NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board (business and risk)
Tuesday 25 April 2023 at 9.30am
Large Conference Room, Wellbeing and Development Centre, Fieldhead

AGENDA

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.30	**1. Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
9.31	**2. Declarations of interest**	Chair	**Verbal item**	2	To receive
9.33	**3. Questions from the public** *(received in advance in writing by e:mail to membership@swyt.nhs.uk)*	Chair	**Verbal item**	5	To receive
9.38	**4. Minutes from previous Trust Board meeting held 28 March 2023**	Chair	**Paper**	2	To approve
9.40	**5. Matters arising from previous Trust Board meeting held 28 March 2023 and board action log**	Chair	**Paper**	5	To receive
9.45	**6. Service User / Staff Member / Carer Story**	Chief Operating Officer	**Verbal item**	10	To receive
9.55	**7. Chair's remarks**	Chair	**Verbal item**	3	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.58	**8. Chief Executive's report**	Chief Executive	**Paper**	7	To receive
10.05	**9. Risk and assurance**				
10.05	9.1 Board Assurance Framework	Director of Finance, Estates and Resources	**Paper**	10	To receive
10.15	9.2 Strategic Risks for 2023/24	Director of Finance, Estates and Resources	**Paper**	5	To approve
10.20	9.3 Corporate / organisational risk register	Director of Finance, Estates and Resources	**Paper**	15	To receive
10.35	9.4 Data Security and Protection Toolkit update	Director of Finance, Estates and Resources	**Paper**	5	To approve
10.40	9.5 Draft Annual Governance Statement	Director of Finance, Estates and Resources	**Paper**	5	To receive
10.45	9.6 Executive Champion for Learning Disabilities role	Chief Medical Officer	**Paper**	5	To receive
10.50	9.7 Assurance and approved minutes from Trust Board committees and Members' Council - Collaborative Committee 4 April 2023	Chairs of committees	**Paper**	5	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	- Audit Committee 11 April 2023 - Clinical Governance Clinical Safety Committee 11 April 2023 - Finance, Investment and Performance Committee 17 April 2023				
10.55	*Break*			*10*	
11.05	**10. Performance**				
11.05	10.1 Integrated Performance Report (IPR) month 12 2022/23	Executive Directors	**Paper**	35	To receive
11.40	10.2 Financial and Operational Planning	Director of Finance, Estates and Resources	**Paper**	5	To receive
11.45	10.3 Safer Staffing Report	Chief Nurse and Director of Quality and Professions	**Paper**	5	To receive
11.50	**11. Integrated Care Systems and Partnerships**				
11.50	11.1 South Yorkshire update including and South Yorkshire Integrated Care System (SYICS)	Chief Executive/ Director of Strategy and Change	**Paper**	10	To receive
12.00	11.2 West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Director of Strategy and Change/Director of Provider Development	**Paper**	10	To receive
12.10	11.3 Provider Collaboratives and Alliances	Director of Finance Estates and	**Paper**	10	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		Resources/Director of Provider Development			
12.20	*Break*			*10*	
12.30	**12. Governance**				
12.30	12.1 Compliance with NHS provider licence conditions and code of governance - self-certifications	Director of Finance, Estates and Resources	**Paper**	5	To approve
12.35	12.2 Audit Committee annual report including committee annual reports and terms of reference	Audit Committee Chair	**Paper**	10	To receive
12.45	12.3 Going concern statement	Director of Finance, Estates and Resources	**Paper**	5	To approve
12.50	**13. Strategies and policies**				
12.50	13.1 Strategic objectives, priorities and programmes 2023/24	Director of Strategy and Change	**Paper**	5	To receive
12.55	13.2 Policy on policies	Director of Finance, Estates and Resources	**Paper**	5	To receive
13.00	13.3 Standards of Conduct in Public Service Policy (conflicts of interest)	Director of Finance, Estates and Resources	**Paper**	5	To approve
13.05	**14. Trust Board work programme**	Chair	**Paper**	2	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
13.07	**15. Date of next meeting** The next Trust Board meeting held in public will be held on 27 June 2023	Chair	**Verbal item**	1	To note
13.08	**16. Any other business**	Chair	**Verbal item**	2	To discuss
13.10	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 28 March 2023
Large Conference Room Wellbeing and Development Centre
Fieldhead Hospital

Present:	Marie Burnham (MBu)	Chair
	Mike Ford (MF)	Senior Independent Director
	Mandy Rayner (MR)	Deputy Chair
	Erfana Mahmood (EM) (via MS teams)	Non-Executive Director
		Non-Executive Director
	Natalie McMillan (NM)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	David Webster (DW)	Chief Executive
	Mark Brooks (MBr)	Chief Operating Officer
	Carol Harris (CH)	Director of Finance, Estates and Resources
	Adrian Snarr (AS)	Chief Medical Officer
	Dr.Subha Thiyagesh (ST)	Chief Nurse and Director of Quality and Professions
	Darryl Thompson (DT)	Deputy Chief Executive/Director of Strategy and Change
	Salma Yasmeen (SY) (via MS teams)	
Apologies:	Nil	
In attendance:	Greg Moores (GM)	Chief People Officer
	Sean Rayner (SR	Director of Provider Development
	Andy Lister (AL)	Company Secretary (author)
Apologies:	Julie Williams (JW)	Deputy Director of Corporate Governance
Observers:	Two members of the public	

TB/23/16 Welcome, introduction and apologies (agenda item 1)

The Chair, Marie Burnham (MBu) welcomed everyone to the meeting. There were no apologies noted, and the meeting was deemed to be quorate and could proceed.

MBu outlined the Microsoft Teams meeting protocols and etiquette and reported this meeting was being live streamed for the purpose of inclusivity, to allow members of the public access to the meeting. MBu reported Erfana Mahmood (EM) and Salma Yasmeen (SY) are both joining the meeting today via Microsoft Teams.

MBu informed attendees that the meeting was being recorded for administration purposes, to support minute taking, and once the minutes had been completed the recording would not be retained. Attendees of the meeting were advised they should not record the meeting unless they had been granted authority by the Trust prior to the meeting taking place.

MBu reminded members of the public that there would be an opportunity at item 3 for questions and comments, received in writing.

TB/23/17 Declarations of interest (agenda item 2)

MBu reported the annual declarations of interest process for Board members has taken place as below and asked for any comments from Board members.

Name	Declaration
Chair	
BURNHAM, Marie	Independent Chair of Lancashire Place Chair of NICE Committee for weight management Chair of Pennine Multi Academy Trust
Non-Executive Directors	
FORD, Mike Non-Executive Director Senior Independent Director	Chair of the Joint Audit Committee for the West Yorkshire Combined Authority and West Yorkshire Police
RAYNER, Mandy Non-Executive Director Deputy Chair	Spouse - works for a global not for profit organisation (HIMSS) selling consultancy services to healthcare bodies. Working within the advisory sector as a private consultant for a number of technology organisations who provide technology to the NHS. Any work that may link to the Trust will be declared at the time any future interest arises Director/Owner of "Opinicus" providing IT consultancy to organisation/suppliers in Healthcare.
WEBSTER, David Non-Executive Director	Director and minority shareholder - Horizon Platforms Ltd (Horizon supplies the Trust with powered access) Director and joint-owner - Tango Residential Ltd Non-executive trustee director - The Mast Academy Trust
MAHMOOD, Erfana Non-Executive Director	Non-Executive Director for Riverside Group. Non-Executive Director for Omega / Plexus part of Mears Group. Sister – Employed by Mind in Bradford.
MCMILLAN, Natalie Non-Executive Director	Director/owner of McMillan and Associates Ltd. Associate - NHS Providers
QUAIL, Kate Non-Executive Director	Director of The Lunniagh Partnership Ltd, Health and Care Consultancy. Inclusion North – expert advisor – care (education) and treatment reviews

