South West Yorkshire Partnership NHS Foundation Trust

Risk Management Governance Framework

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Version 11
April 2022 – April 2025

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What does this policy replace?	Update of previous strategy and re-named to reflect the document purpose (requirement for annual review by Trust Board)
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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 Trust Board 30 April 2019 Trust Board 26 April 2022
Developed by:	Assistant Director of Corporate Governance, Performance and Risk Company Secretary Corporate Governance Manager
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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 put the person first and, in the centre,
- We know that families and carers matter
- We are respectful, honest, open and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

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

1.2. Purpose and scope

The review of this framework has been undertaken in context of the learning from the covid-19 pandemic and its impact on Trust patients, carers, staff and the communities we serve.

The purpose of the risk framework is to provide a comprehensive method for the effective and focused management of the principal risks to achieving the Trusts strategic objectives in line with the values of the Trust.

This is reported in the Board Assurance Framework (BAF) and Organisational Risk Register (ORR) as part of the annual board work plan. This provides direct evidence for the Annual Governance Statement and the Head of Internal Audit Opinion.

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 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 Care Quality Commission (CQC) to be a provider of NHS commissioned services and adherence to Monitor (NHS Improvement) licensing conditions.

The purpose of the framework 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 (Operational Plan). The framework 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 a changing environment, which in 2022/23 will operate within two Integrated Care Systems (ICS), and can deliver within a highly political and financially challenging environment. The Trust is also subject to public scrutiny. 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
- 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 3**. Where risks cannot be managed within the risk appetite of the Trust, they will be subject to further scrutiny by the relevant sub-committee as identified within the committee's Terms of Reference.

Risks can be broadly defined as follows:

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.

Business risks

Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as 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.

Financial risks

Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.

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.

In writing this framework the Trust recognises that some risks may not easily fit into any single category therefore it will ensure that risks are relevantly and accurately aligned to the most appropriate executive director to ensure effective monitoring and mitigation.

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 has a **"Risk Management Procedure"** for staff 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**. 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. Controls include the continuous assessment of the internal and external environment to identify risks to the achievement of the Trust's objectives, ensuring mitigating action is in place and prioritising 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.

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.

As part of its **Licence** (issued by Monitor (NHS England)), 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, 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** (SFIs) 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 risks around its strategic objectives are being managed is summarised and evidenced in the **Board Assurance Framework (BAF).** Where there are gaps in control or Trust Board has received insufficient assurance, these are reflected on the risk register. The BAF is reported to Trust Board on a quarterly basis and provides evidence of actions taken to manage risks.

The BAF 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 BAF and enables Trust Board to closely monitor any risks identified in the BAF 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 all levels of the Trust, including corporate / organisational level (Trust Board), BDU level, and team level. The risk registers held by BDUs are reviewed regularly and any risk which could have an impact across the Trust is reported

to the Executive Management Team (EMT) monthly to ensure risks which may have a Trust-wide impact are recorded on the Trust's corporate / organisational level 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 corporate / organisational level risk register. All risk registers 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** (Operational 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 directorate 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, Quality and Professions, the Medical Director and the Chief People Officer, each cost improvement is subject to a **Quality Impact Assessment (QIA)** and **Equality Impact Assessment (EIA).** The QIA 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; Red: Likely impact on quality). The assessment is based on the Care Quality Commission's (CQC) five key domains: safe, effective, caring, responsive, and well-led. 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 (Integrated Performance Report) are circulated to Trust Board on a monthly basis and each quarter the Board agenda is dedicated to consideration of strategic and business risks, which includes review of performance against plan and compliance.

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

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

In order to ensure consistency of risk quantification across the Trust a standardised set of descriptors and scoring matrices (based upon the Australian/New Zealand Standard AS/NZS 4360:2004; and used across the NHS) is used for risk analysis.

Following the approval of this Framework a **Risk Management Procedure document** will be developed which will underpin this Framework and set out the risk management overview and process and the steps included. This will be approved by the Executive Management Team following the approval of this framework.

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, 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 framework objectives

The risk management framework 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 framework is a key framework 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 framework 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'/ward to Board) 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 framework 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 & Clinical Safety Committee
- Mental Health Act Committee
- People & Remuneration 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 Trust 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 one approved and assurance is provided to Trust Board by the committee chairs. The Audit Committee chair does not routinely attend any other committees to ensure objectivity; however, the Audit Committee chair 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 **Audit Committee** is responsible for assessing the adequacy of systems, 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 and Finance Investment and Performance Committee scrutinises the financial management systems through its links to internal and external audit.

The **Clinical Governance & 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 Clinical Governance & Clinical Safety 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 **People & Remuneration 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 People & Remuneration 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 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 Trust 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.

Some 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 Framework and procedure.

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.

Ongoing 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, clinical and operational Directors and is responsible for ensuring implementation of the framework agreed by Trust Board.

The EMT reviews the risk register and scans clinical risks including 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 of the Chief Executive, all executive Directors, and senior staff including deputy directors, clinical, general management and practice governance leads from BDUs.

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's Business 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 executive 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.

The Chief Operating Officer is responsible for determining the configuration of service lines within the BDUs to optimise quality and efficiency.

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

- combine the work of the voting executive directors, with support from the Director of Strategy and change (Deputy Chief Executive)
- 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
- 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, Quality and Professions and the Medical Director.

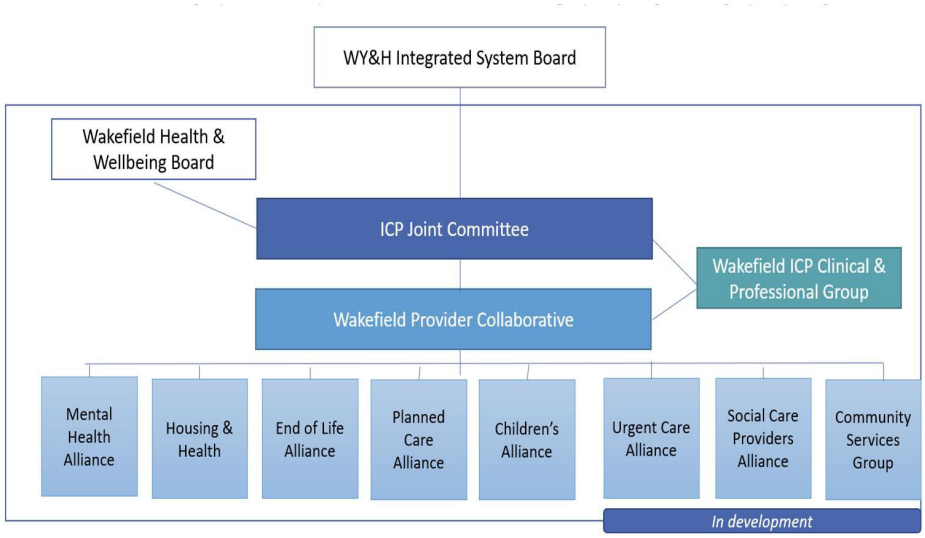
The Trust has a dedicated **Contracting Team** to manage the relationship with commissioners ensuring there are sound systems in place to respond to issues which might affect future commissioning intentions and provide a forum for exploring opportunities for service development. These are supported by 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. The Trust is actively involved in **Integrated Care Systems** in West Yorkshire and South Yorkshire & Bassetlaw.

