Audit Committees on capture of clinical information and impact on data quality	Dec 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, routine reporting to EMT and R&TSC	Quarter 3

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.
- 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 with the exception of CAMHS (being addressed through joint action plan with commissioners).
- 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.

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/G	A/G	A/G	

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/G
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/G
3.3	Failure to deliver efficiency improvements/CIPs	A/R
3.4	Capacity and resources not prioritised leading to failure to meet strategic objectives.	A/G

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	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
A.2	Monthly review and monitoring of performance reports through EMT deviations identified and remedial plans requested	Monthly integrated performance and finance reporting to EMT and Trust Board.
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	Monthly/Quarterly quality/integrated performance reporting to Trust Board.
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	Review of standing financial orders October 2016, tender process – cost/benefit analysis October 2016 Trust Constitution (including Standing Order) and Scheme of Delegation reviewed by Audit Committee in January 2017 prior to approval by Trust Board and Members' Council.
A.5	Quarterly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity	Executive Management Team and Trust Board April 2016
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	Annual Governance Statement 2015/16 approved by Audit Committee in May 2016.
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	Standing item at Remuneration and Terms of Service Committee
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)	Budget and draft operational plan approved by Trust Board March 2016. External review of plan undertaken by Deloitte undertaken March 2016 (reporting to April 2016 Trust Board). Through 2016/17, supported by monthly financial reporting to Trust Board and Monitor and quarterly exception reports. Operational plan for 2017/18-2018/19 approved by Trust Board in December 2016.
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)	Bids and tenders report (standing item delivery EMT)
A.16	Strategic overview and analysis of partnerships in line with Trust vision and objectives through EMT (CRM system) (DMECD)	Bi-monthly meetings of EMT (general) include an assessment and analysis of Trust relationship and partnership with its stakeholders. This includes an analysis of risk and mitigation.
A.17	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place (DCD)	Triangulation of risk, performance and governance presented to each Committee

Gaps in control and what do we need to do to address these and by when	Date
- ORR no. 695(b) – Financial unsustainability if unable to achieve transitions identified in Trust 5 Year Plan, being mitigated through actions set out in ORR.	Quarter 4
- ORR no. 1076 - 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.	Quarter 4
- ORR no. 1077 - risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	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
- 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)	Quarter 4
- Review of contingencies and reserves to meet potential shortfall in CIP	Quarter 3

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.
- Contracts agreed with commissioners subject to certain caveats i.e. demand and capacity.
- Impact of new Single Oversight Framework on Trusts Governance rating re failure to delivery against agency spending cap.
- 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.
- Integrated Performance Report hot spots re. out of area placements and agency spend.
- Impact of non-delivery of CIPs and out of area placements on financial year end outturn.

South West Yorkshire Partnership NHS Foundation Trust

Risk profile Trust Board 31 January 2017

Consequence (impact/severity)	Likelihood (frequency)				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Catastrophic (5)			! Depletion in cash given the inability to identify sufficient CIPs (1076) ! Lose business resulting in a loss of sustainability (1077)	< Reduction in local authority funding to provide services (275) = Impact on clinical services if unable to achieve transitions in five-year strategy plan (695(a)) = Financial sustainability if unable to achieve transitions in five-year strategy plan (695(b)) = Local commissioning intentions (812)	
Major (4)				= Reduction in local authority funding to commission services (772) ! Long waiting lists to access CAMHS treatment and ASD diagnosis and treatment (1078)	> Upgrade to RiO (850)
Moderate (3)					! risk of not securing medication wholesale supply and pharmacy computer system from 1 April 2017 (1079) ! risk that the Trust's information systems could be the target of cyber crime leading to theft of personal data (1080)
Minor (2)					
Negligible (1)	RA (1076), (1077)		RA (275), (695(a)), (695(b)), (772), (812), (850), (1078), (1079), (1080)		

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

With all of us in mind.