Name	Declaration
Chief Executive	
BROOKS, Mark Chief Executive	Trustee for Emmaus (Hull & East Riding) Homelessness Charity

Name	Declaration
	Partner member of South Yorkshire Integrated Care Board
Executive Directors	
YASMEEN, Salma Director of Strategy and Change, Deputy Chief Executive	Spouse is employed as head of clinical governance and quality at Leeds and York Partnership NHS Trust Member of the Board of Thirteen (trading name of Thirteen Housing Group) - a charitable Community Benefit Society registered under the Co-operative and Community Benefits Societies Act 2014 with registered number 7522 Advisory board member for School of Business, Huddersfield University
HARRIS, Carol Chief Operating Officer	Spouse works for an engineering consultancy company specialising in healthcare which has involved work with local NHS Trusts including Mid Yorkshire Hospitals NHS Trust.
MOORES, Greg Chief People Officer	No interests declared.
RAYNER, Sean Director of Provider Development	No interests declared.
SNARR, Adrian Director of Finance, Estates and Resources	No interests declared
THIYAGESH, Dr Subha Chief Medical Officer	Spouse is a Hospital Consultant & Clinical Director at CHFT Member of the NHS Clinical entrepreneurship strategic board Honorary Visiting Professor at Huddersfield University
THOMPSON, Darryl Chief Nurse and Director of Quality and Professions	No interests declared.

It was RESOLVED to NOTE the changes to the declarations of interest for 2023-24.

TB/23/18 Questions from the public (agenda item 3)

No questions were received from the public.

TB/23/19 Minutes from previous Trust Board meeting held 31 January 2023 (agenda item 4)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 31 January 2023 as a true and accurate record.

TB/23/20 Matters arising from previous Trust Board meeting held 31 January 2023 and board action log (agenda item 5)

MBu asked for the Board to note all action updates for March 2023.

The Board accepted all action updates, and no further comments were made.

It was RESOLVED to NOTE the updates to the action log and AGREE to close actions recorded within the action log as complete.

TB/23/21 Service User/Staff Member/Carer story (agenda item 6)

Carol Harris (CH) introduced Jacob Agoro (JA), a member of Trust staff who attended the Board meeting to speak about this role in the Jabali men's network.

JA explained he is a matron in Calderdale for inpatient services, the vice chair of the REACH (race, equality and cultural heritage) staff network and an equity guardian for the Trust.

JA explained the Jabali men's network is a group of senior male nurses from Black, Asian and Minority Ethnic (BAME) backgrounds. The network was developed just after the Covid-19 pandemic and has continued to grow since then.

The purpose of the network is to encourage men from BAME backgrounds to join nursing as a career and develop more male nurses into senior roles within the NHS through to Board level.

The group links with various committees and organisations and offers coaching and mentoring opportunities. JA is also a coach and mentor across the Trust.

The group is sponsored by Ruth May, Chief nursing officer at NHS England, and she joins some of the network meetings. The network is also part of the Ethnic Minority advisory collaborative, which is made up of three networks that can support each other and help hold conversations nationally.

JA reported the Jabali men's network has been recognised for the work it has been carrying out and as a result the network was invited to the House of Lords by the deputy leader of the House of Lords, the Rt Hon Earl Howe, to meet with committee colleagues, from local and national areas, to celebrate the work they have done together.

The experiences of members of the network were shared, as well as other people who had contributed to changes in national healthcare. JA reported there was a mother of a disabled child present, who had fought to get the right care for her child and afterwards she had entered the healthcare system to help others, and this was great to hear.

Greg Moores (GM) reported he had seen the network on Twitter and queried if nurses from mental health and acute backgrounds, are equally represented, and if their experiences differed in any way.

JA reported there are more mental health nurses in the network, and experiences are similar across the different areas, but the representation of BAME staff on NHS boards is generally low.. The network is helping to promote this and there are now more chief operating officers and chief nurses from diverse backgrounds.

Mark Brooks (MBr) thanked Jacob for his story and his contributions to the Trust, noting as well as doing an incredibly challenging day job, JA regularly goes above and beyond t and is a huge advocate of the Trust.

MBr queried if JA has seen any initiatives through the network to encourage or promote senior male nurses from diverse backgrounds that could help the Trust.

JA reported he has been speaking with GM to develop coaching and mentoring across the Trust. JA added it is about educating people to know what they are able to achieve and helping and supporting them to reach their goals and potential.

JA reported he has supported a number of staff in this way and believes there is a need to put a system in place that provides this support, rather than it being done on an individual basis.

Nat McMillan (NM) noted the Trust has carried out reciprocal mentoring. NM reported she is keen to be an ally to this work and asked what more can the Board do to help and support this work?

JA stated he doesn't have an exact answer at this time, but he knows organisations are trying, and the Trust has systems in place to support people, and it is now about supporting people to know the opportunities are there.

Dr.Subha Thiyagesh referred to the recent staff survey results and asked JA how his network could help with the experiences of BAME Trust staff, especially in the area of nursing?

JA reported that the same issues are prevalent everywhere and it is especially difficult in mental health. There are conversations in the REACH network and staff need to know something is being done to address issues.

JA reported he is part of RACE forward strategy group and this work is helping him identify issues and to help people approach matters in different ways. Conversations are now taking place on inpatient wards which is helping things to change.

CH noted JA has offered a lot of support to international recruits to the Trust, and queried if there is a link through the Jabali network for international recruits.

JA reported individual organisations are supporting international recruits, and at the moment he isn't aware there is any national work taking place.
JA has linked with Colin Hill, who is part of the team supporting international recruits, so he can link support these colleagues. There are two international nurses who have now developed to band 6 roles and are doing very well. JA reported this helps the Trust to show we are an international organisation, and how we are able to these staff to progress.

MBu noted it is great that these staff are developing within the Trust and this work needs to continue so that it is part of the Trust culture to support these staff to develop.

MF asked how these positive stories get out for staff to hear rather than them being communicated through The View and Headlines.

MBu noted The View is only one tool, and staff such as JA are going on to wards and talking about the work, which is another way how staff will hear the message.

SY reported individual success stories are shared across the organisation, SY stated stories are linked to awareness days or celebration events in the Trust as well as being shared through all Trust communications channels.

DT thanked JA for all of his work, and his contribution to RACE forward meetings.

Salma Yasmeen (SY) thanked JA for his leadership and his continued support of others, while still progressing on his own journey.

It was RESOLVED to NOTE the Staff Member Story and the comments made.

TB/23/22 Chair's remarks (agenda item 7)

MBu reported the following items will be discussed in the private Board session in the afternoon:

- Complex incidents report
- Provider collaboratives
- Draft financial and operational planning
- Draft strategic priorities
- Older people's transformation update.

It was RESOLVED to NOTE the Chair's remarks.

