Public Document Pack

Black Country Partnership NHS Foundation Trust

Board of Directors Public Meeting

TO BE HELD ON 27 JUNE 2018 at 2.00 pm to 4.00 pm
MEETING ROOM 7 - DELTA HOUSE

A G E N D A

No:	Item	Purpose	Lead	Enclosure /verbal
	5.1 Board Assurance Framework	To review	J Fletcher	Enc. 5.1 3 - 54

DATE AND TIME OF NEXT MEETING:
The next meeting will be held on Wednesday, 25 July 2018 at 10.00 am in Meeting Room 7 - Delta House

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Meeting of: Board of Directors

Date: 28 June 2018

Subject: Board Assurance Framework

Presented by: Joyce Fletcher, Executive Director Nursing, Quality, AHPs and Psychology

Author: Governance Assurance Unit

Purpose: The purpose of the paper is to provide assurance to the Trust Board in relation to the management and mitigation of risks to the delivery of the Strategic Objectives and the Quality Priorities.

Relationship to strategic objectives:

Strategic objectives:	
We will nurture a culture which provides: **safe, effective, caring, responsive and well led services**.	**x**
We will **involve and listen** to patients, carers and family's **experience to continually improve services** we provide.	**x**
We will be a **leading provider** of specialist mental health, learning disability and children's services, proactively seeking opportunities to develop our services, **building partnerships** with others, to **strengthen and expand** the services we provide.	**x**
Attract and retain well-trained, diverse, flexible, **empowered and valued** workforce.	**x**
Resources will be used effectively, **innovatively** and in a **sustainable** manner.	**x**
None	

Relationship to High Level Risks:

High Level Risk Register supports the formulation of the BAF

Recommendation(s):

The Trust Board is asked to

(i) **note** the progress and assurances in terms of controlling and mitigating the top strategic risks on the Board Assurance Framework and to raise any questions or areas of concern.

Equality & Diversity implications:

None Identified

Regulatory and Compliance matters:

	Monitor:	X
	Care Quality Commission:	X
	Other:	
	None:	

Previous consideration

	Board	X		**Business & Performance**	
	Audit			**M H Legislation Scrutiny**	
	Quality & Safety			**Charitable Funds**	
	Finance & Investment			**Turnaround**	
	Other			**None**	

Executive Summary

Outlined within this Board Assurance Framework (BAF) are the principal risks that are associated with the successful delivery of the Trusts 2018/19 Strategic and Delivery Objectives.

Each BAF risk has been aligned to an appropriate Strategic and Delivery Objective. The implementation plans for each strategic objective have been considered and the mitigating action plans for each risk reviewed by the responsible executive.

June Update

There are currently 5 risks graded as High (16-20), 4 Moderate (10-15) and 2 with a current score of low (1-5/6-9).

Throughout May no new risks were escalated for board consideration and there has been no change to the score for any current risk.

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Strategic Objective	Resources will be used effectively, innovatively and in a sustainable manner.				
Delivery Objective	Clinically led sustainable strategies for Mental Health, Learning Disabilities and Children's Services to develop overarching Trust long term plan.				
Associated 2018/19 Key Risks	Financial and Clinical Sustainability				
Risk Description	If we are unable to deliver on agreed specification for PAS/HER solution there is a risk to quality of services				
Risk ID1 – Datix 602	Executive Lead: Paul Assinder, Chris Masikane	Main Manager: Shaun Middlemas, Adrian Kearnes			
Controls:	IT infrastructure IT Department IT Support contracts IT policies IT Strategy IT systems back up plans IT work streams in MERIT programmes 2 weekly IT Services manager meeting(service delay) - input from PMO Monitor and report monthly outages to B&P.				
Gaps in controls:	Clinical Records monitoring group EHR Programme Board				
Assurances:	Internal Audit reviews of IT controls (2016) Report to Management Board				
Gaps in Assurances:	Information Assurance Framework				
Internal Audit Assurance Reviews:	In the 18/19 Internal Audit Plan		**Date Added: 1st June 2016**	**Next Review Date: 30th July 2018**	
	Likelihood	**Consequence**	**Risk Rating**	**Progress**	**Rating History**
Initial Risk Rating	4(Likely)	4(Major)	**16**	◀▶	▼
Current Risk Rating	3(Possible)	3(Moderate)	**9**		
Target Risk Rating	3(Possible)	3(Moderate)	**9**		
Committee where Risk is Monitored:	Quality and Safety Committee				

Actions		
Action	**Due Date**	**Progress Update at Quarter**
Infrastructure upgrade programme	**31st Oct 2017**	Completed- Business Critical Servers for ESH identified and installed
IT will continuously monitor services, to be able to react quickly to outages. Monitoring outputs will also provide monthly reporting to Business and Performance Committee	**28th Feb 2018**	Completed - No major outages have occurred since the last update in July. Any major outages will be reported through IGSG and if required RCAs completed for serious incidents.
IT Forum to be re-established at BCPFT	**31st May 2018**	Completed - IT Management Board to be established with appropriate director oversight
ICT roadmap with associated time scales to be published outlining actions being taken to address linked risks including but not limited to windows XP, ageing PC estate, poor performance, agile working, wireless	**31st June 2018**	The ICT draft strategy has been produced and will be shared with Paul Assinder shortly, once finance colleagues have verified the financials, authorise for release to the Board.
Assurance Framework Audit to be established and completed during quarter 4 - 2017/18 and repeated in quarter 1 - 2018/19	**31st Mar 2019**	Completed- Audit plans now signed off for 2018/19.

Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)

June 2018 Update:

The ICT draft strategy has been produced and is presently being authorised by Board. EPR group established and risks associated with the agreed specification for PAS/HER solution being considered for reference as part of this BAF.

May 2018 Update:

Windows XP, ageing PC estate, poor performance no longer an issue. The ICT draft strategy has been produced and will be shared with executives, once finance colleagues have verified the financials before authorise release to the Board.

April 2018 Update:
A business case for the replacement of PAS/HER was approved at the Board meeting on 28th March 2018. Therefore this risk can be considered for closure.

March 2018 Update:

A business case has been developed for the replacement of PAS/HER. If this is approved at the Board meeting on 28th March 18 this risk can be considered for closure**.**Over the past year, there have been numerous incidents reported through the press and localised NHS forums regarding security breaches. The ICT department has been working on all aspects of service provision which has resulted in minimal disruption on access to systems because of the controls, processes and solutions put in place by the department.
WannaCry, May 2017, caused significant issues to a number of NHS Trusts with remedial costs associated, running into millions of pounds. This Trust was untouched by the outbreak.
The IT department has introduced additional measured including:
Migrated off local E-mail systems and fully adopted the NHS Mail 2 solution,
Removed unsupported operating systems from use i.e. migrated all XP devices to Windows version 7
Undertaking a Windows 10 migration, with Windows 7 being end of life in 2020
Implemented early adoption of Cyber Security solutions direct with Microsoft, to protect the infrastructure
Worked closely with NHS Digital to adopt a full suite of an automatic threat protection solution
Provided solutions that are effective and efficient to support Trust strategic objectives

Currently an ICT strategy document is being formulated and will be sent to Execs for initial scrutiny.

Strategic Objective	Attract and retain a well-trained, diverse, flexible, empowered and valued workforce.	
Delivery Objective	Empowered workforce trusted by accessible and open leaders which celebrates good practise and behaviour.	
Associated 2018/19 Key Risks	Workforce	
Risk Description	If we do not invest in our leadership at all levels of the organisation we will not deliver safe, effective, caring, responsive and well led services.	
Risk ID2 – Datix 677	Executive Lead: Jo Cadman	Main Manager: Becky Crowther
Controls:	Recruitment and retention plan - nursing OD Plan Workforce Committee Strategic objective development sessions Widening participation programme Black Country STP – People strategy Professional registration Alignment to HEE Leadership consultation / standards Board development Cultural Inclusion and Staff Experience Strategy Behavioural Framework	Online leadership offers Equality and Inclusion Board Leadership and engagement plan BAME programmes Leading change, adding value Service delivery plans to monitor team performance at team level Supervision EDHR strategy / WRES action plan Professional development for Band specific Leadership Plan Apprenticeship Levy
Gaps in controls:	Succession plan (organisational wide) Long term retention strategy – robust workforce plan Consistent measures and standards expected – provided but needs to be implemented / embedded	Recording and monitoring
Assurances:	In place leadership bid funding Performance monitoring and reporting Annual planning process and review of strategic objectives Well led audit findings Staff survey HEE / local development	Complaints / grievances – HR monitoring compliance Annual appraisal programme Supervision CQC Assessment
Gaps in Assurances:	No specific external assurance mechanism. Lack of talent management and succession planning.	