South West Yorkshire Partnership NHS Foundation Trust

ORGANISATIONAL LEVEL RISK REPORT

Trust Board – 31 January 2017

	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)	Continued reduction in Local Authority funding (LA as a provider) may impact upon demand for health services as a consequence of cost and demand shifting, which may impact on capacity and resources within integrated teams for service provision. This creates potential service and clinical risks including impact on waiting times, assessment, treatment and management of risk.	➢ Agreed joint arrangements for management and monitoring delivery of integrated teams ➢ Monthly review through delivery EMT of key indicators, which would highlight if issues arose regarding delivery, such as delated transfers of care, waiting times and service users in settled accommodation ➢ Weekly risk scan by Director of Nursing and Medical Director to identify any emerging issues, reported weekly to EMT.	4 Major	5 Almost certain	20	Red/extreme /SUI risk (15-25)	➢ Continues to be monitored through BDU/commissioner forums. Given ongoing financial austerity review of planned activity is reflected in annual plan submission (SR / KT / CH) ➢ Develop Board-to-Board meeting with Barnsley CCG to agree objectives to facilitate a system response to current challenged. (SR) ➢ 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 (SR) ➢ Joint working with Calderdale Council under review through consideration of new ways of working in MCP Vanguard (KT) ➢ Increase use of service line reporting and health intelligence to drill down to facilitate early detection of quality issues (MB) ➢ Identification of leading indicators to highlight where local authority service change and / or benefits changes lead to increased demand. (SR / KT / CH) ➢ Quarterly Strategic overview of business and associated risks to EMT and Trust Board. (JS)		SR on behalf of BDU Directors	Ongoing risk	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performance report) Annual review of contracts and annual plan at EMT and Trust Board		12 (4*3)	Amber/ High (8-12)	Current: no Target: yes	As per actions. [Risk appetite: Clinical risk target 1 – 3, paper to CG&CS committee, setting out actions being taken and consequence of managing the risk to a higher risk appetite]	Every three months prior to business and risk Trust Board
695 (a)	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in the Trust's five year plan.	➢ Transformation project boards in place, Trust transformation plans reviewed through EMT and assurances into Board ➢ Service quality metrics in place highlighting potential hotspots and areas for action and take action as appropriate.	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 (KT / CH / SR) ➢ Quarterly review and update of strategy by Trust Board (JD) ➢ Increased use of service line management information (MB) ➢ Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models and sustainable services (JD) ➢ Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation plans / CEO leads the West Yorkshire STP (RW / AD) ➢ Active engagement in place based plans (JD)		KT on behalf of BDU Directors	As per transformation programme	EMT (monthly) Transformation board (monthly) Trust Board (quarterly)		8 (2*4)	Amber/ high (8-12)	Current: no Target: yes	Risk appetite: Clinical risk target 1 – 3, paper to CG&CS committee setting out actions being taken and consequence of managing the risk to a higher risk appetite]	Every three months prior to business and risk Trust Board