The Trust has historically been engaged in (or led) Provider Collaboratives/Alliances/Networks in several of our Places or across a larger geography, for example - Barnsley Integrated Care Community Partnership; Wakefield Mental Health Alliance; Kirklees Mental Health Alliance; Yorkshire and Humber Operational Delivery Network (for Learning Disability services); Forensic Outreach Liaison Service.

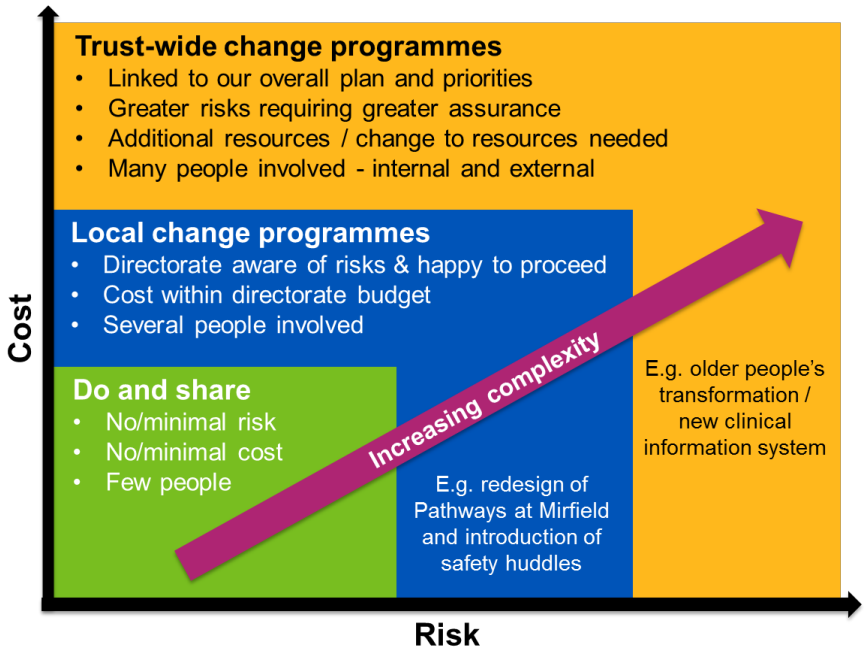
The environment in which the Trust operate will change significantly under the Integrated Care Systems (from 2022/23). An example in one of the Trust's places of the emerging arrangements to be established is summarised in respect of the Wakefield Integrated Care Partnership (ICP) arrangements in the diagram below.



5. Our approach to the management of change

The integrated change framework approach used in South West Yorkshire Partnership NHS Foundation Trust is based on the model for improvement, endorsed by the Institute for Healthcare Improvement and adapted from one of their recommended sources: The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd Edition) Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP San Francisco, California, USA: Jossey-Bass Publishers; 2009.

It is an established and agreed framework approach based on the cost, risk and complexity aiming to reduce bureaucracy and support decision making closest to our services/service users. It provides appropriate support and governance for big Trust-wide changes that are the most complex, highest risk and/or highest cost. The diagram below describes our approach to the three levels of change.



- It is based on the understanding that in order to deliver change we have to manage it (programme and project management) **and** we have to understand the human factors (behaviours, individual response to change).
- Our approach is in line with our values and behaviours and provides a framework for delivery of the Trust strategy. It is founded on co-production and fully using all types of experience. It includes testing as it is based on the concept of continuous improvement and learning from successes and mistakes.
- This includes both learning from others (best practice) and from our own experience so where possible we do things once and learn. It includes evaluation that considers the impact to the individual, the organisation and the system and how we maximise the benefits for all.
- It is based on networked approach with core integrated change team and connections to all others to form integrated change network/community.
- It is underpinned by an integrated change toolkit, with specialist support and also training provided for all of the change network community to use, which contains key information and templates to use in change and improvement work. This includes a project and programme management approach and documentation based on Prince2 and MSP best practice methodology including systematic risk management and benefits processes with opportunities to share/celebrate learning.

6. Risks

Risks identified in the delivery of this framework 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 framework and risk appetite. An implementation plan for the Framework is outlined at **Appendix 6** and monitoring and compliance with the framework is outlined at **Appendix 1**.

7. Resourcing, staffing and technology related issues

Risk management needs to be an integral part of our work right across the organisation. The framework 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 EMT is outlined in **Appendix 6** and set out in the **Risk Management Procedure.**

8. Next steps and governance arrangements

This framework is reserved for agreement at Trust Board and will be delivered through our EMT. The Director of Finance and Resource is accountable for delivery. Implementation of the framework will see involvement from teams across the organisation. An implementation plan for the Framework is set out in **Appendix 6**.

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 framework
- 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.

9. Evaluation and review

This framework covers a period of three years and will be evaluated and reviewed in April 2025.

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

- review of the Framework by Trust Board every three years
- 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
- triangulation of risk process monitored by the Audit Committee
- 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 framework will be monitored through established risk processes already in place within the organisation. These are outlined in **Appendix 1**.

10. Quality and equality impact assessment

The Trust has in place robust systems and processes to assess the impact of risk on equality of care and quality of care. This has never been more important than is it at the time of writing this strategy the levels of inequality that has been highlighted as a result of the Covid-19 pandemic.

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.