Internal Audit Assurance Reviews:	Appraisal Audit May 2017			Date Added: April 2017	Next Review Date: 30th July 2018
	Likelihood	**Consequence**	**Risk Rating**	**Progress**	**Rating History**
Initial Risk Rating	4(Likely)	4(Major)	**16**	◀▶	▼
Current Risk Rating	3(Possible)	4(Major)	**12**		
Target Risk Rating	2(Unlikely)	3(Moderate)	**6**		
Committee where Risk is Monitored:		Workforce Committee			

Actions

Action	Due Date	Progress Update at Quarter
Develop single OD strategy	**1st May 2017**	Completed - for BCP business as usual
Share HEE and external opportunities across the organisation in a timely manner	**1st Jun 2017**	Completed - Trust continues to receive from different sources and distributes within own established channels.
Career pathways	**1st Nov 2017**	Completed - Career pathway framework updated, shared with HEE and used as part of the Apprenticeship pathways. Ward managers development exploratory meeting with DWMH.. Assistant practitioners and associate nurses programmes explored and developed.
Develop links with Universities – in conjunction with HR	**1st Nov 2017**	Completed - This will be continued from an OD perspective on generic leadership and management. L&D will continue this in the apprenticeships and clinical development
Conduct leadership diagnostic 1. Staff survey analysis	**1st Dec 2017**	Completed These are being rolled out and monitored via G Howells. Board interviews will be

2. Leadership behaviours survey 3. Board interviews		completed mid-August and Leadership Behavioural Survey by Oct 17. Outcomes will be designed into OD workbook and prioritised to develop leadership skills. Analysis now being undertaken.
Consider internal capability and resource to diagnose and deliver leadership	**1st Dec 2017**	Completed. Initially we are developing front line staff and as change champions capacity required. Development opportunities are being undertaken and will continue into March 2018. External providers have been commissioned to support clinical work streams and they are supporting the leadership diagnostic through their work. Resource needs to be restructured
Implement the cultural and leadership programme (NHSi toolkit)	**1st Dec 2017**	Completed - plan being implemented and monitored. Utilising the NHS I toolkit to conduct the cultural diagnostic - board interviews started. On track (2 yr. plan).The analysis is now being undertaken.
Explore and implement appropriate leadership opportunities	**1st Dec 2017**	Completed OD strategy created - Diagnostic being undertaken - this will determine leadership priorities. Some 'cross organisational' leadership offers have been made available. On track (2 yr. plan) being monitored
Explore / research leadership healthcare model and wider leadership frameworks available	**31st Mar 2018**	Completed - Will be developed as part of the OD strategy going forward. Working with HEE to consider leadership model. Held discussions with HEE and consultation out until March 18 to utilise

		the forward thinking leadership model. Completed- creating an inclusion and staff experience strategy that incorporates leadership and will utilise the HEE – Forward thinking leadership. Draft to be ready by Dec 17, with plan created for Feb 18 – completed – now out for consultation
WRES / WDES – ensure leadership features within the organisational equality strategy	**31st Mar 2018**	Completed – Cultural Inclusion and Staff experience strategy encompasses Equality. WRES plan created. Yassar Mohammed working with HR to ensure compliance and plans being implemented. Included within the regular update. New Equality objectives being reviewed and in accordance and will be defined in May 2018 MERIT. Completed, WRES submitted and sent to Board
Explore and develop the widening participation agenda – including the offerings of leadership aligned with the apprenticeship levy.	**31st May 2018**	Completed in respect of leadership in generic terms. Apprenticeship Levy & management of team risk paper presented to EMF. Consideration of securing additional funding to support management of apprenticeship levy project and staffing. Wider consultation commenced 10.07.17. Digital monies and identification of numbers determined. Awaiting organisational decision as to recommendations. This is managed through combined L&D and OD workstreams. Work has progressed as far as it can at present and is now dependant on continuation of the Apprenticeship levy. Apprenticeships will be undertaken by the

		organisation and works continues through L&D to determine opportunities. April Update- Paper summited workforce committee to consider development of existing staff in addition to recruiting new apprentices. May 2018 – Paper on leadership apprenticeships presented to Workforce committee and agree – this will be developed and made available initially as a pilot.
On Line leadership offering to be available to organisational leaders	**30th June2018**	Discussions with HEE to clone the online cultural inclusion packages. Leadership Strategy and plan has been submitted to Executives. Proposal shared with Workforce Committee in April. Pilot phase commenced with administration teams in BCPFT. May 18 – Pilot commenced with all administration teams and will be reviewed on 14/5/18 – necessary tweaks made if appropriate and then launched. June 18 – amendments made; e-learning being uploaded onto intranet. Recording processes confirmed to monitor uptake. Additional courses promoted via internal comms channels.
Succession planning strategy/action plan to be created.	**31st Dec 2018**	This is not the key priority at present as we develop the OD plan Talent and succession planning need to be developed and consider the

		possibilities this provides for differing ways of working. This has to be considered in line with the revised Service/HR structures. This is being discussed in the HR and L&D work streams in addition to OD. Correlated to the STP priorities and LWAB task and finish groups. The BC LWAB has generated data from ESR and are defining the BC STP workforce profile. Being monitored by workforce committee May 2018 – This forms part of the recruitment and retention plan but there is no specific succession plan at present. June 18 – suggest this timeframe alters as we need to get the fundamentals in order to understand the workforce profile initially and link with the STP's where possible.

Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)

June 2018
The online learning has been reviewed and tweaked and is currently being uploaded to the intranet. Process configuration to record and report any learning undertaken is being assessed from a central point of view. Further progress will need to be made in this area over the next few months to ensure we can record and report on training. This is heavily reliant on IT infrastructure / systems. The leadership group met to discuss how they will assist in delivering and shaping the leadership offer. A range of external courses have been sent via internal comms to Directors and to the workforce. The development / offer for leadership qualifications has been undertaken with marketing materials ready to share in July.

May 2018 Update:

A pilot for the online leadership package has commenced and due to be reviewed mid May 2018. Necessary amendments will be undertaken and then this will be launched organisational wide. A paper pertaining to utilising the apprenticeship levy has been agreed via workforce committee and monies will now be used to develop Level 3 and Level 5 qualifications. A range of face to face courses and qualification (Coaching, Action learning & Mindfulness) have been offered and are in progress.

A leadership group has been identified in the organisation who will be supporting the implementation of the leadership offer and behavioural framework.

April 2018 Update:

The Cultural Inclusion and Staff Experience Strategy has been reviewed to BCPFT specific as it was created for TCT. This is out for consultation in addition to a BCPFT Leadership Plan. A 'cloned' HEE leadership e-learning site has been created, leadership offerings have been advertised in the areas of coaching, action learning, and mindfulness with more options to follow next month. An Engagement and Visibility plan has been created and under implementation to strengthen the senior leadership of the organisation. As part of the staff survey plan a focus on mandatory training / leadership will be the campaign for the next month and the organisation are being made aware of this.

February / March 2018 Update:
The TCT data has been separated and BCP specific data used to identify priorities.
A leadership visibility and engagement plan has been created and implementation commenced.
The in place leadership bid monies will continue to be used to offer and develop leaders in action learning, mindfulnesss, courageous conversations and coaching.

Access to HEE's online platform will also be available and this will formulate part of the immediate leadership offering.
Clinical leadership continues to progress via the career pathways meetings and Band 7 development programme.

Access to HEE's online platform will also be available and this will formulate part of the immediate leadership offering.
Clinical leadership continues to progress via the career pathways meetings and Band 7 development programme.

Diagnostics have commenced and 3 completed. – Analysis is being undertaken and this will determine what the leadership priorities should be and subsequently designed into the OD workbook and plans over a period of 2 years plus.

TCT is offering a combined leadership programme over the next few months delivered by existing BCHC colleagues. This programme is limited but is still available.

The cultural assessments as part of the TCT work are commencing from May 2017 onwards. Each of the assessments is measured consistently against set criteria. Board interviews are planned; which question the leadership and cultural will take place from June 17 onwards; An organisation wide leadership behavioural survey will also commence from June 2017. The Survey has been completed and analysis continues, the outcome /outputs will be incorporated into the OD workbook and monitored accordingly. The analysis is being undertaken and a leadership visibility plan and leadership 'compact' development has commenced.

External leadership opportunities continue to be undertaken across the organisation.
HR has developed and is delivering a suite of 'management / leadership sessions relating to policy and procedures.
Appraisals are being conducted across the organisation – ambition for completion by end of June. This has been completed and appraisals closed.
Appraisal season once again open for 2018.

Some limitation of HEE introducing National leadership standards, we are currently part of the consultation and we will run our program alongside the national agenda to ensure compliance with standards when released on the 1st April 2018.

December/January – Leadership diagnostic is now complete and analysis is currently being undertaken. A leadership compact is being developed as part of TCT. An BCP leadership (and TCT) visibility plan has been develop and will be implemented over the next 3 months. The staff survey results have been released and leaders will be updated on the most prevalent issues relating to organisational leadership.