TB/23/23 Chief Executive's report (agenda item 8)

Chief Executive's report

MBr asked to take the report as read and highlighted the following updates:

- Industrial action – MBr asked the board to recognise how much planning and work went into managing safe services during the junior doctors' strike.
- A further junior doctors' strike is proposed for April for four days and planning is in progress for this
- An updated pay offer has been made for agenda for change staff
- High demand, acuity and complexity continue in many of our services. Delayed discharges are having an increased impact on Trust services. The Trusts mental health inpatient services were on operations pressure escalation level (OPEL) 4 for five days, this situation was managed well by operational staff
- Integrated care board colleagues have been given a directive to save 20% of their running costs over the next twelve months, and a further 10% the following year.
- The 2022 staff survey has typically seen a slight improvement from last year. There is a wider extended EMT discussion this week to look at these results and agree next steps.
- Work continues around mental health inpatient quality transformation; we are working with our partners in the wider system
- There was a recent landmark employment tribunal about racial discrimination. It reminds us as a Trust about all the equality, diversity and inclusion work we do, and the importance of giving opportunities to everyone.
- Trust performance is holding steady. We have now seen 2 or 3 months of improvement on some of our focused metrics, which is positive
- On 4 May 2023 we have our staff excellence awards and shortlisting has taken place
- Physical health checks for people with learning disabilities - the Trust has made this a priority as part of our alliance with Barnsley Healthcare Federation. Barnsley is leading the way on this work, and there have been strong improvements in West and South Yorkshire
- EMT timeout recently looked at Board Assurance Framework risks for next year and these will come to April board to agree.

Mandy Rayner (MR) noted the potential impact of the Integrated Care Board (ICB) running costs reduction and queried what the impact may be on the Trust.

Adrian Snarr reported the ICB are starting to plan for it now, the impact will be in the next financial year. They are forming structures with this in view, and there are opportunities as well as risks.

MBr reported Tim Ryley is leading some work for West Yorkshire ICB and there is work taking place in South Yorkshire as well around operating models. The Trust will have the opportunity

to contribute to this work and a paper should come to Board in a few months' time explaining what the changes may mean.

Action: Sean Rayner/Adrian Snarr

KQ queried if the proposed pay deal is being covered by the Treasury?

AS reported NHS trusts were told to plan for a 2% increase, and guidance in respect of the pay award is expected imminently.

GM reported the outcome of the ballet on the pay deal won't be known until the end of April.

It was RESOLVED to NOTE the Chief Executive's report.

TB/23/24 Performance (agenda item 9)

TB/23/24a Integrated performance report Month 11 2022/23 (agenda item 9.1)

AS introduced the summary dashboards and priority programmes:

- There is a tendency for Board to focus on areas of red and amber, but there are also many positive performance indicators in the integrated performance report (IPR) that should be noted.
- Care planning and risk assessments have been fully considered by the executive management team (EMT) and operational management group (OMG) with a view to what is driving these metrics. We have made some changes and are confident as a result, there will be a positive impact seen into the next financial year
- Digital dictation is behind our original plan, but additional capacity has been obtained, and there is now a clear timeline for implementation for next year.
- The Trust is strong on most national indicators. Pediatric audiology and eating disorders have seen a slight decline.
- Out of area beds (OOA) are featuring heavily in financial plans. This is driven by high levels of demand and acuity. The Trust is not achieving the target for this metric and a new trajectory has been set, which still has some challenge in it.
- Financial performance - the Trust expects to achieve its financial plan for this year

Quality

DT gave the following highlights from the report:

- The Trust continues to perform well against its quality indicators
- There are challenges regarding up-to-date risk assessments and sharing of care plans and there is a separate paper in today's Board
- Patient Safety Incident Review Framework (PSIRF) - phase 1 work is complete and the Trust is on track for phase 2
- Friends and Family test results for forensic and community services are on target this month
- The Trust trend for incidents remain stable
- There have been three incidents of prone restraint for three minutes or less, and these have all been subject to review by the reducing restrictive practices and interventions (RRPI) team
- There has been the lowest number of falls this month since June 2022 and the Trust has now employed a new falls coordinator

NM noted the prone restraint incidents and reported there had been appropriate challenge at Clinical Governance and Clinical Safety Committee (CGCS) in respect of these. CGCS will conduct a deeper dive into these incidents, but there are no concerns at this time.

NHSI national Indicators

Already covered in AS's introductory summary

Locality report

CH reported the care group summary section has the performance hot spot areas identified for the month of February. With the exception of child and adolescent mental health services (CAMHS) all care groups are under the 80% threshold for appraisals.
In February there has been a dip in all inpatient areas and the operational management group (OMG) are monitoring this.

With the exception of Barnsley general community services, the information governance training is below threshold.
OMG is taking steps to improve performance against this measure.
Delayed transfers of care across mental health and learning disability services are continuing to increase. The Trust is part of the 100-day discharge work and part of multi-agency discharge arrangements in each of our places.

Sickness levels are over threshold in all areas with particular pressures in mental health inpatient services and forensic services.

There are workforce challenges across the wards due to high sickness levels combined with difficulties in obtaining bank and agency staff. Some good work is taking place in respect of trust wide recruitment.

The junior doctors' strike has been felt across services even though it has been managed extremely well. The measures to manage it are not sustainable in the long term, and there is concern about the next planned strikes due to it being immediately after the easter holidays.

Adult and Older People Services

- Acuity and demand are high
- Demand is above capacity in the single point of access teams in the community setting. We use available resources to make sure people who require an urgent service get one, but this has an impact on routine appointments
- The Trust's perinatal service has been awarded accreditation by the Royal College of Psychiatry perinatal quality network, which is a significant achievement

Barnsley Mental Health Services

- A previous data capture

Barnsley Community Services

- Challenges are being experienced in the neighbourhood nursing workforce due to staff absence and turnover. There are plans in place to recruit into vacancies and manage the risk.
- Despite these pressures the two-hour urgent crisis response time continues to be met and exceeded

Forensics, Learning Disability (LD), Autistic Spectrum Disorder (ASD) and Attention Deficit and Hyperactivity Disorder (ADHD)

- In LD the Horizon centre action plan continues to be monitored by the executive trio, and another quality monitoring visit is planned to take place shortly
- Forensic – there are high levels of acuity and turnover

Child and adolescent mental health services (CAMHS)

- Neurological developmental pathway – waiting times are still a challenge and demand continues to exceed commissioned activity
- Access to specialist inpatient services continues to present a challenge, Red Kite View is experiencing issues with capacity and acuity.

MBu queried delayed transfers of care and if there are any community options available to these clients.

CH explained it is about getting the right onward placement and care. The clients affected tend to have complex needs and the right package isn't available in the community.

MBr reported when the service went to OPEL 4 there were 18 people awaiting a placement at this time.

MR congratulated the Trust on its performance given the very challenging environment. MR queried IG training compliance, and queried if there is a plan.

MBr reported every manager will receive a copy of staff who haven't completed the training and there is a strong message across the Trust to bring this training up to the required level.

MF queried if the March IPR will reflect the Trust's performance across the year or the position in March? MF noted there could be benefits to both views.

AS reported it is dependent on the metric. Some have to be reported annually, but as part of the IPR update we are looking to further use statistical process control (SPC) charts which will reflect annual performance and look at the longer term.

NM asked the Board to acknowledge recognition for the Trust's performance in such a challenging environment. It is remarkable that the Trust continues to mitigate against these issues so that our service users are not affected by external pressures.

Communications, Engagement and Involvement
SY asked to take the paper as read.

Finance and Contracts
AS highlighted the following points:

- Capital expenditure for the year is shown as green, but there is an ambitious level of spend towards the end of the year, which is not unusual for capital programmes..