Equality Impact Assessment
Risk Management Framework

Date of EIA: April 2022 **Review Date: April 2025**

Completed by: Asma Sacha, Corporate Governance Manager

	QUESTIONS	ANSWERS AND ACTIONS
1	**What is being assessed?** Prompt: what is the function of this document (new or revised)	This document is a revision of the EIA for the Risk Management Framework approved on 7 March 2019.
2	**Description of the document** Prompt: What is the aim of this document	The overall aim of the framework is to describe the Trust's approach to risk management, this impacts all staff. The purpose of the framework 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 (Operational Plan). The framework 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. All members of staff have an important role to play in identifying, assessing and managing risk. To support staff the Trust is fostering a fair, open and consistent environment and does not seek to apportion blame. In turn, this will encourage a willingness to be open and honest and to report any situation where things have or could go wrong.
3	**Lead contact person for the Equality Impact Assessment**	**Andrew Lister, Head of Corporate Governance/ Company Secretary**
4	**Who else is involved in undertaking this Equality Impact Assessment**	**Asma Sacha, Corporate Governance Manager**

5	**Sources of information used to identify barriers etc** Prompts: service delivery equality data – refer to equality dashboards (BI Reporting - Home (sharepoint.com) satisfaction surveys, complaints, local demographics, national or local research & statistics, anecdotal. Contact InvolvingPeople@swyt.nhs.uk for insight **What does your research tell you about the impact your proposal will have on the following equality groups?**	**March 2021 Workforce Monitoring Report** The Trust currently employs 4,530 staff delivering a range of services including mental health, learning disability, forensic, some physical health and an extensive range of community services. All Trust staff will be affected by this framework, it should have a positive impact on the way risk is managed within the organisation. All staff employed by the Trust have a responsibility in relation to risk management and no factors have been identified which will have any adverse impact on equality groups. The Trust carries a number of risks and if not properly managed have the potential to cause harm to patients, staff and visitors and may contribute to an adverse effect on the Trust's assets and reputation.
5a	**Disability Groups:** Prompt: Learning Disabilities or Difficulties, Physical, Visual, Hearing disabilities and people with long term conditions such Diabetes, Cancer, Stroke, Heart Disease etc. Accessible information standard	• Potential barrier with access to the framework (use of technology) • The area reporting high numbers of staff with disabilities is CAMHS BDU. • The data shows that 6.4% of our staff consider themselves to have a disability, which is not significantly different to the previous year (6.1%). The total number of disabled staff is 292, this is an increase of 26 since last year. • Staff can access the framework using the accessibility mode where the framework can be read out. • Staff can request using an interpreting service for deaf and hearing-impaired staff • We will use the service EIA to ensure we fully understand the nature of the disability so we can adjust and adapt our services according to need, remaining person centred throughout. • The framework has been sent to the staff Disability Network for consultation.

Disability (March 2021)

Area	Yes	No or Unknown	Grand Total
Barnsley	78 *7.0%*	1,039 *93.0%*	1,117
Calderdale and Kirklees	76 *8.8%*	792 *91.2%*	868
Wakefield	16 *4.4%*	348 *95.6%*	364
Forensic Services	43 *6.9%*	583 *93.1%*	626
CAMHS BDU	31 *10.5%*	265 *89.5%*	296
Inpatient Services	22 *6.1%*	337 *93.9%*	359
Support Services	23 *3.1%*	708 *96.9%*	731
Sub-total	**289** ***6.6%***	**4,072** ***93.4%***	**4,361**
Medical Staff	3 *1.8%*	166 *98.2%*	169
Grand Total	**292** ***6.4%***	**4,238** ***93.6%***	**4,530**

	QUESTIONS	ANSWERS AND ACTIONS
5b	**Gender:** Prompt: Female & Male issues should be considered	This framework applies equally to all members of staff • Gender split of staff is 21.5% male 78.5% female – this is indicative of all NHS bodies. • No barrier identified by gender in accessing the framework.

Staff in post by gender and area (March 2021)

Gender/Area	Barnsley	Calderdale and Kirklees	Wakefield	Forensic Services	CAMHS BDU	Inpatient Services	Support Services	Medical Staff
Female	964 86.3%	700 80.6%	303 83.2%	468 74.8%	259 87.5%	269 74.9%	526 72.0%	69 40.8%
Male	153 13.7%	168 19.4%	61 16.8%	158 25.2%	37 12.5%	90 25.1%	205 28.0%	100 59.2%
Grand Total	1,117	868	364	626	296	359	731	169

5c	**Age:** Prompt: Older people & Young People issues should be considered	This framework applies equally to all members of staff • Potential barrier with access to the framework (use of technology) • The data shows that 38.7% of staff are aged 50 or over. The Trust is mindful that staff are choosing to work longer, and an older workforce may require consideration from a health and wellbeing perspective regarding initiatives and support to maintain them in employment.

Age by area (March 2021)

Area	19 & Under	20-29	30-39	40-49	50-59	60-69	70+	Grand Total
Barnsley		102 *9.1%*	274 *24.5%*	275 *24.6%*	348 *31.2%*	110 *9.8%*	8 *0.7%*	1,117
Calderdale and Kirklees		115 *13.2%*	201 *23.2%*	229 *26.4%*	238 *27.4%*	82 *9.4%*	3 *0.3%*	868
Wakefield		37 *10.2%*	78 *21.4%*	86 *23.6%*	115 *31.6%*	45 *12.4%*	3 *0.8%*	364
Forensic Services	6 *1.0%*	152 *24.3%*	148 *23.6%*	148 *23.6%*	132 *21.1%*	36 *5.8%*	4 *0.6%*	626
CAMHS BDU		49 *16.6%*	92 *31.1%*	76 *25.7%*	65 *22.0%*	14 *4.7%*		296
Inpatient Services	8 *2.2%*	112 *31.2%*	77 *21.4%*	69 *19.2%*	72 *20.1%*	20 *5.6%*	1 *0.3%*	359
Support Services	3 *0.4%*	56 *7.7%*	107 *14.6%*	176 *24.1%*	271 *37.1%*	114 *15.6%*	4 *0.5%*	731
Sub-total	**17** ***0.4%***	**623** ***14.3%***	**977** ***22.4%***	**1,059** ***24.3%***	**1,241** ***28.5%***	**421** ***9.7%***	**23** ***0.5%***	**4,361**
Medical Staff		6 *3.6%*	34 *20.1%*	63 *37.3%*	54 *32.0%*	10 *5.9%*	2 *1.2%*	169
Grand Total	**17** ***0.4%***	**629** ***13.9%***	**1,011** ***22.3%***	**1,122** ***24.8%***	**1,295** ***28.6%***	**431** ***9.5%***	**25** ***0.6%***	**4,530**

5d	**Sexual Orientation:** Prompt: Heterosexual, Bisexual, Gay, Lesbian groups are included in this Category	This framework applies equally to all members of staff • The framework has been sent to the staff LGBT+ staff network group for consultation.