Review of internal capability and resources to diagnose and deliver leadership has also been completed. The resource needs to be restructured as part of TCT to ensure the offer is broadened.Analysis is currently being undertaken for Cultural and Leadership Programme as part of the NHSI toolkit. Exploration and implementation of appropriate leadership opportunities will be continual as we move into TCT in order to drive continual improvement and development.An internal leadership catalogue is being developed – ready by March 31st

Strategic Objective	We will involve and listen to patients, carers and family's experience to continually improve services we provide.				
Delivery Objective	Strengthen the role of users, carers and families across all areas of work.				
Associated 2018/19 Key Risks	Possible damage to BCPFT Brand				
Risk Description	Feedback from users, carers and families is crucial to maintain and develop high quality services, without this engagement the quality, income and reputation of BCPFT services will be damaged				
Risk ID3 – Datix 678	Executive Lead: Joyce Fletcher, Jo Cadman	Main Manager: Judy McDonald, Ruth Harvey-Reagan			
Controls:	FFT survey process Patient Experience and Involvement of Communications Patient and Carer user groups established Established complaints/concern management process links with wider patient experience agenda Reports to Quality and Safety Steering Group (Monthly) with subgroup managing exceptions Patient Engagement Involvement, Experience (PEIE) key priorities interim (April – October 2017).	Patient survey workflow across divisions PEIE group (monthly) MERIT recovery work stream			
Gaps in controls:	Improving consistency of approach across all Divisions Developing Trust wide feedback monitoring system	Need to Strengthen FFT process			
Assurances:	Stakeholder quality review visits CQC inspection , October 2016 Reports to Quality and Safety Steering Group (Monthly) with subgroup managing exceptions National Patient survey	Health Watch scrutiny/reporting Recovery College report/support to Trust Patient Story to Board			
Gaps in Assurances:	Limited assurance on effectiveness of controls No systematic evaluation of service transformation	No planned internal audit review			
Internal Audit Assurance Reviews:	None planned	**Date Added: 17th May 2017**	**Next Review Date: 30th July 2018**		
	Likelihood	**Consequence**	**Risk Rating**	**Progress**	**Rating History**
Initial Risk Rating	3(Possible)	3(Moderate)	**9**	◀▶	◀▶
Current Risk Rating	3(Possible)	3(Moderate)	**9**		
Target Risk Rating	1(Rare)	3(Moderate)	**3**		
Committee where Risk is Monitored:	Quality and Safety Steering Group				

Actions		
Action	**Due Date**	**Progress Update at Quarter**
FFT process to be reviewed and relaunched	**31st Jul 2017**	Completed- New process launched on the intranet. Mechanism to ensure sufficient supplies of forms and ensure visibility of PALs boxes across the trust in place
Ensure improvement engagement with the divisional patient experience leads	**31st Jan 2018**	Complete. Greater support/focus to the divisions by the Patient experience team. Patient experience continues to engage with heads of nursing/ and other clinical leaders. Patient experience output now integrated into divisional Q&S reports. Strategic approach to reporting on patient experience continues to develop. Patient experience lead continues to attend DMB's and Q&S groups to regularly report on patient engagement and experience. The patient experience lead has now been added for regular attendance on all professional board meetings (Nursing Board, AHP Board, Psychology Board and Clinical Effectivness Groups).
Launch of Asset Management tool in support of co-production model	**31st Jan 2018**	Completed-.Tools in place, final development work by the software development team continues. tool will now be ready for launch at the end of January. Tool now in operation.
Feedback mechanism for 'you said, we did' and FFT outcomes to front line staff	**31st May 2018**	Reporting mechanisms in place for collating all concerns, compliments and complaints into one template for review by heads of nursing. Patient Experience Manger continues to liaise with the Head of Nursing for LD/Children's to consider effective mechanisms for these divisions. Matron and ward managers are also engaged to continue making improvement in data collection and feedback approaches.
ReQoL rollout as part of recovery work stream to be completed	**31stJuly 2018**	The use of data currently being collated for the first wave of ReQoL will be evaluated to review processes and pathways before implementation into second wave teams. ReQoL will be embedded into evaluation of courses for all students attending the Recovery College. Need to Continue to embed a recovery and safety focus into the ongoing review of CPA, care planning and assessment paperwork

		and processes across all services within the mental health directorate. Thus providing the focus for the 2018/19 Quality Improvement Priority: 'To promote the formulation of personalised, recovery focused care plans for adults accessing BCPFT services in the Mental Health Division. With further action needed to develop and lobby for electronic data collection systems which support the use of ReQoL in clinical practice.
Embed data collection	**31st August 2018**	Embed data collection with all services through reporting and engagement
PEI refresh to be explored	**31st September**	Review of team structures continues with executives considereing revised PEI/complaint structure
User feedback as key aspect of service planning	**31st October 2018**	Service areas to use data and identify priority areas as part of annual business planning cycle

Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)

June 2018 Update:

We have developed a robust process to support, train and grow our network of service improvement volunteers/EbE's, encouraging teams to recruit Experts by Experience to support with service improvement that matter to service users and carers. Work continues to develop a staff training/awareness programme to encourage more connective relationships between all staff and the people using our services. The working title is: 'Everybody Matters – Leading with Kindness'. The complaints policy is being reviewed to explore better ways to report on outcomes and lessons learnt from the action plans. Reporting activity (inc F&F, PREMs) within Datix is working well

May 2018 update:

Consistent process in place for collecting feedback with a single branding, asset management tool developed, next steps are to pilot within a service area whilst looking to incorporate key lines of enquiry for Care Quality Commission.

Achieved since last update:

- Developed 'Get Your Service Feedback' Datix training for teams. All teams can now access all their feedback data (4 C's, FFT scores and PROMS) and can use this info to identify themes of good practice and areas for improvement
- Updated the complaints policy –the 'complaints closure' process will now only close complaints when we receive evidence that the action plan has been embedded into service transformation plans and that recommended actions and changes are underway.
- Updated the volunteer policy to reflect the change to recruitment process. Teams are now being actively encouraged to recruit volunteers to roles that enhance the quality of service provision with a specific emphasis on recruiting Experts by Experience to each service.

- We have linked the 'WHAT MATTERS MOST – Always Events' methodology into the new Quality Boards – which ties in the work with the Quality Improvement Portfolio/Improvement Prioritisation Planner

Plan of action:

- To focus on improving data collection from all services
- To encourage teams to develop their own regular forums for looking at feedback for their teams and feeding improvements made into the clinical effectiveness groups.
- To encourage teams to use the 'PEI – Quality Improvement Portfolio (engagement/co-production mapping and improvement planning tool) to evidence the areas of good practice, engagement with service users and to prioritise 3 top improvements which matter most to their service users/staff to make the service better for users.

Sources of data collection:

- Tell Us How We Did – forms
- Concerns and Complaints Leaflets
- Web based 'Tell Us How We Did' form.
- Cards or messages
- Verbal compliments/comments/suggestions/concerns/complaints

Work is well underway to capture when and where Pals feedback forms are given out in each services patient journey.
We have received a significant increase in the number of forms the PEI team are receiving and are utilising extra admin hours as a result to process the data. This means that teams are on board with this process.

March/April 2018 update:

Consistent process in place for collecting feedback with single a branding, asset management tool developed , next steps are to pilot within a service area whilst looking to incorporate key lines of enquiry for Care Quality Commission.

Plan of action - piloting for both Dale and Brook Wards:

- To focus on improving data collection from both wards on compliments/suggestions and concerns
- To focus on improving feedback on data collected back to wards to look at doing more of what's working as well as looking at making suggested improvements to service delivery.

Sources of data collection:

- Patient Meeting minutes – 'round of thanks' (compliments) 'round of suggestions' (suggestions!)

- Safe ward wall – farewells/thanks/feedback
- Cards or messages
- Verbal compliments/comments/suggestions/concerns/complaints
- PALS/FFT feedback forms.

The Process:
Collection:

- Give out PALS information leaflets on admission and FFT/PALS forms on review and discharge
- Give all compliments/suggestions/concerns to Ward Clerk to feedback to PEI – via Datix or PEI in box.

Feedback:

- PEI/Matron/Service manager to meet monthly to review all complaints/compliments/suggestions/concerns and to:
    - Produce a report on key themes and actions for Divisional Q&S
    - Produce clear communication for wards with feedback from compliments/FFT figures/suggestions/concerns and complaints

Strategic Objective	Attract and retain a well-trained, diverse, flexible, empowered and valued workforce.	
Delivery Objectives	Empowered workforce trusted by accessible and open leaders which celebrates good practise and behaviour.	
Associated 2018/19 Key Risks	Workforce	
Risk Description	If we do not retain and recruit enough and the right skilled staff we cannot create a culture that delivers high quality safe, effective, caring and responsive services	
Risk ID7 – Datix 327	Executive Lead: Judy Griffiths	Main Manager: Michelle Heeley, Jenni Carr Smith and Jacqui Miller-Demirovska
Controls:	Recruitment & Retention Policy & Procedures; Vacancy Control Procedures; includes weekly review of Corporate Vacancies by HR and Finance Staff Forum - Monthly; Workforce Committee - Monthly Performance and Programme Management Board - Monthly Monitoring of Mandatory Training Programme against KPIs - Monthly Monitoring Sickness Absence against KPIs – Monthly Weekly review of Corporate Vacancies by HR/Finance Executives; Recruitment Database and time to hire monitoring. Leadership and Engagement Plan Leavers report Cultural Inclusion and Staff Experience Strategy Leadership plan	
Gaps in controls:	Recruitment and Retention Strategy Systems not consistent in their measuring of actual vacancies versus establishment	Overarching workforce plan ESR/Finance
Assurances:	Reports to Divisional Management Boards(Monthly); Reports to Board of Directors (Monthly); Managers Staff satisfaction survey (Feb 2016) Confirm and Challenge Recovery Plans	Reports to Quality & Safety Committee (Two Monthly) Friend & Family surveys Internal Audit Programme