Workforce
GM highlighted the following points:

- Establishment has grown by 328 full time equivalent (FTE) since April 2022 given service investments. Even in a normal recruitment climate this progress would be difficult to maintain and in the current climate is a significant challenge.
- Employed staff figure - we now employ 140 more staff than at the start of April 2022, noting this is the overall figure of growth. There is slower recruitment and higher turnover into some services such as inpatients, forensics and LD
- We are expecting workforce growth of 3.5% in 2023-24
- There will likely be a strong start to the year, with four assessment centres taking place in April 2023
- There were 70 whole time equivalent (WTE) starters in February 2023 against 38 WTE leavers
- Turnover is slowly reducing; we have the lowest turnover of trusts of our type in both ICSs and the Trust is below the regional average. There are hotspots in LD services (23%) and forensics (16%)
- Sickness has increased from 4.6% to 5.3%
- Staff wellbeing continues to be a focus
- Appraisals, we have seen steady improvement over the last few months
- Statutory and mandatory training, there are some hotspots that are being managed
- Agency is an area of concern, year to date the Trust has spent £8.9m, 4.4% of the pay bill. The agency limit for next year is £7.8m for next year and this will be a key focus from NHSE.

MF asked how the Trust performance on appraisals compares to other trusts in the system? GM agreed to look into this and a report back to Board.

Action: Greg Moores

MF noted there are 944 vacancies, we need more people, this equates to twenty months of new starters, this will be a huge challenge, how will this be managed?

MBr stated this a valid point and the executive team has recognised the Trust needs to re-evaluate its establishment, looking at models of care and new roles. This work will take place over the course of the next year. The Trust has added to its establishment as a result of mental health investment standard (MHIS), and there is now a need to look at cost improvements and establishment.

MBr stated the Board needs an honest conversation about risk appetite. There will be pressure from regulators to reduce agency use and whilst there is a need to use agency staff to maintain safe services.

GM reported safety will always come first, but there is a need to ensure value for money through the agencies the Trust uses.

DW reported Finance, Investment and Performance (FIP) committee have queried where the agency focus group would feed into for oversight and which Board Committee it should report into?

MBr reported the group will report into EMT but there is a question as to where agency should be reviewed at Committee level.

Action: Greg Moores/ Adrian Snarr

MBu summarised by reporting there are some positive indicators in the IPR that demonstrate the commitment and hard work of Trust staff.

NM identified that where the Board has focussed on an area of performance the improvement can be seen.

KQ queried the number of children and young adults on adult wards in the national metrics. KQ stated this metric should be regularly challenged and not accepted as normal. This is a system measure involving multi agencies, and KQ queried if it is the Trust's metric? KQ asked what assurance the Board can get that the system is doing something about it?

CH reported she will need to look at how the Board can receive assurance on this matter.

Action: Carol Harris

MBr reported placing a child onto an adult ward is always the last resort and least worst option. There is a need for the wider system, involving all relevant partners to look at options for the children concerned, as they are not being provided with the right care in the right environment..

It was RESOLVED to NOTE the Integrated Performance Report and COMMENTS made during discussion.

TB/23/25 Risk and Assurance (agenda item 10)

TB/23/25a Serious Incidents Quarterly report (agenda item 10.1)

DT introduced the item and highlighted the following points:

- The report reflects data from the third quarter (Q3)
- The number of incidents recorded is an upward trend, but low or no harm incidents are at 97%, which shows evidence of a strong reporting culture

- Violence and aggression against staff has increased, which indicates high acuity
- Serious incidents did not include any apparent suicides in this quarter
- The report includes serious incidents and the Trust's learning from deaths
- Deaths of patients with a learning disability are reported via the LeDER programme. At the time of the writing of the report 12 cases were pending reporting to LeDER, these have all now been submitted.
- Year to date inpatient deaths: 7 deaths were expected with end of life care in place, 9 were unexpected and resulted from a physical health cause, and 1 is pending information, which will be included in the quarter 4 (Q4) and annual report.

MR noted a reduction of capacity to deal with incidents and investigations.

DT reported this was a temporary situation in the patient safety team which presented short term challenge and this has now been resolved.

MBr asked DT to explain how the data contained in the report is used to help prevent future deaths and learn from incidents.

DT reported all incidents rated as amber or red are reviewed at the clinical risk panel by the executive trio. Any issues related to care are given a proportionate level of investigation. These reviews include any monitoring of staffing issues or incident related to protected characteristics.
All actions from serious incidents investigations are held at care group level and learning events are held after investigations at care group level or Trust wide level if appropriate. Learning events are also held in relation to homicide investigations.
Any incident where there is the opportunity for immediate learning will go out across the Trust as a blue light alert.
National learning is also monitored through various networks and shared across the organisation.

In reference to incidents reported between 01/01/2022 – 31/12/2022 MR noted that Wakefield community have nine incidents, and this seems disproportionate.

DT reported this hasn't been flagged by the team as an outlier and the team are very strong on trend analysis, but DT will check and report back to Board.

Action: Darryl Thompson

MR noted the continued theme of recording keeping in serious incidents.

DT reported the main interface between patients and care is records. Where record keeping is identified as an action from a serious incident, quality of the records is reviewed as well as performance.

MF noted the table (figure 3) in the report reflecting trends in care groups. MF commented it seems hard to compare care groups but noted that any trends in a particular care group could be identified through the weekly risk panel.

DT reported benchmarking between care groups is difficult due to populations and differing service provision by each care group.
DT noted that high incidents in Kirklees have been a topic of previous Board conversations. Sean Rayner (SR) has spoken with Kirklees place and there is a meeting planned between the Trust's patient safety team and Kirklees' patient safety team to establish if the number of incidents is relative to the population.

MF noted the final sentence on page 142 references national reporting and learning and there is a large increase in the number of incidents reported from Q2 to Q3?

DT agreed to confirm if these figures are correct.

Action: Darryl Thompson

Erfana Mahmood (EM) reported each Trust collates serious incident reports differently, and queried how we benchmark properly against other trusts?

DT reported there is the national reporting system STEIS. As we move into the patient safety incident review framework (PSIRF) over the next year trusts will be expected to comply with this nationally.

NM reported CGCS have asked for PSIRF to come to the next non-executive directors' meeting so that all non-executive directors are aware of the content.

Action: Mandy Rayner

ST reported thematic reviews are carried out when trends are identified, such as choking and clozapine issues. When issues arise with particular teams, in addition to learning from incidents, we also look at how well teams are supported when incidents take place.

MBu noted the triangulation work of the executive trio is working well.

CH noted in relation to violence and aggression, there are approximately 12 incidents of violence and aggression against staff a day. The majority of these are in inpatient areas, half in mental health inpatients and the other half between learning disability and forensic services.

KQ noted that people detained under the Mental Health Act are more likely to be violent in their presentation.

MBu noted that following a recent visit to learning disability services, the leadership has changed, and more activities are taking place, which is positive.

It was RESOLVED to RECEIVE the quarterly report.

TB/23/25b Strategic Overview of Business and Associated Risk (agenda item 10.2)

SY introduced the item and asked to take the paper as read:

- The paper was presented to Board in the strategic session in February and has been through a good level of discussion and is presented today for approval.

MF reported he has some questions for SY and will pick these up outside of the meeting.

Action: Mike Ford / Salma Yasmeen

It was RESOLVED to APPROVE the report and confirm it provides the required assurance.

TB/23/25c Review of Risk Appetite Statement (agenda item 10.3)

AS asked for the paper to be taken as read and highlighted the following points:

- The Board had a risk appetite session in January with 360 Assurance, the Trust's internal auditor to consider and updates to our risk appetite and risk categories
- It is presented to Board to approve before being added to the Risk Management Governance Framework

It was RESOLVED to APPROVE the risk appetite statement.