Sexual Orientation (March 2021)

Area	Heterosexual	Gay or Lesbian	Bisexual	Unknown	Grand Total
Barnsley	928 *83.1%*	15 *1.3%*	9 *0.8%*	165 *14.8%*	1,117
Calderdale and Kirklees	716 *82.5%*	28 *3.2%*	10 *1.2%*	114 *13.1%*	868
Wakefield	298 *81.9%*	12 *3.3%*	2 *0.5%*	52 *14.3%*	364
Forensic Services	515 *82.3%*	21 *3.4%*	7 *1.1%*	83 *13.3%*	626
CAMHS BDU	254 *85.8%*	5 *1.7%*	14 *4.7%*	23 *7.8%*	296
Inpatient Services	287 *79.9%*	12 *3.3%*	6 *1.7%*	54 *15.0%*	359
Support Services	559 *76.5%*	9 *1.2%*	3 *0.4%*	160 *21.9%*	731
Sub-total	**3,557** ***81.6%***	**102** ***2.3%***	**51** ***1.2%***	**651** ***14.9%***	**4,361**
Medical Staff	137 *81.1%*	5 *3.0%*		27 *16.0%*	169
Grand Total	**3,694** ***81.5%***	**107** ***2.4%***	**51** ***1.1%***	**678** ***15.0%***	**4,530**

5e	**Religion & Belief:** Prompt: Main faith groups and people with no belief or philosophical belief issues should be considered	This framework applies equally to all members of staff.

Religious belief (March 2021)

Area	Atheism	Christianity	Islam	Other*	Unknown	Grand Total
Barnsley	160 *14.3%*	610 *54.6%*	10 *0.9%*	114 *10.2%*	223 *20.0%*	1,117
Calderdale and Kirklees	188 *21.7%*	372 *42.9%*	39 *4.5%*	97 *11.2%*	172 *19.8%*	868
Wakefield	60 *16.5%*	181 *49.7%*	7 *1.9%*	53 *14.6%*	63 *17.3%*	364
Forensic Services	151 *24.1%*	281 *44.9%*	25 *4.0%*	56 *8.9%*	113 *18.1%*	626
CAMHS BDU	79 *26.7%*	125 *42.2%*	4 *1.4%*	52 *17.6%*	36 *12.2%*	296
Inpatient Services	80 *22.3%*	147 *40.9%*	19 *5.3%*	41 *11.4%*	72 *20.1%*	359
Support Services	105 *14.4%*	363 *49.7%*	13 *1.8%*	73 *10.0%*	177 *24.2%*	731
Sub-total	**823** ***18.9%***	**2,079** ***47.7%***	**117** ***2.7%***	**486** ***11.1%***	**856** ***19.6%***	**4,361**
Medical Staff	15 *8.9%*	43 *25.4%*	35 *20.7%*	49 *29.0%*	27 *16.0%*	169
Grand Total	**838** ***18.5%***	**2,122** ***46.8%***	**152** ***3.4%***	**535** ***11.8%***	**883** ***19.5%***	**4,530**

5f	**Marriage and Civil Partnership** Prompt: Single, Married, Co-habiting, Widowed, Civil Partnership status are included in this category	This framework applies equally to all members of staff.

Marital Status (March 202)

Area	Civil Partnership	Divorced/Legally Separated	Married	Single	Widowed	Unknown	Grand Total
Barnsley	9 *0.8%*	109 *9.8%*	638 *57.1%*	341 *30.5%*	15 *1.3%*	5 *0.4%*	1,117
Calderdale and Kirklees	16 *1.8%*	94 *10.8%*	401 *46.2%*	337 *38.8%*	8 *0.9%*	12 *1.4%*	868
Wakefield	4 *1.8%*	38 *10.8%*	199 *46.2%*	112 *38.8%*	7 *0.9%*	4 *1.4%*	364
Forensic Services	9 *1.4%*	51 *8.1%*	251 *40.1%*	305 *48.7%*	5 *0.8%*	5 *0.8%*	626
CAMHS BDU		33 *11.1%*	137 *46.3%*	122 *41.2%*		4 *1.4%*	296
Inpatient Services	2 *0.6%*	28 *7.8%*	127 *35.4%*	200 *55.7%*	1 *0.3%*	1 *0.3%*	359
Support Services	9 *1.2%*	76 *10.4%*	416 *56.9%*	212 *29.0%*	9 *1.2%*	9 *1.2%*	731
Sub-total	**49** ***1.1%***	**429** ***9.8%***	**2,169** ***49.7%***	**1,629** ***37.4%***	**45** ***1.0%***	**40** ***0.9%***	**4,361**
Medical Staff	2 *1.2%*	4 *2.4%*	132 *78.1%*	29 *17.2%*	1 *0.6%*	1 *0.6%*	169
Grand Total	**51** ***1.1%***	**433** ***9.6%***	**2,301** ***50.8%***	**1,658** ***36.6%***	**46** ***1.0%***	**41** ***0.9%***	**4,530**

5g	**Pregnancy and Maternity** Prompt: Currently pregnant or have been pregnant in the last 12 months should be considered	This framework applies equally to all members of staff.
5h	**Gender Re-assignment** Prompt: Transgender issues should be considered	This framework applies equally to all members of staff • The framework has been sent to the LGBT+ network for consultation.
5l	**Carers** Prompt: Caring responsibilities paid or unpaid, hours this is done should be considered	This framework applies equally to all members of staff • The framework has been sent to the staff carers network for consultation.
5j	**Race** Prompt: Indigenous population and BME Groups such as Black African and Caribbean, Mixed Heritage, South Asian, Chinese, Irish, new Migrant, Asylum & Refugee, Gypsy & Travelling communities.)	• The Trusts staff profile has a comparable White British representation to the local demographic of the people that it serves collectively at just over 89%. Mixed race staff are under-represented by 0.15%, Black staff are over-represented by 2.19% and South Asian staff are under-represented by 2.49%. However, the Trust's local demographic has large variation in BAME representation and there is a significant under-representation of South Asian staff in Kirklees/Calderdale (exact figures not available due to mixed teams) • Staff can request the framework is interpreted into a different language. • The framework has been sent to the REACH (Race, Equality and Cultural Heritage) staff network for consultation.