Gaps in Assurances:	Long term Workforce Plan, Internal Audit Review and workforce milestones				
Internal Audit Assurance Reviews:	ESR Annual Leave Audit and Recruitment Audit currently being completed in April 2018		**Date Added: October 2014**	**Next Review Date: 30th July 2018**	
	Likelihood	**Consequence**	**Risk Rating**	**Progress**	**Rating History**
Initial Risk Rating	5(Almost Certain)	4(Major)	**20**	◀▶	▼
Current Risk Rating	3(Possible)	4(Major)	**12**		
Target Risk Rating	3(Possible)	4(Major)	**12**		
Committee where Risk is Monitored:		Quality and Safety Committee			

Actions

Action	**Due Date**	**Progress Update at Quarter**
Reviewed the recruitment process for 8wk target, with full implementation of recruitment database and better reporting	**30th Jun 2017**	Completed - Rollout of Time to Hire KPI complete
Appropriate offer of jobs to students/ apprentices	**30th Jun 2017**	Completed - Program withdrawn following closure of Ridge Hill
Home growing, HCSW progress	**30th Jun 2017**	Completed – ongoing piece of work through the apprenticeship scheme.
Develop stronger links to University (ies)	**30th Sep 2017**	Completed – Work now continues through the MERIT partnership agenda.
New approaches being taken to advertising and open days programme and measurements. Working closer with clinical services, bank and agency staff	**30th Sep 2017**	Completed
Development of recruitment campaign – Joint recruitment campaign with Merit – Geography/ approach/ innovative	**30th Sep 2017**	Completed - Progress being undertaken through the MERIT partnership agenda
Organisational Development (Shaping our Future) Plan	**30th Sep 2017**	Completed - An organisational development plan has been created that covers business as usual Reported into QSRG (Quality Risk and Governance committee) as well as continual business cycle to include staff survey and WRES.
Cultural Alignment programme	**30th Sep 2017**	Completed - This programme has now merged into the wider OD plan - the specific cultural alignment that commenced has ceased and has converted into differing elements. The NHSi tool kit is being

		used as part of the diagnostic to formulate the OD plan. This will be monitored and governed by Int. Board and QRGC in the new organisation.
Second follower wave pilot- National pilot program to develop new roles	**31st Jan 2018**	The first cohort are on track TNA steering Group. . These are both monthly meetings. There is a shared approach currently in place for this Programme of work This will also include a decision on future cohorts of TNAs as part of the workforce planning.
Developed approach to management of career pathways, Apprenticeship Levy, Team Leader Development Programme	**30th April 2018**	The career pathways group has commenced work on the ward manager development Programme which will later extent to all team leaders. Aligned to NHS I retention plan
Electronic DBS implementation	**30th Sept 2018**	PID presented to Gateway in April 2018, further work requested in respect of the structure applied to charging staff for DBS checks
Strategic HR work plan developed for 2018/2019	**30th May 2018**	Draft plan developed, to be finalised in May 2018
Implement HR strategy with key focus on recruitment and retention and staff health and wellbeing	**31st July 2018**	Strategy being developed
Secondments into hard to reach areas such as PICU and community	**31st July 2018**	Development of a rotation program continues, new community preceptorship in place
Policy Review	**30th Mar 2019**	Full policy review initiated with plan being established with review of all expected throughout 2018/19.
Increased presence at recruitment events	**Ongoing**	HR team increased presence at a schedule of recruitment events- aligned to HR strategy.
Development of bespoke recruitment campaign for PICU/Hallam Street	**June 2018**	HR are working in partnership with managers in urgent care to develop a campaign, including reviewing adverts and strengthening offers available
Development of bespoke recruitment campaign for CAMHS Crisis & Home Treatment Team	**September 2018**	HR are working in partnership with Service Manager to develop a bespoke recruitment campaign exploring options for preceptorship and rotational posts within Core CAMHS and CAMHS Crisis to support the current difficulties recruiting to Band 6 posts

Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)
June 2018 Update:

Time to Hire has marginally increased above 55 working days KPI at 56 days. Only the Corporate Division met the KPI, this will be addressed within each division and centrally reviewed within the Recruitment Team to ensure learning can be applied. Time to hire will continue to be monitored monthly and reported to PPMB where KPI breaches are identified. Ongoing work linked to the NHSI Retention Programme continues and will be monitored through the revised framework aligned to the Workforce Committee. A draft Workforce Strategy has now been developed and will further support and embed the programme of work.

May 2018 update:

Time to hire has shown a further improvement in April 2018 and is now reported below KPI at 51 days. All Divisions are below KPI for April 2018. Time to hire will continue to be monitored monthly and reported to PPMB where KPI breaches are identified. Ongoing work linked to the NHSI Retention Programme continues. Revised TOR for Workforce Committee are currently being finalised to ensure the committee has an appropriate framework for monitoring delivery of the Workforce Strategy.

April 2018 update:

Time to hire continues to show improvement, , however remains slightly above the KPI for March 2018 at 56 working days. LD & MH Divisions have achieved compliance against the KPI in March 2018. With the implementation of the Performance and Programme Management Board (PPMB) approach, recovery plans are prepared where Divisions exceed the time to hire and vacancy rate KPIs to ensure a targeted approach to improve recruitment and retention. Risk reviewed in the absence of TCT. TOR for Workforce Committee and planning process being revised throughout Q1 2018/19

March 2018 update:
Time to hire has shown a continued improvement, however remains above the KPI of 55 days. With the implementation of the Performance and Programme Management Board (PPMB) approach, recovery plans are prepared where Divisions exceed the time to hire and vacancy rate KPIs to ensure a targeted approach to improve recruitment and retention. Risk reviewed in the absence of TCT. TOR for Workforce Committee and planning process being revised throughout Q1 2018/19

Recruitment and Selection training was delivered to managers during September 2017 to support further reductions in time to hire. In addition, the Trust continues to ensure regular attendance at recruitment fairs to widen the pool of potential applicants. Joint work programme continues through MERIT. The Staff satisfaction survey results for 2017 have been submitted and results will be available for comparison in January. Scheduled review of action plan in relation to recruitment is due to take place within the next quarter. The Internal audit review has been linked to Time to Hire was completed, compliance to this KPI has improved with a revised KPI to 11 weeks or 55 WDs.

Strategic Objective	Attract and retain a well-trained, diverse, flexible, empowered and valued workforce.				
Delivery Objective	Improve the Health and Wellbeing of all Staff.				
Associated 2018/19 Key Risks	Workforce				
Risk Description	If we do not ensure that staff are engaged, supported and whose health and wellbeing is maintained, then there is a risk that this will impact on the quality and financial/performance goals of the Organisation.				
Risk ID8 – Datix 332	Executive Lead: Judy Griffiths	Main Manager: Michelle Heeley , Jenni Carr-Smith			
Controls:	Vacancy control procedures HR strategies and policies Managing attendance policy Sickness/absence reports through line management, performance meetings and Trust Board Occupational Health Service Health & Well Being Strategy in place including the Intranet Page Gateways process Annual feedback report from Staff Support Service	Bank and agency staff management Workforce Committee HR Business Partnership work Staff support Service Staff survey action plan Leaver questionnaire			
Gaps in controls:	Starter questionnaires : measures	Predictability & planning of future workforce			
Assurances:	Reports to Quality & Safety Committee (Two Monthly) HR Business Partners monitor and review action plan Internal Audit reviews (2016) Balance score card Occupational Health Service bi-monthly meeting	Reports to Board of Directors (Monthly) ESR – Manager self-service for sickness Internal Audit 2017 Performance report to Board Annual report from staff support			
Gaps in Assurances:	Limited evidence of deliveries against yearly staff survey results				
Internal Audit Assurance Reviews:	Sickness Absence management audit completed April 2017 to be repeated between April and June 2018		**Date Added: October 2014**	**Next Review Date: 30th July 2018**	
	Likelihood	**Consequence**	**Risk Rating**	**Progress**	**Rating History**
Initial Risk Rating	4 (Likely)	4 (Major)	16	◀▶	▼
Current Risk Rating	4 (Likely)	3 (Moderate)	**12**		
Target Risk Rating	4 (Likely)	3 (Moderate)	**12**		

Committee where Risk is Monitored:	Quality and Safety Committee

Actions

Action	Due Date	Progress Update at Quarter
Review of sickness absence management policy	**31st Mar 2017**	Completed - revised policy to be considered
Strategy/action plan to improve the Health and Wellbeing of staff being fully implemented	**30th Apr 2017**	Completed - Strategy in place with board report submission in July
Submission of bid to Sport England for £10,000 to support staff health and wellbeing initiatives	**30th Nov 2017**	Completed – Contract to be finalised with Sport England. Successfully won bid - plan to be set up to implement wellbeing initiatives
Report on access to Staff Support Services and Occupational Health Services aligned to Health and Wellbeing of staff at band level	**31st Dec 2017**	Completed – There is now an annual report provided by Staff Support Services which includes feedback on all contacts and activity. Occupational Health Service also meets at least bi-monthly to discuss any operational issues – this is monitored by BCPFT as they are an external provider.
Delivery of HR Toolkit training for sickness absence and staff health and wellbeing	**31st March 2018**	Completed – training developed and dates set throughout 2018. First session being delivered in April 2018
Review of Sickness Policy	**31st May 2018**	Revisions to existing policy made with staff side consideration in May 2018
Implement HR strategy with key focus on recruitment and retention and staff health and wellbeing	**31st July 2018**	1st Draft being presenting to workforce committee in July 2018
Review of the Occupational Health(OH) Service Provision and options to work in partnership with DWMH	**31st Sept 2018**	Current contract has been extended until March 2019, full procurement planned for completion April 2019.
H&WB communication strategy and branding to be developed to support staff in understanding what the Trust offers to improve their H&WB	**30th Sept 2018**	H&WB Steering Group reinstated with effect from May 2018, proposals to be discussed and then

		presented to Workforce Committee for approval

Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)
June 2018 Update:

Sickness Absence whilst marginally increased remains just above KPI at 4.95%, each division will be monitoring both long and short term absences with the HR Management Toolkit continuing to be rolled out for managers to access. Health and wellbeing Steering Group met in May 2018 with positive work undertaken regarding plans for staffs' financial wellbeing, this will be reviewed and presented to the Workforce Committee. The overarching action plan will be reviewed in June 2018 linked to the draft Workforce Strategy proposal

May 2018 Update:

Sickness has shown a further decrease as at the end of April 2018, with overall Trust sickness totalling 4.11% against a KPI of 4.5%. Sickness absence and staff health and wellbeing continue to be a focus and are supported by the newly developed HR toolkit training delivered monthly from April 2018 onwards. The Health and Wellbeing Steering Group has been reinstated with effect from May 2018 with significant work planned linked to improving staff health and wellbeing, including the development of a communication plan and branding. The health and wellbeing action plan will be refreshed by the Steering Group and delivery will be monitored through Workforce Committee.

April 2018 Update:
Sickness has shown a significant decrease in March 2018 with overall Trust sickness totalling 4.69% against a KPI of 4.5%. There is still a key focus on sickness absence and staff health and wellbeing, with HR toolkit training launched in April 2018 which will support managers with sickness absence management and improving staff health and wellbeing. This training will provide targeted support in relation to staff mental health and wellbeing as this continues to be the main reason for long-term sickness.
March 2018 Update:
Senior HR team revisiting the provision of OH going forward and aligned to revised strategy with the risk reviewed in full to account for the additional actions not implemented in the absence of TCT. A significant amount of work has been undertaken across the Trust in respect of Staff Health and Wellbeing in order to continue to progress the implementation of the Health and Wellbeing Strategy. The Health and Wellbeing Group continues to take place on a bi-monthly basis with management, clinical and staff side attendance to ensure that the programme of work maintains pace. Various initiatives are being offered across the Trust to support staff in improving their health and wellbeing, including physical exercise classes, staff support workshops and health eating campaigns. Further work continues to expand the range of initiatives available to staff. There is now an annual report provided by Staff Support Services which includes feedback on all contacts and activity. Occupational Health Service also meets at least bi-monthly to discuss any operational issues – this is monitored by BCPFT as they are an external provider. This closes the gap previously identified in controls.

Strategic Objective	Resources will be used effectively, innovatively and in a sustainable manner.		
Delivery Objective	Clinically led sustainable strategies for Mental Health, Learning Disabilities and Children's Services to develop overarching Trust long term plan.		
Associated 2018/19 Key Risks	Changing Environment		
Risk Description	If we are unable to innovate and develop sustainable strategies for each Division it will lead to a break up of Trust services, and a risk to the future delivery of quality specialist mental health and learning disability services in the future		
Risk ID9 – Datix 211	Executive Lead: Jo Cadman	Main Manager: Jo Treacy	
Controls:	Financial Plan Service Delivery Plans to monitor performance at team level Standing Financial Instructions Financial governance arrangements Cost Improvement Programme performance reporting Budgetary Control policy Good ideas process established Identify additional business opportunities Service Line Management Quality Impact Assessments	Operational Plan Workshops to identify potential schemes Scheme of Delegation Financial procedures Annual budget and plan Enhanced Project Management Office Use of balance sheet flexibilities to address shortfall Regular review of downside scenario plans Operational and Clinical ownership Performance reporting	
Gaps in controls:	Plans to deliver CIP recurrently Strategic Trust wide transformational continuous improvement approach to longer term efficiency plans		
Assurances:	Reports to Finance & Investment Committee (Monthly) Reports to Board(Monthly) Reports to Executive Committee (Monthly) Monitor investigation (Apr 2016)	CQC Inspection (October 2016) Internal Audit review (2017)	
Gaps in Assurances:	Lack of quality benchmarking and comparative data Benefits realisation, return on investment (ROI)		
Internal Audit Assurance Reviews:	In the 17-18 Internal Audit Plan	**Date Added: April 2014**	**Next Review Date: 30th July 2018**

	Likelihood	Consequence	Risk Rating	Progress	Rating History
Initial Risk Rating	4 (Likely)	4 (Major)	**16**	◀▶	◀▶
Current Risk Rating	4 (Likely)	4 (Major)	**16**		
Target Risk Rating	2 (Unlikely)	4 (Major)	**8**		
Committee where Risk is Monitored:		Finance and Investment Committee			

Actions

Action	Due Date	Progress Update at Quarter
Establish new Gateway process for determining CIP's	**1st Apr 2017**	Completed – Gateway process in now live for all Divisions
Implement early planning process to develop plans for 2018/19 and beyond	**30th Sep 2017**	Completed - Gateway 1 dates in place planned to take place during October and November, significant planning jointly between Ops and PMO.
Identification of additional business opportunities	**1st Oct 2017**	Completed – agreed process to review, capture and manage new business opportunities – assessed for strategic, operational and financial fit for approval through EMF to commit resources to explore further; Reports to management board and other committees to provide an opportunity for operational/corporate leads to identify further opportunities
Benchmarking to generate future ideas	**30th April 2018**	On-going – strengthen business partnering approach from PMO team regularly reviewing benchmarking data to identify opportunities for working differently
Good ideas approach to be expanded	**30th April 2018**	Completed –PMO teams will meet in Oct/Nov to plan forward consistent strategy (see below). Launched and plan to refocus based in quality improvement Reinvigorate good ideas approach through development of workshops, drop ins and business partnering with Divisions (including Corporate areas)

Strengthen reporting and process to focus on recurrent schemes	**1st Nov 2017**	Completed – significant efforts to align Directors perspectives and agree approach (i.e. financial reporting aligned to PMO and Ops understanding). Fortnightly meetings will support this agreed approach. Amended reporting to focus on recurrent schemes as key to adjust the culture.
Gateway 1 panels to be completed	**20th Nov 2017**	Completed - Gateway 1 panels have taken place in Nov/Dec 17.
Challenge recurring CIPS	**20th Nov 2017**	Completed for 17/18 -until recurrent schemes are fully in place the Gateway panels will continue to challenge for recurrent delivery. The panel will need to consider an alternative plan if Divisions are unable to identify sufficient opportunities. Additional challenge in ops to transfer non-recurrent schemes to recurrent where possible
Reporting & monitoring process to be reviewed and strengthened to replace Aspyre system	**30th April 2018**	Ongoing- Team review underway & priorities to be aligned d process within 6 weeks.
Agree strategy to strengthen the quality improvement approach to deliver efficiencies	**30th April 2018**	Explore opportunities to strengthen the clinical ownership of ideas. Share Mersey Care approach with schemes led by Medical Director. Explore how ownership can be shared & supported across all Executive team. Develop programme of transformation sessions to consider innovative ideas; Develop communication programme to support; Agree sessions at Leadership for Quality events
Gateway 2 & 3 panels to be arranged for the 2018/19 cycle of business	**31st Mar 2018**	Completed- All Gateway II panels have been rearranged during March; Sessions will be scheduled in full for next financial year.
Maintain close management of the financial position to identify key variance drivers and enable managers to take remedial	**30th Mar 2018**	Completed for 17/18 -CIPs to be identified and removed at budget Simplify the process and provide greater assurance on delivery in year and more opportunity to develop transformational schemes during the financial year rather than trying to convert non-recurrent

		Schemes to recurrent schemes.
Use of independent review to identify detailed transformational plans	**30th Mar 2018**	Completed - Newton Europe have completed an opportunity assessment across the Mental Health services and presented the findings at EMF and Management Board during December 17. The Mental Health Division are in the process of developing business case to transform and redesign the Mental Health services supported by Newton Europe. Newton Europe are also in dialogue with DWMHT re: completing an opportunity assessment which will support the development and delivery of the Mental Health work stream plan.
Challenge recurring CIPS	**30th June 2018 (& on-going**	Currently there is only a small % of CIPs planned for recurrent delivery. Gateway panels & PMO business partners continue to challenge, and will continue to do so until the full balance is identified recurrently. Director of Strategy; Associate Director of Transformation; Director of Finance and Director of Operations meet regularly to review, assess and determine next plans to address.
Maintain close management of the financial position to identify key variance drivers and enable managers to take remedial action action	**Monthly review30th Mar 2018**	PMO & Finance partners review and assess the opportunities Director of Finance, Director of Strategy & Director of Operations meet regularly to review and assess the position

Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)

April 2018 update:

Gateway 2 panels have taken place in March for all clinical divisions and 18/19 CIP schemes have been presented to panel. A corporate Gateway panel is scheduled for 27th April 2018. There is still a clear gap in recurrent plans and this will remain a key priority for April and May.