TB/23/25d IPC Board Assurance Framework report (agenda item 10.4)

DT introduced the item and highlighted the following points:

- We would normally present the Trust's compliance with the national infection prevention and control framework (IPC)
- The assistant director of nursing, quality and professions has been part of a national group reviewing the IPC board assurance framework (BAF)
- The outcome is for trusts to await the outcome of this review before reporting on compliance
- The Trust remains compliant with the current IPC BAF and the report flags the renewed timetable for compliance against the new framework

It was RESOLVED to RECEIVE the update.

TB/23/25e Risk Assessment and Care Planning update (agenda item 10.6)

DT introduced the item and highlighted the following points:

- There is a clear process of quality improvement, and this being supported by the integrated change team
- There is a continued focus on the quality and patient experience of care planning and risk assessments.
- Changes in our approach to care planning are showing some improvement recently
- Risk assessments are complex by their nature, and it has been identified that when a service user moves into a different pathway of care, the clock restarts and this is an issue that is being reviewed
- A detailed report will be presented to EMT next month before going to CGCS to identify what learning has taken place and new trajectories
- A driver diagram has been used to give the project a quality improvement approach and will include service user and carer engagement

MBr noted the reason this report has come to Board is this is one of the Trust's priority programmes where the expected progress hasn't been made. The report shows recent progress and improvement in performance and provides assurance to the Board that the scrutiny and oversight is there.

MR acknowledged the fact the work is being co-produced and complimented the report.

EM queried how the improvement work will become embedded?

DT reported the quality improvement approach is designed to deliver improvement over the long term.

A discussion took place regarding how process change will lead to quality change and that the current work taking place will help the Trust set realistic targets and trajectories for the future.

NM noted that care planning and risk assessments are an issue across all mental health trusts. If the Trust is able to find a good outcome from this work, it should be shared with other trusts to help them improve.

It was RESOLVED to receive the update.

TB/23/25f Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 10.6)

Collaborative Committee (CC) 7 February 2023

- The Committee has been reviewing terms of reference and

- Looking at the right balance of committee work between lead/co-ordinating provider and being a provider in other collaboratives

Clinical Governance & Clinical Safety Committee (CGCS) 7 February/ 14 March 2023
Nat McMillan (NM) reported the following:

- The executive trio report is an excellent triangulation report
- Pockets of culture, there are some areas still to improve from quality monitoring visits (QMVs), and there is a link into the people and remuneration committee
- Assurance on QMVs, the committee follow up on actions that arise from visits
- Clinical governance has improved, and reports to committee have improved
- Outstanding work for the accreditation of the perinatal service by the Royal College of Psychiatry

Members' Council 24 February 2023
MBu highlighted the following:

- Members' Council approved the update to the Constitution, Standing Financial Instructions and Scheme of Delegation.
- Members' Council approved their two year objectives from 1 April 2023 until the 31 March 2025.
- Members' Council approved the re-appointment of Non-Executive Directors.
- Members' Council approved the re-appointment of Lead Governor.
- Members' Council received a presentation on the Trust proposal to become a Teaching Hospital.
- Members' Council received the process for the Chair's appraisal in 2023.

Mental Health Act Committee (MHAC) 17 March 2023
KQ asked to take the report as read and highlighted the following:

- The committee has a focus on CAMHS and services into Wetherby Young Offenders Institute (YOI) and Adelbeck
- Section 132 rights compliance has seen considerable improvement through focused work
- Cancellation of section 17 leave has been the subject of focused work and has risen from 30% to 87% compliance

Equality, Inclusion and Involvement Committee (EIIC) 14 March 2023
MBu highlighted the following:

- Assurance - the trust wide strategy and action plans have been delivered for 22/23
- Equality dashboard – progress continues, and we are helping ICS colleagues to capture more data

SY added:

- Equality Delivery System 2 (EDS2) has been submitted as "achieving"
- EDS 23 is a revised approach going forward and will involve people across the organisation
- The committee received a LGBTQ network presentation
- "All of us" artwork is going up across sites and has been co-produced with staff and service users to symbolize inclusion across the Trust
- The committee reviewed the risk in relation to inequalities given the substantial work that has taken place over the last two years
- The way the Trust is using data and insight to reduce inequalities is positive and the Trust has been invited by NHSE to be a case study for the national inequalities programme

Finance, Investment & Performance (FIP) Committee 20 March 2023
DW highlighted the following from the March meeting:

- The 23/24 plan was approved, and it is a stretching plan including cost improvements with agency and OOA beds being the focus for 23/24

MF noted the Bank of England rates have crossed the threshold for different routes for savings. Audit committee receives a quarterly report on treasury and noted FIP holds responsibility for investment.

AS reported audit committee is responsible for treasury investment decisions, FIP oversees the plan and looks at how it is maximised.

MF to speak to AS outside of the meeting to discuss committee duties in relation to investment of Trust monies.

Action: Adrian Snarr

People and Remuneration Committee 21 March 2023

NM highlighted the following:

- The annual workforce equity report and the freedom to speak up annual report have been rescheduled, there is no associated risk
- Discussion about appraisals and the improvement work taking place
- Agency improvement work
- Workforce metrics in the IPR are starting to improve
- High level results of the staff survey were also received

It was RESOLVED to RECEIVE the assurance from the committees and Members' Council and RECEIVE the minutes as indicated.

TB/23/26 Integrated Care Systems and Partnerships (agenda item 11)

TB/23/26a South Yorkshire updated including South Yorkshire Integrated Care System (SYBICS) (agenda item 11.1)

MBr asked to take the paper as read and highlighted the following points:

- Operational pressures have eased since the peak of winter, but remain challenging
- Each place provides an update report to the ICB with some great examples of innovation - Rotherham for example held a mental health think tank to share learning where 130 people attended. This may be something we want to consider in our places.
- The Trust's stroke rehabilitation service were recognised for its work

MHLDA collaborative

- A communication and engagement plan is in development as is an IPR
- The terms of reference came to Board earlier this year and will come back for final approval in April

SY highlighted

- The Barnsley Health and Care Partnership have approved their priorities and health and care plan for 23/24
- The alliance with Barnsley Healthcare Federation has madereal progress on annual health checks for people with learning disabilities and severe mental illness.
- Work around annual health checks for those with frailty and dementia is now taking place

It was RESOLVED to NOTE the SYB ICS update.

TB/23/26b West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism (MHLDA) Collaborative and place-based partnership update (agenda item 11.2)

SR highlighted:

- At Wakefield health and wellbeing board, a presentation was given, including Trust staff, regarding support for children in schools, and the focus shifted to CAMHS waiting times because of the metrics presented to the board.

It was RESOLVED to RECEIVE and NOTE the update on the development of Integrated Care Systems and collaborations:
West Yorkshire Health and Care Partnership;
Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees and RECEIVE the minutes of relevant partnership boards/committees.

TB/23/26c Provider Collaboratives and Alliances (agenda item 11.3)
AS presented the item and asked to take the report as read:

- Challenges around staffing and acuity are prevalent in collaboratives
- Forensic CAMHS lead provider collaborative has been approved for go live on 1 April 2023 and the Trust is working through this with NHSE for a memorandum of understanding
- If this date has to slip the Board will be informed, but there will be limited consequence
- Perinatal provider collaborative proposal is going into private board

It was RESOLVED to RECEIVE and NOTE the Specialised NHS-Led Provider Collaboratives Update and RECEIVE and NOTE the Terms of Reference of the South Yorkshire and Bassetlaw Provider Collaborative Partnership Board.