									➢ Development of pricing principals to engage with commissioners (MB) ➢ Update five year forward plan and actions in light of updated planning assumptions and system intelligence.									
695 (b)	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	Risk of financial unsustainability if the Trust is unable to achieve the transition identified in the five year plan.	➢Updated position submitted in 2016/17 operational plan submitted to NHS Improvement in April 2016. Demonstrates recurrent financial surplus in 16/17 after achievement of challenging CIP ➢Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation Plans / CEO leads the West Yorkshire STP ➢Active engagement on place based plans ➢Enhanced management of CIP programme in 2016/17 including a targeted management and admin review and effective use of temporary staffing.	5 Major	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Increased use of service line management information (MB) ➢ Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services (JD) ➢ Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation plans / CEO leads West Yorkshire STP (RW / AD) ➢ Development of pricing strategy to engage with commissioners in 2016/17 (MB) ➢ Enhanced management of CIP programme in 2016/17 including a targeted management and admin review and effective use of temporary staffing (MB) ➢ Update five year forward plan in light of updated planning assumptions and system intelligence (MB)		Director of Finance (MB)	Annual review	EMT (monthly) Trust Board (quarterly)	8 (2*4)	Amber/ high (8-12)	Current: no Target: yes	Risk appetite: Clinical risk target 1 – 3, paper to CG&CS committee setting out actions being taken and consequence of managing the risk to a higher risk appetite]	Every three months prior to business and risk Trust Board
772	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	Impact of continued reduction in Local Authority budgets (LA as commissioner) may have a negative impact on level of financial resources available to commission services.	➢District integrated governance boards established to manage integrated working with good track record of 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. Positive engagement of overview and scrutiny transformation boards ➢Monthly review through performance monitoring governance structure of key indicators, which would indicate if issues arose regarding delivery, such as delayed transfers of care, waiting times 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 ongoing financial austerity review of planned activity is reflected in annual plan submission (SR / KT / CH) ➢ Agreement of safe transfer plan for 0–19 services in Barnsley with local authority (SR) ➢ 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 (KT) ➢ Work in partnership with Locala as a lead provider of an integrated 0-19 service for Kirklees (CH) ➢ Service line strategy review work tested with Trust Board identified direction of travel for service lines, which are challenged by NHS and local authority austerity and commissioning practices. Enables timely decision making (exit / partner etc.) as opportunities arise (SR / KT / CH) ➢ Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation plans / CEO leads West Yorkshire STP (RW / AD) ➢ Further support for the transfer and redeployment of staff (AD) ➢ Creation of alternative delivery of services and mitigate financial risks (SR / KT / CH)		SR on behalf of BDU Directors	Annual review	EMT (monthly) Trust Board (each meeting) Annual review of contracts and annual plans at EMT and Trust Board	12	Amber/ high (8-12)	Current: no Target: yes	Risk appetite: Clinical risk target 1 – 3, paper to CG&CS committee setting out actions being taken and consequence of managing the risk to a higher risk appetite]	Every three months prior to business and risk Trust Board

				➢Regular ongoing review of contracts with local authorities.															
812	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	Risk that Trust's sustainability will be adversely impacted by commissioning intentions from CCGs and NHS England due to impact of funding restrictions, other system pressures and the creation of local place based solutions.	➢Developing a clear service strategy through the internal transformation programmes to engage commissioners and service users on the value of services delivered ➢Ensure appropriate Trust participation and influences in STP, place based solutions and other system transformation programmes ➢Progress on system and service transformation reviewed by Trust Board and EMT ➢Quality Impact Assessment process for CIP and QIPP savings ➢Horizon scanning for current measures ➢Planned improvement in bid management process including additional skills building an increase in joint bids with partners ➢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	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Trust is proactive in involvement and influence in system transformation programmes, which are led by commissioners and include four Vanguard programmes (RW) ➢ Alignment of our plans with CCGs commissioning intentions (SR / KT / CH) ➢ Horizon scanning for new business opportunities (JD) ➢ Develop a communication, engagement and involvement strategy and subsequent annual action plans (KH) ➢ Maintain tight control on costs to maximise contribution (MB) ➢ Review of CQUIN income attainment by EMT and OMG with action plan to improve (JD) ➢ Update of strategy and two year plan requirements (JD / MB) ➢ Review of commissioning intentions by EMT and contract negotiation stances and meetings in place to progress agreement of contracts for 2017/18 and 2018/19 (JD) ➢ Develop a more systematic and robust approach to stakeholder engagement, with relationship management arrangements in place through EMT (KH)		Interim Director of Planning and Strategy (JD)	Ongoing	EMT (monthly) Trust Board business and risk (quarterly)	8	Amber/ high (8-12)	Current: no Target: yes	Risk appetite: Clinical risk target 1 – 3, paper to CG&CS committee setting out actions being taken and consequence of managing the risk to a higher risk appetite]	Every three months prior to business and risk Trust Board
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 which are impacting on the Trust's ability to effectively support clinical services operationally as well as in the production and submission of central returns and accurately recording 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. Proposed solution(s) tested before implementation ➢Update of national OCS files to RiO. ➢New version of medicode available for installation which includes the diagnosis module ➢Health & Social Care Information Centre have been informed	4 Major	5 Almost certain	20	Red/extreme /SUI risk (15-25)	➢ Targeted approach to advice and support from Information Governance Manager through proactive monitoring of incidents (MB) ➢ Rebranded materials and advice to increase awareness in staff and reduce incidents (MB) ➢ Increase in training available to teams including additional e-learning and face to face training from Q4 (MB) ➢ Weekly internal call to assess impact of fixes and prioritisation of further work / developments (MB) ➢ Weekly calls with Servelec to discuss impact of fixes implemented and development of further fixes (MB) ➢ Commission a review of evaluating a new system (MB) ➢ Implement actions from Deloitte independent review and KPMG internal audit.		Dir. of Finance (MB)	31/10/2016.	Weekly update call EMT IM&T Forum Trust Board		Yellow/ Moderate (4-6))	Current: no Target: yes	Risk appetite: Clinical risk target 1 – 3, paper to CG&CS committee setting out actions being taken and consequence of managing the risk to a higher risk appetite]	Every three months prior to business and risk Trust Board