A full gateway panel schedule has been developed and Gateway panels are scheduled for the remainder of the 18/19 financial year. Gateway and PMO documentation is being reviewed along with the reporting and monitoring process for 18/19.

March 2018 Update – Gateway 2 panels have been completed and the remainder planned weekly during March due to the transfer to BCPFT only panels. There is still a clear gap in recurrent plans will be a key priority for March and April.
Newton Europe have completed an opportunity assessment across the Mental Health services and presented the findings at EMF and Management Board during December 17

There has been significant work on strengthening the approach to delivery of recurrent CIPs – reporting has been amended to support the change in culture to consider only recurrent schemes as viable, whilst contingency may be supported through non-recurrent actions. Gateway panels have encouraged CIPs to be owned by all Executive Directors, a shift to be led by clinical leaders should be encouraged and will be developed as we move forward through TCT.

Whilst there has been significant work in strengthening the recurrent approach to CIP delivery there continue to be gaps in the proportion of schemes that are delivered recurrently, The recent dissolution of TCT has caused a delay in the development of recurrent plans for BCPFT in isolation as a number of schemes were predicated on the benefits of working in partnership. Alternative approaches are now being developed, however, this will have invariably resulted in a delay to delivery during 2018/19. There are still further opportunities to develop schemes in partnership, particularly building on the work developed with Dudley & Walsall Mental Health Partnership Trust for Mental Health services and alternative back-office schemes.

December/ January – Gateway 1 panels completed

Strategic Objective	Resources will be used effectively, innovatively and in a sustainable manner.				
Delivery Objective	Ensure the funding for each service line is sufficient to cover the costs of delivering against the service specification				
Associated 2018/19 Key Risk	Financial and Clinical Sustainability				
Risk Description	If we are unable to describe the specification of services provided and link to commissioner objectives or fail to measure against these specification in line with the management of SLR, we risk poor decision making and risk being unstainable.				
Risk ID10 – Datix 685	Executive Lead: Paul Assinder	Main Manager: Hywel Morris			
Controls:	Monthly reporting to divisions on contract targets Activity Working Group Data warehouse and information reporting tool (i.e. Business Objects).				
Gaps in controls:	Proactive and regular reporting of data quality to divisional teams Automated performance management tool Standardised data recording, calculating and reporting via a data warehouse and information reporting tool No automated performance management tool to enhance current warehouse and reporting tool to assist with the standardised data recording and reporting.				
Assurances:	Data Quality policy audit Activity Working Group Standing operating procedures for recording if patient information within timelines , completeness and accuracy IG Steering Group Engagement with Newton Europe to scope efficiency opportunity in key areas of the business.				
Gaps in Assurances:	Benchmarking data, benefits realisation – ROI Trust wide strategic transformational approach to measure performance				
Internal Audit Assurance Reviews:	None planned		**Date Added: April 2017**	**Next Review Date: 30th July 2018**	
	Likelihood	**Consequence**	**Risk Rating**	**Progress**	**Rating History**
Initial Risk Rating	4(Likely)	4(Major)	**16**	◀▶	◀▶
Current Risk Rating	4(Likely)	4(Major)	**16**		
Target Risk Rating	3(Possible)	4(Major)	**12**		
Committee where Risk is Monitored:		Finance and Investment Committee			

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Actions		
Action	**Due Date**	**Progress Update at Quarter**
Ensure KPI definitions and performance against them is understood across services.	**30th April 2018**	Complete- Meetings with Executive Directors and divisional directors to review Trust and divisional scorecards for 2018/19 have been undertaken. Definitions, targets and trajectories are being agreed in preparation for reporting April data. Month 1 Trust and Divisional scorecards have been published together with an explainer document detailing definitions.
Develop DQ action plan to address areas of improvement and consult within working group	**30th June 2018**	Members of Activity Working Group have been requested to list quality issues for inclusion in the 2018/19 DQ Action Plan
Scope data warehouse development	**30th July 2018**	Meetings have taken place between Business Intelligence, IT Development and Dudley & Walsall Mental Health Trust as part of the joint PAS migration project.
Scope use of performance tool	**30th December**	Initial meetings have been organised between Business Intelligence and IT Development to discuss possible solutions. New Data Warehouse needs to progress initially. linked into the delivery of the IT Strategy

Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)
June 2018 Update

KPI definition and explainer documented presented and accepted by May Board, DQ action plan remains on plan and the recommendations for data warehouse development are due to be discussed at the EPR programme Board in July.

May 2018 Update:
Month 1 Trust and Divisional scorecards have been published together with an explainer document detailing definitions.

March/April 2018 Update:
The above actions have been revised in light of the decision not to progress with TCT. Plans to reduce the risk will develop as the strategic direction of the Trust becomes clearer.

Strategic Objective	We will be a leading provider of specialist mental health, learning disability and children's services, proactively seeking opportunities to develop our services building partnerships with others, to strengthen and expand the services we provide		
Delivery Objective	Strengthen Stakeholder engagement and develop partnerships that improve clinical and financial sustainability.		
Associated 2018/19 Key Risk	Changing Environment		
Risk Description	If we do not effectively engage our stakeholders we will damage our reputation and miss opportunities to maintain and strengthen our market share; and risk damage to the quality of services offered from working across care pathways with partners.		
Risk ID11 – Datix 648	Executive Lead: Jo Cadman	Main Manager: Jo Cadman	
Controls:	Strategic Programme reports at Board and management board Executive lead role across localities and planned meeting attendance at all levels Attendance at Dudley Partnership Board Engagement in Dudley MCP procurement exercise Dudley CCG have committed to initial sub-contracting of LD services to maintain BCPFT economy of scale Agreement of MERIT continuation and reporting through Strategic Programme reports Executive Director attendance at MERIT Steering Group Board CEO and Medical Director. Executive Director attendance at Wolverhampton and Sandwell Health & Wellbeing Boards Development of collaborative arrangement with DWMH with full Executive team involvement		
Gaps in controls:	Stakeholder map in development (link to stakeholder strategy currently in development) No proactive engagement with voluntary sector No proactive engagement with Walsall system		
Assurances:	Reports to Board of Directors,(Monthly) Executive Committee and Finance & Investment committee (Monthly) Deloitte's MCP Risk Review (Q4 16/17)		
Gaps in Assurances:	No identified gaps at this time		
Internal Audit Assurance Reviews:	Agreed – date tbc	**Date Added: June 2015**	**Next Review Date: 30th July 2018**

	Likelihood	Consequence	Risk Rating	Progress	Rating History
Initial Risk Rating	4 (Likely)	4 (Major)	**16**	◀▶	◀▶
Current Risk Rating	4 (Likely)	4 (Major)	**16**		
Target Risk Rating	3 (Possible)	4 (Major)	**12**		
Committee where Risk is Monitored:		Board of Directors			

Actions

Action	Due Date	Progress Update at Quarter
Strategy for approach to MCP to be agreed by Board	**30th Jun 2017**	Completed - Board of Directors have approved a strategic partnership response to PQQ with Primary Care and Dudley Group of Hospitals. Board have agreed that at PQQ stage BCPFT interest will be that of a sub-contractor to BCHC.
	30th April 2018	BCPFT agreed at Board – Dudley Group are lead provider with DWMH and BCPFT as sub-contractors. BCPFT fully engaged as key partner (Note delays likely for contract roll out date to October 2019 at the earliest)
Local project team to be established to develop Trust Strategy for Dudley MCP response.	**30th Jun 2017**	Completed - Project team established, with BCHC as lead across MCP partnership.
Stakeholder engagement plan to be developed	**30th Jun 2018**	Stakeholder mapping taking place, and strategy for each stakeholder will be developed accordingly
Tender Websites regularly checked to keep appraised of any procurement opportunities	**30th Jun 2018**	Re introduced process in PMO and reporting agreed through Executive Committee, Chief Executive Team Meeting (if more timely decision required), and Finance & Investment Committee

Updated value proposition to Board (March 1st 2017)	**30th Jun 2017**	Completed
Develop an internal MERIT group - A steering group with membership partners developed to manage the MERIT programme	**30th Jun 2017**	Completed - Meetings planned with Dudley & Walsall Executives and Program Director for Walsall
Consolidated reporting of strategic programmes to Management Board / Executive Committee	**30th June 2018**	Completed – reports provided to Executive Committee on a Monthly basis Reports in place – first full Executive Committee meeting to be held in June 2018, verbal updates provided at May meeting
Develop and agree approach to Wolverhampton Integrated Care Alliance identified at Wolverhampton Health and Wellbeing Board on 18th October 2017	**30th Jan 2018**	Completed – governance process in place and key leads identified at governance and clinical groups to ensure influence and engagement. Meetings now attended by appropriate personnel monthly and reported back through Executive Committee
Development of DWMH collaboration plan	**31st July 2018**	In Progress – significant engagement to date through Exec to Exec sessions (x2); CEO/Chair sessions; Board to Board session in June

Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)
June 2018 Update:
Following the dissolution of TCT there has been a period of regaining stability ensuring that effective strategic relationships are maintained across the Black Country. There are lead individuals identified for all formal strategic relationships, whilst more informal and engagement strategies continue to be refreshed and reinvigorated. These are reported to Executive Committee for a full leadership engagement opportunity to ensure that representatives are fully informed and therefore minimise the risk and maximise the opportunity for BCPFT.