TB/23/27 Governance matters (agenda item 12)

TB/22/120c Trust Seal (agenda item 12.1)
AS reported the Trust seal has been used three times since the last report in November 2022:

- Extension of the lease for the Priestley Unit, Fox View & Cullingworth Street, Dewsbury District Hospital (Mid Yorkshire Hospitals NHS Trust)
- Transfer agreement relating to the sale of the Keresforth Centre to the secretary of state for levelling up, housing and communities. (Signature witnessed by the Deputy Chair in the Chair's absence)
- Licence to charge in relation to the Airedale health centre in Castleford. The Trust owns Airedale health centre. A lease was assigned to the current tenant in 2020 and a charge was placed on the title by Lloyds Bank. A charge should not have been placed without the Trust's consent and the licence is retrospective consent. (Following agreed constitutional changes in January 2023 signature witnessed by company secretary)

It was RESOLVED to NOTE the use of the Trust Seal since the last report in November 2022.

TB/23/28 Strategies and Policies (agenda item 13)

TB/23/28a Estates Strategy update (agenda item 13.1)
AS asked to take the paper as read:

- This is a bridging update between old and new strategy
- The new strategy is being refined to make sure it aligns to Trust strategies and priorities
- There is a need to look at where we are now and what may need to change
- Our inpatient estate standards vary dependent on ownership
- News ways of working, remote working and different use of buildings will be a theme
- The challenge is for the strategy is to match ambition and take into account realism regarding availability of capital budgets.

NM noted the Trust estates strategy should align to the ICS estates strategy and noted the ICS strategy isn't finished yet and will there be any challenge in this?

AS noted one key area may be around relative priorities. The Trust may have priorities, but they may not necessarily be a similar level of priority for the ICS and this is where discussions will need to take place.

MR queried if the Trust's backlog will compromise the Trust in any way?

AS reported there is backlog to deal with but there is capital ringfenced to deal with backlog issues in the capital plan. The Trust has experienced challenges with supply chain during 2022/23.

MF noted the FIP committee training session for capital regimes in NHS and would be interested too. AS reported the offer would be opened out to all non-executive directors.

Action: Adrian Snarr

It was RESOLVED to NOTE the update on the existing strategy and progress towards key milestones and NOTE the development of the new estates strategy and some of the emerging themes.

TB/23/28b Quality Strategy update (agenda item 13.2)

DT asked to take the paper as read:

- This the strategy that came to strategic board
- It has been reviewed in detail by CGCS and is submitted to Board for formal approval

SY noted the priority programme diagrams need to be changed to reflect the strategy runs over a number of years. DT will liaise with the comms team for the best approach.

Action: Darryl Thompson

It was RESOLVED to APPROVE the Quality Strategy for 2023-2026.

TB/23/29 Trust Board work programme 2023/24 (agenda item 14)

It was RESOLVED to APPROVE the work programme.

TB/23/30 Any other business (agenda item 15)

Nil

TB/23/31 Date of next meeting (agenda item 16)

The next Trust Board meeting in public will be held on 25 April 2023

Signature: Date:

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 28 March 2023 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 28 March 2023 (draft)

Min reference	Action	Lead	Timescale	Progress
TB/23/23	MBr asked for a report to come to Board in relation to West Yorkshire and South Yorkshire ICB's revised operating models as a result of forthcoming cost saving initiatives	Adrian Snarr/Sean Rayner	July 2023	
TB/23/24a	MF asked how the Trust performance on appraisals compares to other Trusts in the system? GM agreed to look into this and a report back to Board.	Greg Moores	April 2023	Some manual benchmarking manual benchmarking against local similar Trusts will be included in the narrative bit of this month's IPR.
TB/23/24a	A discussion took place in relation to agency spend and the vacancies challenge across the Trust. MBr reported the Board needs to have a conversation about risk appetite for agency use. The Board agreed to hold discussions about agency use and look at which committee will maintain oversight and also where the key risks are for the Trust in terms of staffing and establishment	Greg Moores/Adrian Snarr	May/August 2023	
TB/23/24a	KQ raised the number of children on adult wards and raised what assurance the Board can receive that the wider system is addressing this issue. CH reported she will look at how the Board can receive assurance on this matter.	Carol Harris	June 2023	

TB/23/25a	In reference to incidents reported between 01/01/2022 – 31/12/2022 MR noted that Wakefield community have nine incidents, and this seems disproportionate. DT reported this hasn't been flagged by the team as an outlier and the team are very strong on trend analysis, but DT will check and report back to Board.	Darryl Thompson	April 2023	The refreshed figure for Wakefield Community MH for Q3 is now 6 red incidents rather than the 9 that were reported in Q3 incident report. The 6 red incidents reported in Q3 are across 6 different teams are all deaths. Initial reporting is usually upwardly biased, as managers may not have reviewed or gathered further information required at point of report. This is why the figures may differ from the previous quarter. From SPC charts Wakefield do not appear to be an outlier.
TB/23/25a	MF noted the differential on the figures on pg 142 of the Serious Incidents report in relation to Q2 and Q3 number of incidents. There seemed to be a significant difference. DT agreed to look into this.	Darryl Thompson	April 2023	An error was identified in the report. In Quarter 3 2022/23, 1160 incidents were reported to the National Reporting and Learning System (as at 12/1/2023) compared to 1672 in Quarter 2. This totals 5825 in the year to date (2022/23). The report has been updated and re-published in the March papers.
TB/23/25a	The Patient Safety Incident Reporting Framework needs to be scheduled to go to the non-executive directors monthly meeting	Mandy Rayner	June 2023	
TB/23/25b	MF asked to speak to SY about the Strategic overview of business and associated risk outside of the board meeting	Mike Ford/Salma Yasmeen	April 2023	A meeting has been requested between MF and SY.
TB/23/25e	NM reported that risk assessments and care planning is an issue across all mental health organisations. Once the Trust sees a continued improvement because of the work that is taking place this should be shared with other Trusts. To be monitored by CGCS.	Darryl Thompson	July 2023	

TB/23/25f	MF noted the Audit Committee is responsible for the treasury investment decision but noted FIP holds responsibility for the best return on cash. AS to meet with MF to confirm committee responsibilities.	Adrian Snarr	May 2023	
TB/23/28a	MF noted the FIP committee is to receive training on the NHS capital regime and MF requested to be included in this training. AS reported the invite would be extended to all non-executive directors.	Adrian Snarr	May 2023	
TB/23/28b	SY noted the priority programme diagrams in the quality strategy need to be changed to reflect the strategy runs over a number of years. DT will liaise with the comms team for the best approach.	Darryl Thompson	April 2023	DT has liaised with Comms colleagues, it will be specified in the strategy that the priorities may change over time, and a link to all current priorities is being included.

Actions from 31 January 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/06	Greg Moores (GM) noted the use of WhatsApp by the Specialist Paediatric Epilepsy Service and asked if there has been any sharing of this good practice and would Phil McNulty (PM) be happy to share this? PM reported with the evolution of smart phones WhatsApp has easily enabled the sharing of videos in a secure way. It is a fantastic solution – especially for families with learning disabilities, and videos are received on a Trust secured	Salma Yasmeen	June 2023	

TB/23/12a	Trust Board general duties have been updated in the constitution to include culture, and the Board being able to assess and monitor the culture of the organisation JW is working with the lead governor on how this may be a joint enterprise with the lead governor and will report back to the Board on progress	Julie Williams	April 2023	New governors will be appointed from 1 May 2023. Inductions are being held w/c 24 April 2023. Following completion of inductions, a focus group of governors will be created to take this work forward supported by the lead governor and the deputy director of corporate governance. This will be taken forward through the Members Council.