				and a request to put a health warning on our data has been sent ➢ Commissioners are being updated during monthly routine meetings ➢ Executive management meetings held with Servelec Executive Team to ensure focus and prioritisation of issues ➢ Support Contract under review														
1076	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support.	➢ Financial planning process includes detailed two year projection of cash flows ➢ Working capital management process including credit control and creditor payments to ensure income is collected on time and creditors paid appropriately ➢ Capital prioritisation process to ensure capital is funded where the organisation most needs it ➢ Stated aim of development of financial plans that achieve at least a small surplus position ➢ Estates strategy with the intent of selling surplus buildings	5	3	15	Red/extreme /SUI risk (15-25)	➢ Increased focus on prioritisation of capital expenditure (Deputy Director of Estates / Deputy Director of IM&T) ➢ Increased focus on raising of invoices to ensure timely payment (Deputy Director of Finance) ➢ Increased focus on robust financial management via training (Deputy Director of Finance) ➢ Increased robustness of CIP and expenditure management (Director of Finance)		Dir. of Finance (MB)	31/03/17	EMT (monthly) Board (monthly)	8	Amber/ high (8-12)			Every 3 months prior to business and risk board
1077	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	➢ Systematic and integrated monitoring of contract performance, changes in specification and commissioning intentions to identify and quantify contract risks ➢ Regular reporting of contract risks to EMT and Trust Board	5	3	15	Red/extreme /SUI risk (15-25)	➢ Formulation and delivery of proactive contract risk management plans for specific services (Acting Deputy Director Strategic Planning & Contracting) ➢ Development and maintenance of longer term financial planning (Deputy Director of Finance). ➢ Development of targeted programme of business growth focused on specific services and markets and aligned to strategy (BDU Directors). ➢ Refresh of Trust strategy to identify role the Trust can best play in each geography given rapidly changing operating environment (Interim Director of Strategic Planning). ➢ Scenario planning in Operational Plan and Strategy regarding place based developments, where this could result in step-changes in income in either direction (Interim Director of Strategic Planning). ➢ Develop an understanding of clinical and operational interdependencies and minimum volumes for high quality care. ➢ Conduct a stakeholder survey and identify actions to develop and improve relationships with stakeholders (Director of Marketing, Comms & Engagement).		Dir. of Finance (MB)	31/03/17	EMT (monthly) Board (monthly)	6	Yellow/ Moderate (4-6))	Yes	Note the need to manage the transition of this portfolio smoothly – starting January 2017.	Every 3 months prior to business and risk board
1078	Corporate/ organisation level risk (corporate use only EMT)	Calderdale and Kirklees	Risk that the long waiting lists to access CAMHS treatment and ASD diagnosis and treatment lead to a delay in young people	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	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 implement care pathways and 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		Dir. of Specialist Services (CH)	January 2017	Performance reporting to EMT Assurance report to Clinical Governance Committee		Amber/ high (8-12)			