There has been significant effort in enhancing and developing relationships with DWMH to build on the work from TCT, which should see a clearer plan for strengthening collaboration across the Black Country developed by the end of June, for further discussion at Board.

March /April 2018 Update:
The dissolution of TCT has had a significant impact on all strategic plans, and therefore there is significant work to complete over the coming months to ensure that BCPFT has a sustainable strategy moving forward.

Key actions to develop the strategy are as follows:

- Complete stakeholder mapping exercise and identify effective strategies to ensure BCPFT is engaged at the appropriate level with all current and potential strategic partners, this will include planned representation and deputies at all key strategic forums
- Refresh of strategic priorities has taken place, which will feed into the Board strategy day on 28th March 2018
- Regular sharing and updating of information regarding strategic partnerships to ensure considered in local Divisional strategies & plans
- Strategic updates will be provided to Executive Committee monthly

Strategic Objective	Resources will be used effectively, innovatively and in a sustainable manner.				
Delivery Objective	Clinically led sustainable strategies for Mental Health, Learning Disabilities and Children's Services to develop overarching Trust long term plan				
Associated 2018/19 Key Risk	Financial and Clinical Sustainability				
Risk Description	If the Trust cannot generate surplus cash it will be unsustainable and risk the delivery of quality services.				
Risk ID12 – Datix 442	Executive Lead: Paul Assinder	Main Manager: Angus Hughes			
Controls:	Financial Plan Standing Financial Instructions Financial governance arrangements Cash flow monitoring Debtor management Annual budget and plan Monthly Cash Meetings Service Delivery Plans to monitor performance at team level Workshops to identify potential schemes Cost Improvement Programme performance reporting Use of balance sheet flexibilities to address shortfall	Operational Plan Budgetary Control policy Financial procedures Scheme of Delegation Creditor management Capital programme management Regular review of downside scenario plans Identify additional business opportunities Good ideas process established Enhanced Project Management Office			
Gaps in controls:	Cash draw down/Loan Facility Agreed capital plan for dealing with identified clinical risk estates issues	CIP gap and underperformance analysis			
Assurances:	Reports to Finance & Investment Committee (Monthly) Reports to Board (Monthly) Monitor investigation (Apr 2016) Internal Audit reviews (2017 and 2018) Working Capital Review- Grant Thornton (June 2017)	Quarterly NHSI Updates (October 2017) Established Capital Review Group (April 2017) CQC Inspection (October 2016) External Audit opinion (May 2017) NHSI support confirmed following TCT termination (27th February 2018)			
Gaps in Assurances:	Planned internal assurance review and benchmarking data				
Internal Audit Assurance Reviews:	None Planned	**Date Added: June 2015**	**Next Review Date: 30th July 2018**		
	Likelihood	**Consequence**	**Risk Rating**	**Progress**	**Rating History**
Initial Risk Rating	4 (Likely)	4 (Major)	**16**	◀▶	◀▶
Current Risk Rating	3 (Possible)	4 (Major)	**12**		
Target Risk Rating	3 (Possible)	3 (Moderate)	**9**		

Committee where Risk is Monitored:	**Finance and Investment Committee**

Actions		
Action	**Due Date**	**Progress Update at Quarter**
Establish new Gateway process for determining CIP's	**1st April 2017**	Completed - in effect
Manage payments to creditors. Ensure all payments within reasonable timeframes within available cash balances. Identify additional business opportunities.	**31st Oct 2017**	Completed - Statement reconciliations are regularly completed. No immediate cash pressures.
Implemented daily cash forecasting on 12 month rolling basis	**31st Oct 2017**	Completed and ongoing
Fortnightly cash meetings- monthly grip and control	**31st Oct 2017**	Completed and ongoing - Review of accounts payable and credit control processes and actions
Potential intercompany loan through business case with providers being considered	**31st Oct 2017**	Completed and ongoing - Current Modelling suggests cash flow can be managed until merger completes
Proactive discussions with key stakeholders on cash management arrangements, and establishment of loan facility	**31st Oct 2017**	Completed and ongoing - Current Modelling suggests cash flow can be managed until merger completes
CIP and Income risks under review	**30th Mar 2018**	Completed - CIP risks constantly reviewed
Benchmarking submissions made, waiting report generation.	**30th Mar 2018**	Completed - Benchmarking returns allow us to compare our payment profiling against sector comparatives. At this point in time the Trust is effectively managing it's working capital through effective credit control and management of supplier payments
Maintain close management of the financial position to identify key variance drivers and enable managers to take remedial action.	**30th Mar 2018**	Current modelling suggests cashflow can be managed positively until merger completes
Maintain Grip and control measures.	**30th Mar 2018**	Completed and ongoing - Current modelling suggests cashflow can be managed positively until merger completes
Use of Benchmarking analysis to determine potential CIP areas	**30th Mar 2018**	Completed - Benchmarking analysis undertaken for all transformational plans
Continued drive to identify and implement CIP's	**30th Mar 2018**	CIP Program encourages team to take local ownership

2017/18 Annual plan being developed with revised CIP targets for each budget area	**30th Mar 2018**	Completed and ongoing - Draft plan produced, CIP for each area agreed
Annual plan being developed with revised CIP targets for each budget area	**30th Mar 2018**	Completed and ongoing - Financial plans for 17/18, assumed non-recurrent vacancy savings to mitigate effect of unidentified CIP schemes
2018/19 Annual plan submitted with reported deficit, revised CIP targets and projected cash drawdown plan	**31st March 2019**	Financial performance will be reported monthly to F&I Committee and monitored against the plan. Regular interface with NHSI will ensure that liquidity and performance is constantly reviewed and supported.

Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)

June 2018 Update:
An application for funding from NHSI has been made in June for receipt in July. At this point in time current forecasts indicate £800k will be applied for. This can be reduced prior to the actual receipt in July subject to current cash forecasts at that point in time. However, there continues to be a potential key risk that further cash funding may be required if specific material uncertainties arise (settlement of the LGPS exit fee – potential risk of £3.7m cash – timing and repayment terms not yet known).

May 2018 Update:
The final 2018/19 annual plan submission plans for cash support from July 2018 based on the final year end out-turn. A drawdown of c.£2.1m will be required to fund the full 2018/19 financial year whilst complying with the £1m minimum cash balance limit. However, there is a potential key risk that cash funding may be required earlier if specific material uncertainties arise (settlement of the LGPS exit fee – potential sirk of £3.7m cash outflow in Q1).

April 2018 Update
The 2018/19 annual plan submission now plans for cash support with effect from September 2018. A drawdown of c.£1.3m will be sufficient to fund the full 2018/19 financial year. However, there is a potential key risk that cash funding may be required earlier if specific material uncertainties arise (settlement of the LGPS exit fee – potential risk of £3.7m cash outflow in Q1).

March 2018 Update:

The Trust has been notified by NHSI that it will make cash borrowing available during 2018/19

Cash balances are reasonably stable and improved working capital management ensure that cash outflows are matched against inflows. Essential cash payments are made as required ensuring business as usual continues. Developed relationships with suppliers and improved confidence in the purchase ledger function.

Weekly payment runs continue to be monitored making sure that essential payments are made. Daily cash flow monitoring and forecasting ensures that projected cash outflows are sufficient to meet liabilities.

December/ January - Cash balances continue to exceed plan and whilst the Trust will end up in a favourable cash position at year end, the prolonged delay of TCT increases the risk to the continued financial sustainability of BCP. There is a cash opportunity for the Trust to benefit from an allocation of the NHSI STF for every £ improvement against the plan. Should the TCT delay extend into 2018/19 then the Trust will need to commence discussions with NHSI to source additional cash funding in Quarter 1 of the next financial year.

Owing to the delay in TCT and unkown transaction date, the risk is increased due to the fact that BCPFT will continue to report a deficit and hence reduce the cash balance it holds. The current expectation is that the Trust will run out of cash at the beginning of quarter 3 (October), and will be required to drawdown a revolving working capital facility with NHSI. Discussions with NHSI have been held concerning this scenario, and these will continue over the coming months to ensure that the proper controls and procedures are in place to manage the working capital facility as and when it is required. This is currently being considered as part of the annual budget setting process

Strategic Objective	We will nurture a culture which provides :safe, effective, caring, responsive and well led services				
Delivery Objective	Clinically led sustainable strategies for Mental Health, Learning Disabilities and Children's Services to develop overarching Trust long term plan				
Associated 2018/19 Key Risk	Financial and Clinical Sustainability				
Risk Description	If we do not configure and develop our estate in line with emerging clinically led divisional strategies alongside other legal requirements, we risk being unable to support service efficiencies and delivery of strategy.				
Risk ID 14 – Datix 204	Executive Lead: Paul Assinder, Chris Masikane	Main Manager: Sophie Wray			
Controls:	Estate management Tenancy/lease agreements Estate terrier Capital Programme (Annual) Estate representative at Group Management Board Investment & Finance committee agreed to focus capital spend 17/18 on key maintenance areas instead of strategic developments Programme of audits, assets register & management		Service contracts Planned Preventive Maintenance schedule Estate Strategy		
Gaps in controls:	No clinical strategy to influence /define an estates strategy /rationalisation plan Capital funding may be insufficient for requirements				
Assurances:	Reports to Finance & Investment Committee (Monthly) Reports to Quality & Safety Committee (Two Monthly) CQC Inspection (Oct 2016) PLACE visits (Annually)		Reports to Board (Monthly) Internal Audit Board to Ward Visits PLACE Assessments (Annually)		
Gaps in Assurances:	Complex challenge in estate management of "older" infrastructure				
Internal Audit Assurance Reviews:	In the Internal Audit Plan 17-18		**Date Added: April 2014**	**Next Review Date: 30th July 2018**	
	Likelihood	**Consequence**	**Risk Rating**	**Progress**	**Rating History**
Initial Risk Rating	**4 (Likely)**	**4 (Major)**	**16**	◀▶	◀▶
Current Risk Rating	**4 (Likely)**	**4 (Major)**	**16**		
Target Risk Rating	**2 (Likely)**	**4 (Major)**	**8**		
Committee where Risk is Monitored:		Quality and Safety Committee			