Actions from 29 November 2022

Min reference	Action	Lead	Timescale	Progress
TB/22/103b	Dr. Subha Thiyagesh (ST) will be the executive champion for learning disabilities. This role will place additional focus on learning disabilities and will look to influence Trust partners and focus on the Trusts own services, this should be noted by CGCS. MBu asked for a paper to be brought back to Board in relation to learning disabilities and the context of ST's role and what her initial views are, identify key areas of focus and what CGCS will focus on in relation to learning disabilities.	Subha Thiyagesh	April 2023	Paper on the agenda for April 2023
TB/22/117b	EM queried the community safer staffing judgement tool and whether this had been paused. DT clarified that it had been paused to allow the alignment of inpatient and community safer staffing agendas, so that work can then continue. EM noted the report doesn't reflect this and asked that this is adjusted for future reports	Darryl Thompson	April 2023	This has been clarified in the Safer Staffing report presented at today's committee.

TB/22/117b	MBr noted the safer staffing report is a comprehensive, detailed and lengthy report. MBr asked if CGCS could look to streamline the report to avoid any duplication from other reports such as updates on international recruitment.	Darryl Thompson	April 2023	This feedback has been taken into account in the development of the Safer Staffing report presented at today's committee.

Actions from 25 October 2022

Min reference	Action	Lead	Timescale	Progress
TB/22/102f	KQ queried if there is non-executive clinical representation on the committee. MF reported ST provides clinical representation on the committee at present but non-executive membership on the committee will be considered in the committee 12-month review.	Adrian Snarr	April 2023	The committee reviewed its terms of reference and membership as part of its annual effectiveness review and as an evolving committee, membership will be considered throughout the coming year. Once recruitment processes for associate NED's have taken place, consideration will be given to those with a clinical background being co-opted onto the Collaborative committee.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 8

Private/Public paper:	**Public**		
Title:	**Chief Executive's Report**		
Paper presented by:	Mark Brooks - Chief Executive		
Paper prepared by:	Mark Brooks - Chief Executive		
Purpose:	To provide the strategic context for the Trust Board conversation.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	N/A.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Chief Executive's report provides Trust Board with national, regional and local context for the Board meeting and updates on how the organisation is contributing to the objectives of the Integrated Care Systems (ICS), in both West and South Yorkshire, and includes Trust work through partnerships in places.		
Any background papers / previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the meeting and also external papers and links.		
Executive summary:	**This report is being written as the latest period of industrial action by junior doctors comes to an end.** This action took place over four days following the Easter holiday. The Trust is again indebted to its staff who planned and covered the impact of the strike action to ensure safe patient care. At the time of writing this report it is not clear whether a settlement is any closer or, if and when further industrial action by junior doctors will be scheduled. Nurses in the Royal College of Nursing union have rejected the government's most recent pay offer and industrial action for two days between 30th April and 2nd May has been announced. Members of the Unison union voted to accept the most recent pay offer. **Operational pressures continue unabated across many Trust services,** and it is important the Board recognises this. Our integrated performance report (IPR) clearly demonstrates where these pressures are particularly surfacing and the hard work of our staff to manage these pressures is acknowledged and recognised. **The review conducted by Rt Hon Patricia Hewitt into integrated care systems has been published**. Key headlines from this report include:		

- Reducing the number of national targets to give local leaders the 'time and space' to lead. It suggests that there should be no more than ten national priorities, and that local priorities should be treated with equal weight.
- Developing high accountability and responsibility partnerships for more mature ICSs.
- Emphasis on the need to shift the focus to prevention and health improvement, including through more joined up central government, an increase in prevention spending, and a focus on inequalities and discrimination.
- recognises the importance of collaboration and co-design as drivers of improvement.
- The report aims to set out clearly the responsibilities and accountabilities of the different players in systems locally, regionally, and nationally.
- Regarding finance and capital, the report recommends reviewing the entire NHS capital regime, reducing the use of short-term funding pots, and learn from good practice (including internationally) around payment models. A review of the current capital arrangements will be welcomed by many trust leaders.
- Recognises the need to join up health and social care in many ways, and the challenges of doing so.

The financial planning process for the NHS has been extended until early May. The scale of deficit from the April plan submissions nationally (£3bn) has not been accepted, prompting the need for a further submission. Both South and West Yorkshire systems submitted a planned deficit of £110m, with organisations and collaboratives in each system asked to identify how these deficits can be improved upon.

A new government policy paper has stated £250m will be invested into the adult social care workforce over the next two years, which represents half of the £500m that was previously stated. It is widely recognised that the social care sector requires sustainable funding and reform.

The focus of this Trust Board meeting is on business and risk. The papers feature our latest Board Assurance Framework and Organisational Risk Register, as well as a proposal for our updated strategic risks for 2023/24. The combination of high demand and acuity, industrial action, staffing levels in some services, and a return to greater financial challenge mean the environment we are operating in contains several risks. It is important the Board is sighted on these and aware of the mitigations we have in place to manage the risk.

As reported on at the last Trust Board meeting the results of the 2022 staff survey have now been published. At a face to face extended executive management team meeting in March there was good discussion about the results of the survey, what they mean to us, and what our next steps are in terms of engagement with the wider workforce and improvement actions. Trust Board will receive a fuller report and be regularly updated on progress.

This same meeting also featured a presentation by Rashik Parmar on the role of digital on sustainability. **This comes at a time when the Trust has successfully completed its roll out of electronic prescribing medication administration (EPMA) to its mental health inpatient wards.** This is a very real example of how a digital solution can improve the effectiveness and quality

	of the care we provide. **NHS Providers have published 'Digital Boards – Effectively embedding digital in your Trust'.** This is a helpful summary and we will review the document to identify if there are any further improvements we can make to how operate as a Board when it comes to our own role in digital innovation and solutions. **We are very much looking forward to our annual excellence awards, which are taking place on May 4th**. This will be an excellent opportunity to recognise and celebrate the achievements of our staff. This a helpful segue into recognising that even given the significant operational pressures our services are experiencing we continue to see positive change and recognition in many areas. For example, our **Wakefield enhanced team west received the following compliment** "I thought that after 25 years, my life couldn't be made better and I thought I was going to feel depressed and exhausted forever. I couldn't have been more wrong. After finishing therapy, I feel like I'm finally learning who I really am, and I'm noticing all the great things that life has to offer. I can finally open a new chapter of my life." **Our perinatal mental health team have** been awarded a Chief Nursing Officer Healthcare Support Excellence Award for their exceptional contribution to nursing practice. **Speech and language therapy assistant Jordan Clarke was acknowledged in the Royal College of Speech and Language Therapists' bulletin** for her "Speech steps" display, which helps her team support children with communication difficulties from sounds to sentences The Board papers also include an update from our chief medical officer Professor Subha Thiyagesh **regarding how we are placing particular focus on using our role in the both the Trust and wider system to improve lives for people with a learning disability**. Our alliance with Barnsley Healthcare Federation has identified the provision of annual health checks for people with a learning disability as a priority, and at the time of writing this report Barnsley has the highest recorded take up across both South and West Yorkshire. **As we enter 2023/24 it is worth recognising the key role many of our corporate staff play regarding year-end reporting for 2022/23**. Our finance team are producing year-end accounts and responding to external and internal audit requirements, whilst our corporate governance team are completing our annual report and other returns, including our annual governance statement, an initial draft of which is included in the Trust Board papers. Work is underway in both of our integrated care systems to respond to the need to reduce their running costs by 30% by April 2025. We will continue to work with colleagues on the re-design of operating models and offer support, where we can, to staff affected by these changes. The previously reported planned merger of NHS Digital and Health Education England with NHSE England came into effect on April 1st **Recently autism awareness week took place** and its timing closely coincided with the publication of 'A national framework to deliver improved outcomes in all age autism assessment pathways'. Demand for autism assessments has risen rapidly in recent years and nationally people waiting for an assessment

	increased by 34% between October 2021 and July 2022. We will continue to work with partner colleagues with the aim of reducing waiting times **Finally, I would like to record my personal congratulations as well as those of the Trust Board to Salma Yasmeen on her appointment as chief executive officer at Sheffield Health & Social Care NHS Foundation Trust**. This is a tremendous and very well-deserved achievement for Salma. It is also a positive endorsement that Trust executives are sought after and appointed to such key leadership roles. The process to recruit a replacement for Salma has commenced and we are targeting completion of the process by the end of June. This report updates The Brief attached **[ANNEX 1],** which itself outlines priorities and actions for all Trust staff. The Brief provides continuity of communications alongside The View, the most recent Coronavirus update and the weekly Headlines.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**