			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.	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.					reviewing the impact of the Future in Mind investments on demand for specialist CAMHS investment into FPOC has demonstrated a positive impact on access and demand in Kirklees. The learning from this is being applied to other areas. ➢ The CAMHS team have supported commissioner bids for waiting list initiative funding. The outcome is awaited. ➢ The bids for Calderdale and Kirklees have been submitted with proposals for integrated working which better manage demand across a range of partners. ➢ CAMHS teams are implementing processes to contact people who are waiting, to keep in touch and to carry out well-being checks.				Individual district performance reports reviewed by BDU					
1079	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	Risk of not securing medication wholesale supply and pharmacy computer system from 1 April 2017.	Following serving of notice by current suppliers, formal procurement exercises were unsuccessful. Current supply guaranteed by NHS partners on extended basis to March 2017.	5	3	15	Red/extreme /SUI risk (15-25)	➢ Negotiations underway with alternative NHS Trust to commence both wholesale supply and computer system support. ➢ Current supplier made aware of risk to commencement date with potential to extend service level agreement. ➢ Transition board established to oversee negotiations and internal redesign required to facilitate new supply. ➢ Early recruitment of staff agreed to support preparation and transition workload.	Value of new supply arrangements unknown.	Medical Director	April 2017	Bi-weekly pharmacy team meetings with monthly project board oversight.	12	Amber/ high (8-12)	Yes	Recent positive engagement of NHS providers has mitigated both likelihood and impact ratings however failure to progress satisfactorily will return to high level of risk.	
1080	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)	Risk that the Trust's information systems could be the target of cyber crime leading to theft of personal data.	➢ McAfee anti-virus software in place including additional email security and data loss prevention ➢ Security patching of all servers, client machines and key network devices ➢ Annual infrastructure, server and client penetration testing ➢ Appropriately skilled and experienced staff who regularly attend cyber security events	5	3	15	Amber/ moderate/SUI risk (12-15)	➢ Explore potential to install Intrusion Detection and Intrusion Prevention (Deputy Director of IM&T) ➢ Implementation of 3 year infrastructure plan including security and firewall rules for key network and computer devices (Deputy Director of IM&T) ➢ Daisy currently drafting a cyber-security overview which will include recommendations for improvement (Deputy Director of IM&T)		Dir. of Finance (MB)	31/07/17	IM&T Managers Meeting (Monthly) EMT (Quarterly) Audit Committee (Half yearly)	6	Yellow/ moderate (4-6)	Yes		Every 3 months prior to business and risk board

				➢ Disaster recovery and business continuity plans which are tested annually ➢ Data retention policy with regular back ups and off-site storage														

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 January 2017
Agenda item 10

Title:	**Board self-certification and assessment of operational, clinical and quality risks**
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 Single Oversight 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:	Papers and discussion at Trust Board highlight any concern around performance and compliance.
Executive summary:	**Background** NHS Improvement authorises NHS foundation trusts on the basis that they are well-governed, financially robust, legally constituted and meet the required quality threshold. Under the previous Risk Assessment Framework (now replaced by the Single Oversight Framework from 1 October 2016) the Trust Board was 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. On 3 October 2016, NHS Improvement advised that due to the launch of the new Single Oversight Framework (from 1 October 2016) they would not be collecting governance returns for Quarter 2. At the Trust Board meeting on 25 October 2016, Trust Board delegated authority to the Chair/Deputy Chair and Chief Executive to approve the final version of the Trust's governance return, which included any exception reporting should it be requested. To date, NHS Improvement have not issued a new governance template for in year Governance declarations. Should NHS Improvement request the Q3 governance return prior to the next Trust Board meeting, Trust Board will be asked to delegate authority to the Chair/Deputy Chair and Chief Executive to approve the final version of the Trust's governance return, which includes exception reporting. The finance submission, which was submitted on 24 January 2017, is summarised in the integrated performance report. **Self certification and exception report** As stated above, Trust Board was 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 previous Risk Assessment Framework used an in-year quality governance metric and the Trust was required to provide information on the total number of executive (voting) posts on the Board, the number of these posts that were 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 previous governance return also provided a formal mechanism for the Trust to report any exceptions around performance and compliance. This is included in the papers presented to Trust Board (including the Integrated Performance Report and Assurance Framework and risk register) and discussion. Due to the launch of the new Single Oversight Framework, NHS Improvement indicated that they will not be requiring an in year Governance declaration. Trust Board is advised that if requested an exception report would contain the following items and is asked to consider whether any further narrative should be included based on the discussions at this meeting: - Performance issues. - Care Quality Commission return visit. - Agency spend and impact regarding the new Single Oversight Framework. - Any changes to services and contracting risks. - Appointment of Director of Strategy. - Non-Executive Director Jonathan Jones end of term 31 December 2016. Recruitment held until summer 2017. - Adoption of the Guidance for the use of off-payroll arrangements for substantive and interim NHS office holders. - Members' Council election timeline and vacancies.
Recommendation:	**Trust Board is asked to NOTE the above report and to DELEGATE AUTHORITY to the Chair/Deputy 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.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 January 2017