Race (March 2021)

Area	Asian	Black	Chinese or Other	Mixed	White	Unknown	Grand Total
Barnsley	15 *1.3%*	8 *0.7%*	4 *0.4%*	8 *0.7%*	1,079 *96.6%*	3 *0.3%*	1,117
Calderdale and Kirklees	51 *5.9%*	34 *3.9%*	4 *0.5%*	14 *1.6%*	760 *87.6%*	5 *0.6%*	868
Wakefield	10 *2.7%*	11 *3.0%*	1 *0.3%*	7 *1.9%*	335 *92.0%*		364
Forensic Services	30 *4.8%*	36 *5.8%*	3 *0.5%*	7 *1.1%*	548 *87.5%*	2 *0.3%*	626
CAMHS BDU	7 *2.4%*	12 *4.1%*		6 *2.0%*	271 *91.6%*		296
Inpatient Services	17 *4.7%*	29 *8.1%*	1 *0.3%*	3 *0.8%*	307 *85.5%*	2 *0.6%*	359
Support Services	26 *3.6%*	7 *1.0%*	3 *0.4%*	7 *1.0%*	684 *93.6%*	4 *0.5%*	731
Sub-total	**156** ***3.6%***	**137** ***3.1%***	**16** ***0.4%***	**52** ***1.2%***	**3,984** ***91.4%***	**16** ***0.4%***	**4,361**
Medical Staff	82 *48.5%*	10 *5.9%*	11 *6.5%*	7 *4.1%*	58 *34.3%*	1 *0.6%*	169
Grand Total	**238** ***5.3%***	**147** ***3.2%***	**27** ***0.6%***	**59** ***1.3%***	**4,042** ***89.2%***	**17** ***0.4%***	**4,530**

6. Action Plan

EIAs are now reviewed using a grading approach which is in line with our Equality Delivery System (EDS). This rates the quality of the EIA. This means that the team can review the EIA and make recommendations only. The rating and suggested standards are set out below:

- **Under-developed** – red – **No data**. **No strands** of equality
- **Developing** – amber – **Some census data plus workforce**. **Two strands** of equality addressed
- **Achieving** – green – **Some census data plus workforce. Five strands** of equality addressed
- **Excelling** – purple –**All the data and all the strands** addressed

Potential themes for actions: Geographical location, built environment, timing, costs of the service, make up of your workforce, stereotypes and assumptions, equality monitoring, community relations/cohesion, same sex wards and care, specific issues/barriers.

6.1. Action

Who will benefit from this action? (tick all that apply)		Action 1: This is what we are going to do	Lead/s	By when	Update - outcome	RAG
Age	√	Review the risk management procedure document to guide staff of the formulation, assessment, and management of risk, ensuring it is accessible.	Assistant Director of Corporate Governance, Performance and Risk Head of Corporate Governance Corporate Governance Manager	April 2022	(Review every 3 years)	**Developing**
Disability	√					
Gender reassignment	√					
Marriage and civil partnership	√					
Race	√					
Religion or belief	√					
Sex	√					
Sexual Orientation	√					
Pregnancy maternity	√					
Carers	√					

6.2. Action

Who will benefit from this action? (tick all that apply)		Action 1: This is what we are going to do	Lead/s	By when	Update - outcome	RAG
Age	√	When risks are identified to ensure equality impact is considered and if it impacts staff, carers and service users disproportionately. This is to be incorporated into the procedure document.	Assistant Director of Corporate Governance, Performance and Risk Head of Corporate Governance Corporate Governance Manager	April 2022	(Review every 3 years)	**Developing**
Disability	√					
Gender reassignment	√					
Marriage and civil partnership	√					
Race	√					
Religion or belief	√					
Sex	√					
Sexual Orientation	√					
Pregnancy maternity	√					
Carers	√					

7. Involvement & Insight: New or Previous

(please include any evidence of activity undertaken in the box below)

An integral element of the Risk Management Framework and Equality Impact Assessment is to involve the various groups and support networks, i.e., LGBT+, REACH (formerly BAME), carers and Disability networks to ensure there continues to be no unintended consequences to individuals.

8. Monitoring of progress on actions

This is available on the Trust intranet and via Freedom of Information request.
The Equality Impact Assessment has been published as an integral part of the Risk Management Framework.

9. Publishing the Equality Impact Assessment

This framework will be reviewed by the Audit Committee and Executive Management Team.

10 Signing off Equality Impact Assessment

James Sabin, Interim Director of Finance – approved 26.04.2022

Lindsay Jensen, Interim Director of HR and OD – Peer review – approved 26.04.2022

Asma Sacha, Corporate Governance Manager – approved 04.04.2022

Andrew Lister, Head of Corporate Governance/Company Secretary – approved 04.04.2022

Equality and Involvement Team – approved 04.04.2022

11. Appendices

Appendix 1 – Monitoring compliance with the framework

Risk process	Purpose	Frequency	Lead	Outcome
Review of the Risk Management Framework	To ensure it is appropriate for the Trust, reflects current priorities and the external environment, and is fit for purpose.	Every three years	Company Secretary	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 (NHSE/I).
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 the 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 Finance and Resource /	Feedback to Trust Board and annual reports to the Audit Committee and, through the Committee, to Trust Board.

Risk process	Purpose	Frequency	Lead	Outcome
			Company Secretary	
Internal audit programme	This takes a risk-based approach to provide assurance that the Trust's key 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.	Annual work programme	Director of Finance and Resource	Presentation of reports to the Audit Committee. Head of Internal Audit Opinion 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 Finance and Resource	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.	Annually	Director of Finance and Resource	Trust Board and members of the Extended Executive Management Team undertake mandatory risk management training annually via information booklet available on the intranet. To be rolled out to other staff as appropriate.
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 Finance and Resource / Company Secretary	Presentation of report to Audit Committee.

Appendix 2 – 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

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
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
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

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)
What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

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

Risk scoring = consequence x likelihood (C x L)

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

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

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

Instructions for use

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

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

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

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

Appendix 3 – 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.

The Trust recognises that its long-term sustainability depends upon optimising risk in relation to the delivery of its strategic objectives, and also that the relationship with patients, staff, contractors, the general public and other stakeholders is key to the Trust's success.

As such, SWYPT upholds a duty of care to ensure that Health and Safety is not compromised and therefore, taking into consideration that most risks cannot be completely eliminated, the Trust will have a low tolerance to risks that could result in a negative impact on the Health and Safety of patients, staff, contractors, the general public and other stakeholders.

However, within the boundaries of regulatory constraints, the Trust has an open appetite to take well-considered and balanced risks to pursue innovation and opportunities where positive gains can be expected, whilst being confident that through good risk management the threats can be averted.

The Trust will review its risk appetite at least annually as part of the review of its Risk Management Strategy.

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.