Actions		
Action	**Due Date**	**Progress Update at Quarter**
Regular review of capital programme in partnership with clinical and Divisional leads	**30th Jun 2017**	Completed- Capital Programe review continues on a monthly basis
Mock inspections by Board of Directors/KLOE visits	**30th Jun 2017**	Completed- Schedule of Reviews in place
Head of Estates improved links with Divisional management to identify area of risk	**2nd Oct 2017**	Completed- Estates representative at Management Board
Rationalisation of estate as part of Estates Strategy to ensure most effective use of capital	**31st May 2018**	Awaiting Clinical Strategy, to inform a combined estates strategy and associated rationalisation plan, Due date for review post TCT

Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)

June 2018 Update:

Clinical Strategy is still required in order to direct the Estates Strategy and ensure that efficiencies and changes to the estate proposed through the estate strategy does not impact negatively on clinical or operational functions and further matches any forward commissioning intentions.

May 2018 Update:

Clinical Strategy is still required in order to direct the Estates Strategy and ensure that efficiencies and changes to the estate proposed through the estate strategy does not impact negatively on clinical or operational functions and further matches any forward commissioning intentions.

March/April 2018 Update-

Until we have a clinical strategy we are effectively unable to develop a supportive estates strategy. Therefore it is unclear whether we have access to sufficient capital or not. Until we have completed this work, the risk remains that we cannot generate sufficient capital funds internally to maintain our current estate. Trust still generating depreciation and funding maintenance capital spend.

Monthly Capital Review groups to prioritise allocation of Trust Capital funds. Inadequate funds to address the existing estate. Inadequate funds to fully mitigate the estates backlog and clinical risks. However, mitigations are in place to manage risks and the Capital Review Group monitor existing and

collate detail around new risks as they are escalated to the Group.

October - An order has been placed by all three Trusts for an Estates Strategy from an external company. The Clinical strategy will not be initiated until post TCT, as the transaction date has now changed the due date for the actions have also been amended.

December /January- Archus have been commissioned to undertake a combined estates strategy (across TCT). Nifes have been commissioned to undertake a 7 facet survey across the three Trusts. This will provide the Trusts with a greater understanding of the condition of its buildings and opportunities to rationalise (subject to alignment to the new Clinical Strategy).

Strategic Objective	We will nurture a culture which provides :safe, effective, caring, responsive and well led services			
Delivery Objective	Continuous Improvement to build on 'Good' CQC rating			
Associated 2018/19 Key Risk	High Level Risk			
Risk Title	There is a risk that the Trust will fail to meet its statutory/regulatory duties in relation to fire safety due to inadequate estate and a lack of compliant training and that this may result in enforcement action.			
Risk Description	There is a risk that the Trust will fail to meet its statutory and regulatory requirements under the Regulatory Reform (Fire Safety) Order 2005, and associated NHS Guidance regarding fire safety provision due to a variety of estates related issues including damaged fire doors, lack of assurance regarding fire 'compartmentalisation' across the Trust estate portfolio, fire call points in some areas are able to be tampered with by patients leading to fire alarm actuations and lack of assurance regarding fire hydrant provision. The risk is increased due to a lack of attendance on fire safety training by clinical staff, no site-specific fire safety training being in place and a lack of fire drills being carried out within in-patient areas.			
Risk ID 17 – Datix	Executive Lead: Joyce Fletcher	Main Manager: Brenda Tattersall		
Controls:	Estate Management - six monthly inspections of premises including fire doors. Doors which are beyond repair are being prioritised for capital Spend 17/18 and 18/19. Planned Preventive Maintenance schedule shows 100% compliance. Capital Programme to rectify issues on a priority basis. Investment & Finance committee agreed to focus capital spend 17/18 on key maintenance areas instead of strategic developments. Revised Mandatory Face – Face Fire Training to all Trust Staff, Mandatory Fire E- Learning Every other year (Non Clinical Staff). Emergency Routes. Reporting to Management Board			
Gaps in controls:	Capital funding insufficient for requirements. Monies for replacement works that do not meet criteria for Capital Funding. Maintenance and replacement programme not robust. One Fire Trainer across Trust. E-Learning non-compliant with Fire Training for in-patient staff. Staff DNA training. Lack of site-specific fire safety training for in-patient areas. Non adherence to ensuring Emergency Routes are clear (Edward Street & Penn)			
Assurances:	Representative at Group Management Board. Reports to Health & Safety Committee. Escalation reports to Quality & Safety Committee. Board to Ward Visits to include Fire Safety/Training. West Midland Fire Service Inspection. Micad reporting system			
Gaps in Assurances:	Estate maintenance system (Micad) does not provide assurance level required			
Internal Audit Assurance Reviews:			**Date Added: February 2018**	**Next Review Date: 30th July 2018**

	Likelihood	Consequence	Risk Rating	Progress	Rating History
Initial Risk Rating	**4 (Likely)**	**4 (Major)**	**16**	◀▶	◀▶
Current Risk Rating	**4 (Likely)**	**4 (Major)**	**16**		
Target Risk Rating	**2 (Unlikely)**	**4 (Major)**	**8**		
Committee where Risk is Monitored:		Health & Safety Committee and Quality and Safety Steering Group			

Actions		Due Date Progress Update at Quarter
Monthly review of capital programme in partnership with H&S Manager /Fire Officer	30 June 2018 **Monthly**	Members of the CRG are invited to escalate new risks to the group and collectively consider how they should be prioritised against the annual programme.
Mock inspections by Board of Directors/KLOE visits to include Fire Safety / Training	30th September 2018	Meeting being scheduled to discuss how Fire Safety /Training can be incorporated into these visits
Head of Estates and Divisional Management and H&S Manager / Fire Officer to identify area of risk associated with Fire Safety	September 2018	Fire Risk Assessments are completed by the Fire Officer and actioned accordingly. Action plan in place for monitoring via Executive Committee that outlines the areas of high risk.
Compartmentation work to be prioritised and monitored monthly via an Action plan	30th June 2018 **Monthly**	In 2015 the Trust commissioned Nifes to undertake a compartmentation survey of the freehold estate. Capital funds have been identified on a rolling annual programme to address these issues. Funds available to address this are allocated by the Chair of the Capital Review Group and based on risk score against other capital bids.
Face to Face Fire training to be delivered across Trust to all in-patient staff Yearly and every other year to all staff	30th May 2018 Completed	Funding has now been secured for an external trainer to deliver face to face training for all Trust staff. This training has now commenced
Fire Doors – A maintenance and replacement programme to be developed to address the non-compliance to Fire Safety.	30th July 2018	Doors on McArthur to be repaired / replaced.
Ensure all staff within in-patient areas undertake 'site specific' evacuation training	30th August 2018	The Trust Fire Officer will now completed all Fire Specific Evacuation training
Red Routes and Collapse Barriers to be installed to ensure Emergency Routes are kept clear	30th June 2018	Awaiting contractor to start works
Progress: (What is the effect/impact of the actions undertaken in reducing the risk? How is the risk being mitigated – context/narrative)		

June 2018 Update

Fire Action Plan has now been updated and will go to the June Executive Committee
Fire Training remains ongoing delivered by STK. Releasing staff remains an issue but is being monitored.
Awaiting date for WMFS 3 month inspection which will be Trust wide.

May 2018 Update:
McArthur – Fire Doors – Doors have now been ordered and awaiting delivery.
May Management Board meeting was cancelled the Fire Action Plan will now be monitored via the Executive Committee**.**
Funding has now been secured and External Fire training has commenced
We have now received the WMFS recommendations which are being incorporated into the Fire Action Plan. We have not received a date for the scheduled 3 month inspection

April 2018 Update:
Action plan outlining areas of high risk are being presented to Executive Committee in May 2018.

An immediate review of the Trusts Fire Training requirements is being completed and benchmarked. Recommendations/options will be presented for consideration.

WMFS attended 10th 2018 (follow up visit) - Recommendations are being sent to the Trust and a repeat inspection in 3 months of Trust premises.

March 2018 Update:
Action plan outlining areas of high risk being presented to Management Board in April 2018.

Number of staff requiring both Fire Response and Fire Evacuation training is 392, to date 108 (9 Sessions) staff trained in the Fire Response and 62 in the Evacuation training (10 sessions in total).

There are still 181 staff on the register that require the Fire Response training and an further 271 that require the Evacuation training.

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