Agenda item 11 – Assurance from Trust Board Committees

Audit Committee

Date	24 January 2017
Presented by	Laurence Campbell
Key items to raise at Trust Board	➢ Assurance framework and risk register. ➢ Internal audit on sickness absence. ➢ Internal audit recommendations around the medicine management review and job planning review. ➢ External audit on Agresso software upgrade. ➢ Head of audit opinion.

Equality and Inclusion Forum

Date	30 January 2017
Presented by	Ian Black
Key items to raise at Trust Board	Verbal update to be provided.

Trust Board annual work programme 2017

Agenda item/issue	Jan	Mar	Apr	June	July	Sept	Oct	Dec
Customer services quarterly report	✘		✘		✘		✘	
Assurance framework and risk register	✘		✘		✘		✘	
NHS Improvement quarterly return	✘		✘		✘		✘	
Investment appraisal framework	✘		✘		✘		✘	
Strategic overview of business and associated risks	✘		✘		✘		✘	
Use of Trust Seal		✘		✘		✘		✘
Serious incidents quarterly report		✘		✘		✘		✘
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	✘		✘		✘		✘	
Annual items								
Review of Treasury Management Policy	✘							
Draft Annual Governance Statement (final approval by Audit Committee)		✘						
EMSA declaration		✘						
Information Governance toolkit		✘						
Strategic objectives		✘						
Audit Committee annual report			✘					
Planned visits annual report			✘					
Risk assessment of performance targets, CQUINs and SOF and agreement of KPIs for 2017/18			✘					
Annual report, accounts and quality accounts				✘				
Customer services annual report				✘				
Health and safety annual report				✘				
Serious incidents annual report				✘				
Equality and diversity annual report					✘			
Sustainability annual report						✘		
Code of Governance compliance						✘		
Assessment against NHS Constitution							✘	
Operational plan								✘

Agenda item/issue	Jan	Mar	Apr	June	July	Sept	Oct	Dec
Trust Board annual work programme								✘
Compliance with NHS Improvement/Monitor licence *(date to be confirmed by NHS Improvement)*								
Biannual items								
Policy on policies *(due in July 2018)*								
Review of standing orders, standing financial instructions and scheme of delegations *(due in January 2018)*								
Standing items								
Declaration of interest	✘	✘	✘	✘	✘	✘	✘	✘
Minutes of previous meeting	✘	✘	✘	✘	✘	✘	✘	✘
Chair and Chief Executive's report	✘	✘	✘	✘	✘	✘	✘	✘
Integrated performance report	✘	✘	✘	✘	✘	✘	✘	✘
Assurance from Trust Board Committees	✘	✘	✘	✘	✘	✘	✘	✘

	Business and Risk (includes quarterly performance reports and quarterly reports to Monitor/NHS Improvement)
	Performance and monitoring
Strategic sessions are held in February, May, and November which are not meetings held in public.	
There is no meeting scheduled in August.	
# Corporate Trustees for the Charitable Funds which are not meetings held in public.	