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. A 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 (EMT), through its regular review of the Organisational Risk Register. and the Operational Management Group through its review of care group 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 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 care group and directorate registers of 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 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 Board Assurance Framework (BAF) provides the Trust Board with a simple but comprehensive method for effective and focused management of the risks to meeting the Trust's strategic objectives show below:

Our four strategic objectives	
Improving health	**Improving care**
Improving resources	**Make this a great place to work**

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. When considering risk appetite and areas of risk the Trust will take into consideration any potential impact on inequalities, maintaining a low threshold in this regard.

Risk appetite target scores

We have reviewed and defined our risk appetite in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix update published in May 2020 and 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)**
None: 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 value for money (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 Governance Framework, we have defined the following five 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.*

<u>Clinical Safety and Quality risks:</u> Risks arising as a result of clinical or healthcare practice(s) or those risks created or exacerbated by the environment, such as cleanliness or ligature risks or workforce	**Good governance matrix: Minimal – Cautious**	**Risk target 1-6**

i.e. the inability to recruit or retain an appropriately skilled workforce	**Risk appetite: Low-Moderate**	
Examples of clinical safety and quality risk are:		
• Risks to service user/public safety. • Risks to meeting recognised clinical and/or environmental standards e.g FIRM (Formulation informed risk management) , record keeping, infection prevention and control, and NICE guidance • Risks to staff safety • Risks to meeting mandatory training requirements, within limits set by the Board.		

<u>Business risks:</u> Risks which might affect the sustainability of the Trust or its ability to achieve its plans, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.	**Good governance matrix: Open** **Risk appetite: High**	**Risk target 8-12**
Examples of business risks are:		
• Reputational risk, negative impact on perceptions of service users, staff, and the wider system, including commissioners and providers (in carrying out the role of lead/coordinating provider for services across West and/ or South Yorkshire), and the public • Workforce risk, inability to attract and retain appropriately qualified staff to deliver Trust plans. • Environmental risk, not having appropriate Estates and Facilities structures and systems to deliver high quality, modern safe services • Missed opportunities, the Trust fails to identify opportunities for growth impacting on business sustainability and development.		

<u>Compliance risks:</u> Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.	**Good Governance matrix: Minimal-Cautious** **Risk appetite: Low - Moderate**	**Risk target 1-6**
Examples of compliance risks are:		
• Risk of failing to comply with NHS England requirements impacting on the Trust's license • Risk of failing to comply with CQC standards and potential of compliance action. • Risk of failing to comply with health and safety legislation • Risk of failing to comply with Fire Safety (England) Regulations 2022 • Risk of failing to comply with data security protection toolkit standards, including meeting cyber essentials standards • Risk of failing to comply with our statutory responsibilities under the Equality Act 2010, especially the Public Sector Equality Duty (PSED) and the Health and Social Care Act 2022.		

- Risks to meeting statutory training requirements e.g. information governance, Oliver McGowen training.

<u>Financial risks:</u> Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.	**Good Governance Matrix: Minimal-Cautious** **Risk appetite: Low-Moderate**	**Risk target 1-6**
Examples of financial risks are:		
• Financial risk associated with plans for existing/new services as the benefits for patient care may justify the investment • Risk of breakdown in financial controls, loss of assets with significant financial value. • Risk of impact of wider financial system pressures on the Trust's ability to deliver its own operational and financial plan		

<u>Strategic risks:</u> 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.	**Good Governance Matrix: Open** **Risk appetite: High**	**Risk target 8-12**
Examples of strategic risk are:		
• Delivering transformational change ensuring a safe place to receive services and a safe place to work. • Developing partnerships that enhance the Trust's current and future services. • Delivering the Trust Social Responsibility and Sustainability strategy in line with the NHS Long Term and Green plans • The risk the Trust fails to innovate and fulfil its strategic ambitions • Ensuring that equality, involvement and inclusion is central to everything the Trust does to reduce inequalities, tackle stigma and eliminate discrimination		

Approved by Trust Board: 26 March 2024

Appendix 4 – Board risk assurance and risk 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 assurance and risk escalation 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 Equality Involvement Communication and Membership 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/Freedom to Speak Up (Whistleblowing) Policy , Equity Guardians, Freedom to Speak up Guardians, Being Open Policy, Risk Management Framework, Incident Reporting and Management Policy, Customer Services Policy, safeguarding policies and procedures, staff surveys, through the Staff Side Partnership Forum and the Trust formal staff network groups; carers staff network group, disability staff network group, LGBT+ staff network group and the Race, Equality and Cultural Heritage (REACH) staff network group.

Governor Involvement

The members' council was fully consulted in the development of the Equality Involvement Communication and Membership Strategy, as a result of which it now receives regular updates against strategy action plans. Actions include the development and use of the Insight Report providing governors with up-to-date information about key issues and concerns from members of the public and the health monitoring organisations e.g. Care Quality Commission and Healthwatch. This enables Trust governors' access to information which they may wish to bring to the Trusts attention through risk escalation route. This is in addition to governor engagement with patients, carers and staff though engagement in quality monitoring visits and Patient Led Assessment of the Care Environment (PLACE) visits.

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).

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 (TAG) reports
- Integrated Performance Report (IPR)
- Minutes (of key meetings)
- Internal Audit reports
- Local Counter Fraud reports
- Staff Survey Results
- Serious Incident (SIs) Reports
- Annual Governance Statement
- Data Security and Protection Toolkit (DSPT)
- Quality Impact Assessments (QIAs)
- Equality Impact Assessments (EIAs)
- Members' Council Quality Group
- Quality Monitoring Visits

External
- External visits / inspection reports such as CQC visits
- Independent reviews (such as Ombudsman Reports)
- External accreditations such as IIP, Clinical Network Reviews
- Quality Account and its independent audit
- Annual Audit letter
- National staff surveys
- National Patient Satisfaction Surveys (Friends and Family Test)
- Patient Led Assessment of the Clinical Environment (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
The Trust is a large organisation offering a wide number of services across multiple places. During 2022/23 the Trust will move to operate within two Integrated Care Systems (ICS) and will deliver services within a complex and financially challenging environment. The formal governance arrangements are being developed at the time of writing and are to be finalised and approved in early 2022/23. It is expected that these will continue to be formal mechanisms which can be used by key stakeholders, such as commissioners and regulators to raise concerns such as contract performance and quality issues. The NHS Improvement Quarterly Review Meetings (QRMs) with the EMT will continue in this new operating environment.

Trust's internal quality and performance monitoring
The Trust has a number of groups where quality and performance is discussed. The key performance meetings are the Operational Management Group (weekly) and EMT performance and monitoring meeting (monthly). Trust Board committees provide assurance following each meeting including approved committee Minutes.

Performance is managed at a local level through monthly BDU performance and governance meetings. 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 OMG and any key risks or areas of performance requiring escalation are elevated to the EMT to be managed accordingly.

The Clinical Governance & 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 (BAF), which is submitted quarterly to the Board.

Trust Board receives an Integrated Performance Report (IPR) 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 (CIPs)
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 (QIA) 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 Quality 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 Account, 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 (CQC)

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 & 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 England/Improvement (Monitor)

Trust Board confirms compliance with NHS Improvement (NHSI) regarding the conditions of Monitor's provider Licence in relation to all targets and national core standards, on an annual basis as part of the Annual Business Plan (Operating Plan) submission and through the submission of other requested statements to NHSI as requested. NHSI holds a Quarterly Review Meeting (QRM) with the EMT to review performance.

Risk escalation framework

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

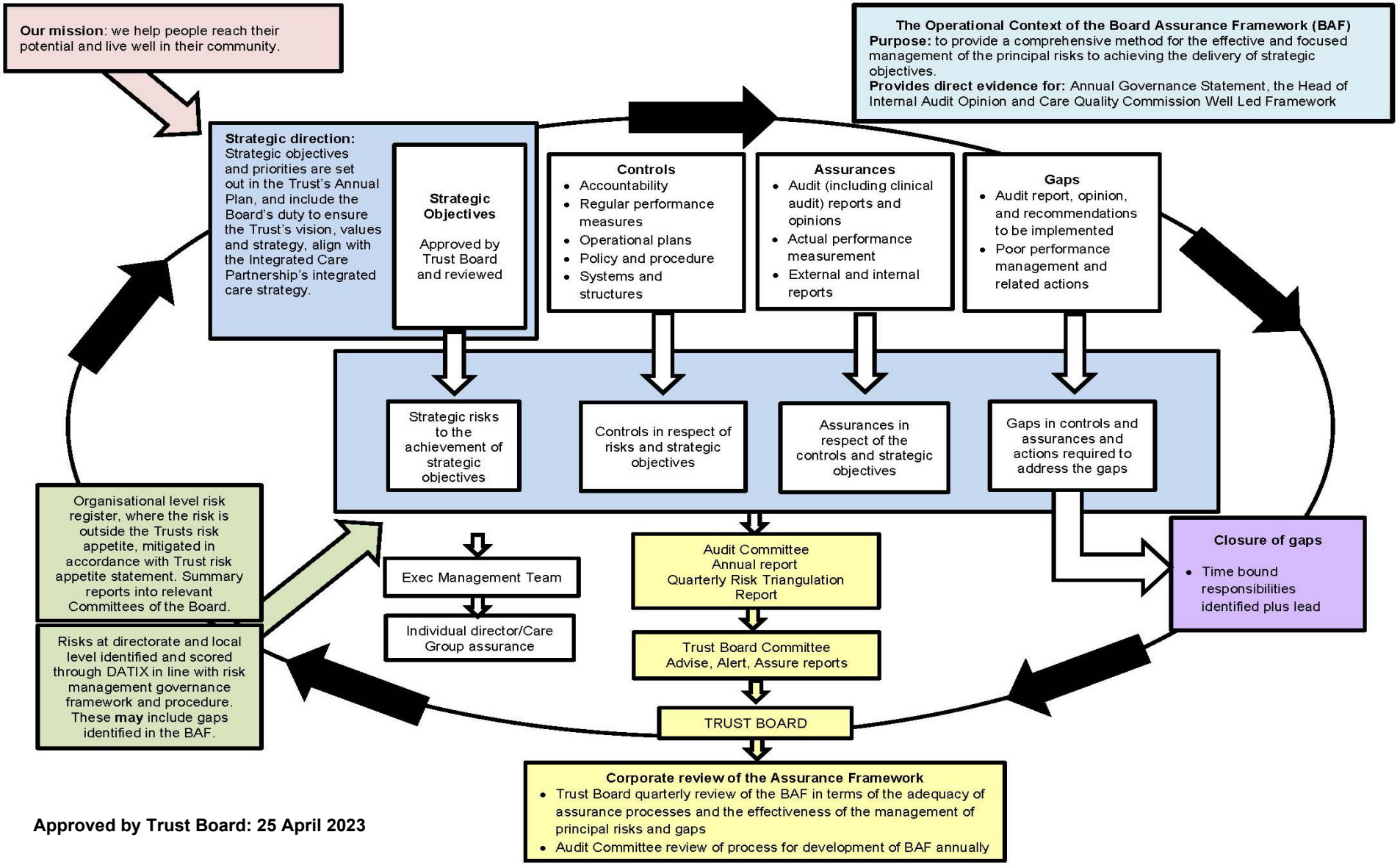
The Corporate / Organisational Risk Register is reviewed and updated by the EMT on a cyclic basis, and reviewed on a quarterly basis by the Trust Board in conjunction with the Trust's Board Assurance Framework (BAF) and Risk Appetite Statement.

Board Assurance Framework (BAF)

Strategic risks are identified by the Trust Board and reviewed quarterly on receipt of the BAF and annually against the Trust's strategic objectives. The Board Assurance Framework (BAF) underpins the delivery of the Trust strategic objectives and includes the Trusts highest risks. The Board Assurance Framework is the process by which the Trust produces risk statements that align to the Trusts principal risks to delivering its strategic objectives in line with Trust values and a commitment to the community it serves.

The BAF is reviewed on a quarterly basis by the Executive Management Team (EMT) and the Trust Board. The BAF 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.

Board Assurance Framework – structure and process



Approved by Trust Board: 25 April 2023

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

- Committee annual self-assessments and Annual Reports.
- External effectiveness reviews including the CQC's well-led review.
- Annual assessment against the Annual Governance Statement, completed in accordance with NHS Improvement's Annual Reporting manual.
- Board strategic and development sessions.
- Scrutiny of Trust Board and committee Minutes, robust monitoring and follow up of the Trust Board's action points and work programme.
- Trust Board director induction and appraisal.
- Assurance reports from the committees to Trust 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.

Appendix 5 – Trust Board and Members Council 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 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 Framework and Business Plan. Until the substantive appointment of a new Director of Finance and Resources the Chief Executive is responsible for environmental management, fire safety, health and safety, security management, and waste management. Director lead for the strategic approach to the Trust's estate.
Director of Finance and Resources	Executive Director with accountability for strategic financial planning and management, demonstrating probity, including counter fraud, and value for money. Substantive responsibility for facilities and estates maintenance, catering and food hygiene, performance management and information management and technology. Holds the role of Senior Information Risk Officer and lead Director for co-ordination of the risk agenda.
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, Quality and Professions), the Mental Health Act, and shared accountability for clinical quality with the Director of Nursing, Quality and Professions.
Chief People Officer	Executive Director with accountability for overseeing the delivery of the workforce strategic plan for making the Trust a great place to work, the organisational development strategy, workforce planning, recruitment and retention, and staff wellbeing, including Occupational Health.
Director of Nursing Quality and Professions	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, and professional leadership for non-medical clinical staff. Has shared accountability for clinical quality with the Medical Director. Holds the role of Caldicott Guardian.
Director of Strategy and Change (Deputy Chief Executive)	Executive Director who supports the Trust Board to set the strategy and strategic direction including priorities for the Trust. She plays a key role in strategic partnership developments in our places and systems and her portfolio also includes leading the integrated change team; marketing, communications, involvement and inclusion teams, and library and knowledge management services. She is also the executive lead for our charities and the equality involvement and inclusion committee.
Chief Operating Officer	Director with strategic and operational accountability for general community, mental health, CAMHS, learning disability and forensic services in all of our places (including overview of our role as Lead Provider for West and South Yorkshire).
Director of Provider Development	Director with strategic and operational accountability for partnership and integrated care system arrangements.
Non-Executive Directors	Non-Executive Directors form part of the unitary board and provide independent views and independent thinking to board discussion. Non-Executive Directors ensure the effectiveness of the Executive team and maintain oversight of execution of the agreed Trust strategy by the Executive team.

Members' Council	Governors are responsible for holding non-executive directors to account both individually and collectively for their scrutiny of the executive directors execution of the agreed strategic objectives.

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

Function	**Lead**
Accounting Officer	Chief Executive
Caldicott Guardian	Director of Nursing, Quality and Professions
Senior Clinical Information Oversight	Chief Clinical Information Officer
Oversight of Risk Management	Assistant Director of Corporate Governance, Performance and Risk
Corporate Governance	Company Secretary
Controlled Drugs	Chief Pharmacist
Counter Fraud	Director of Finance and Resource
Director for security	Chief People Officer
Emergency planning	Chief People Officer
Fire	Chief Executive
Health and Safety	Chief Executive
Income from overseas	Chief Operating Officer
Lead Governor	Public Governor of the Members' Council
Registration Authority Manager	Director of Finance and Resource
Senior Independent Director	Non-Executive Director
Senior Information Risk Officer	Director of Finance and Resource
Freedom to Speak Up	Senior Independent Director

Appendix 6 – Implementation plan

Action required	Action plan	Review date	Lead	Training implications
Review Board meeting cycle, agenda setting process and committee functions to ensure focus of each meeting is clear and ensure adequate focus on strategy, risk and performance.	Review agenda setting to ensure balance of focus on strategy and retrospective performance monitoring. Review terms of reference and membership of committees to ensure clarity of function and effective Board assurance.	Annually	Chair, Chief Executive and Company Secretary	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.	Annual review of the Integrated Performance Report and metrics to ensure they meet Board, internal and national requirements	Annually	Director of Finance and Resource and Director of Nursing, Quality and Professions	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 are amended in the light of changes to the risk register	Annually (April)	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.	Every 3 years Annually Quarterly Quarterly	Chair / CE led SID with Members' Council Chair Chief Executive	None None None None

Action required	Action plan	Review date	Lead	Training implications
	Assessment of skills and experience of Trust Board to ensure remains fit for purpose as a Foundation Trust Board.	As part of role of Nominations Committee	Chair	Access to training as appropriate
Assessment of effectiveness of Members' Council and individual governors	Annual evaluation session Individual reviews with Chair Individual induction meetings with the Chair Trust responsibility to ensure development and maintenance of skills and knowledge of governors	Annually (February) Annually (Jan/Feb/Mar) On appointment Annual Training Programme	Chair Chair Chair Chair	Review of training arrangements for governors underway
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 – risks are aligned to relevant committees to provide additional assurance to Board	Public Board meetings (eight per annum)	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.	Quarterly	Chair of Audit Committee, Chief Executive	
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.	Quarterly	Chief Executive, Deputy Chief Executive	
	Review Standing Orders, Standing Financial Instructions and Scheme of Delegation.	Biennially	Chief Executive, Director of Corporate Development and Director of Finance and Resource 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. Training booklet to be made available on the Trust intranet.	Biennially Biennially	Director of Finance and Resource Director of Finance and Resource	
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, reviewed quarterly by Corporate Policy Group	Quarterly	Director of Finance and Resource	Training relevant to roll out of individual policies as and when they are revised.

Appendix 7 - Risk related Trust documents – policies, procedures, protocols and guidelines relating to risk management, internal systems of control, and regulatory and statutory obligations

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.

Appendix 8 – Checklist for review and approval

Date: April 2022

	Risk Management Framework	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?	YES	
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?	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	

Appendix 9 – Version control sheet

Version	Date	Author	Status	Comment / changes
1	December 2008	Integrated Governance Manager	Final	Final version approved by Trust Board
2	October 2010	Integrated Governance Manager		Changes made to reflect transfer of services from NHS Barnsley. Approved by Trust Board
3	December 2011	Integrated Governance Manager	Final	Annual review approved by Trust Board
4	October 2012	Integrated Governance Manager	Final	Inclusion of Datix processes approved by Trust Board
5	December 2013	Integrated Governance Manager	Final	Annual review approved by Trust Board
6	January 2015	Integrated Governance Manager	Final	Annual review approved by Trust Board
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
9	January 2019	Company Secretary Corporate Governance Manager	Final	Reviewed for approval by Trust Board. Approved 30 April 2019.
10	April 2022	Assistant Director of Corporate Governance, Performance and Risk Company Secretary Corporate Governance Manager	Final	Reviewed by Audit Committee (Senior Independent Director) and Deputy Chair (March 2022) prior to presentation to EMT, Audit Committee and Trust Board.
11	April 2023	Assistant Director of Corporate Governance, Performance and Risk Company Secretary Corporate Governance Manager	Final	Review of risk appetite statement, approved by Trust Board: 28 March 2023 Review of BAF schematic, approved by Trust Board: 25 April 2023 Review of risk appetite statement, Approved by Trust Board: 26 March 2024