NHS
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NHS Foundation Trust

The Brief

30 March 2023

Monthly briefing for staff, including feedback from Trust Board and executive management team (EMT) meetings

With **all of us** in mind.

Our mission and values

During challenging times is it important we focus on our values.

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

To achieve our mission we have a strong set of values:

- We put people first and in the centre and know that families and carers matter
- We're respectful, honest, open and transparent
- We constantly improve and aim to be outstanding so that we're relevant today and ready for tomorrow

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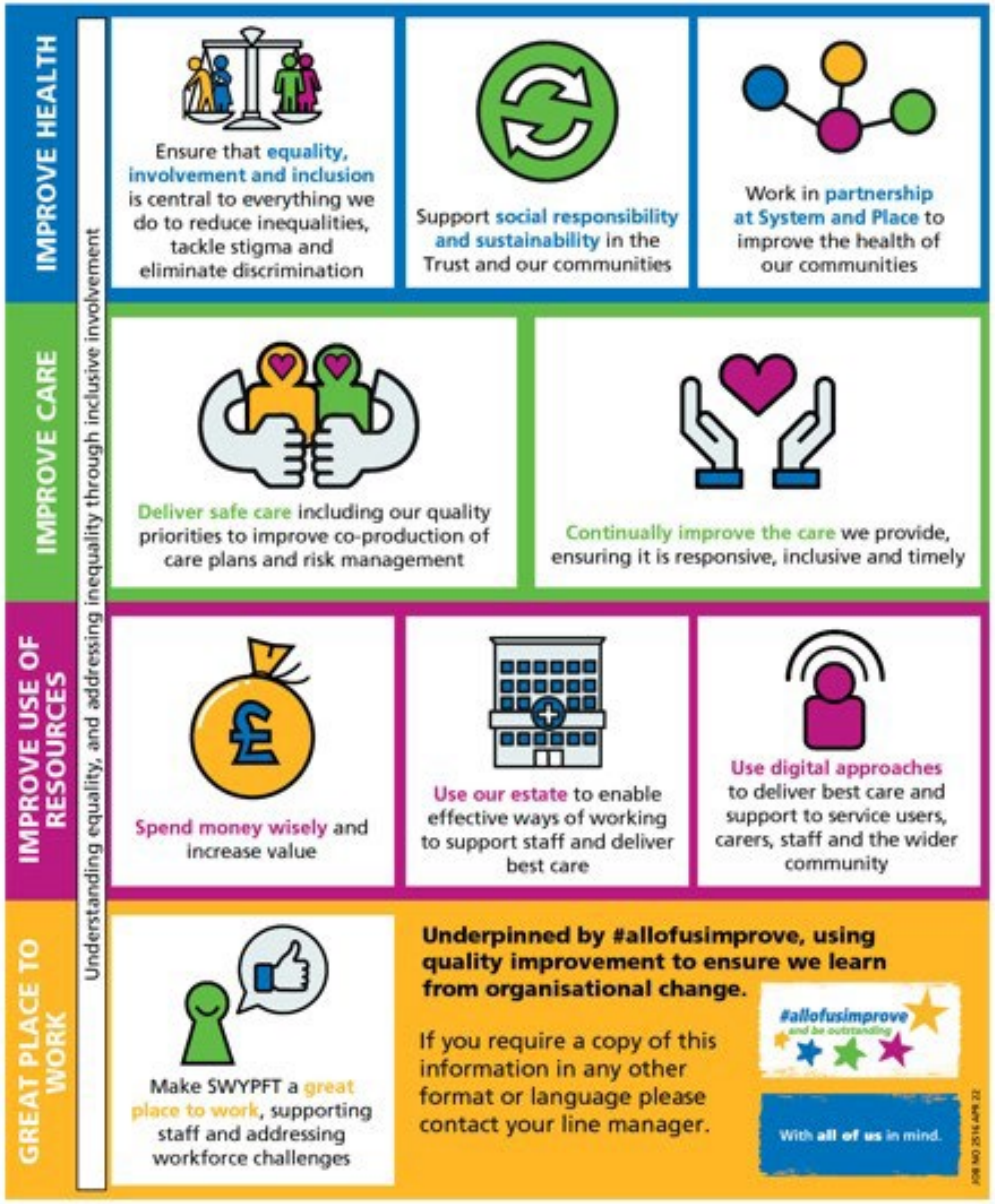
NHS Foundation Trust

Matron Karen Riordan was one of many people from across the Trust who helped us to celebrate 'Nutrition and Hydration Week' by making a pledge on how they make a difference to the lives of our service users and staff every day.

With **all of us** in mind.

Our priorities 2022-23



We have made good progress on our priorities for 2022-23. However, some of our priorities still need more work so will continue into 2023-24.

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Our **new priorities** for 2023-24 have now been agreed. Our comms team are currently designing a new poster which will be sent to you shortly.

Digital dictation: we will shortly be starting a procurement process for our digital dictation project. We promise to keep you involved and engaged throughout.

All of Us: Continue to encourage your colleagues and service users to share their personal equality data. It helps us to make sure services match individual needs.

Older people's transformation: Following a successful stakeholder event in December our business case development is nearly complete. We are now working with partners on pre-consultation engagement with Overview and Scrutiny Committees.

The national, regional and local context

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We are continuing to work with our partners in each of our places to create a local and sustainable approach to health and care, building on the local progress we have already made.

Following extensive discussions in and beyond the mental health, learning disabilities and autism programme, the programme board has agreed that the West Yorkshire public grief and loss line and online chat service will be withdrawn from 31 March. The West Yorkshire Staff Mental Health and Wellbeing Hub is not closing despite the uncertainty around national funding. However, the staff support line number 0808 196 3833 is changing however and we will communicate the new number as soon as it is established.

South Yorkshire Integrated Care Partnership has launched its new strategy. Read more about the strategy on the intranet. Find out how you can get involved in the development of their joint forward plan.

Barnsley is leading the way across South Yorkshire on the uptake of learning disability annual health checks at 75% completed so far. This means over 1,080 people have had their annual health check. The team is on track to exceed their target of 80% by the end of March.

Barnsley Community Health and Care Alliance

A new specialist children's home has opened in Pontefract. Called The Croft, it is a therapeutic residential children's home jointly run by the Trust and Wakefield Council. It will provide placements for children with complex needs, closer to their home. Our Wakefield CAMHS team will be working in the new centre to provide mental health care to support our young people to live well in their local communities.

Creative Minds and S2R Create Space have worked together to produce activity and wellbeing packs, to support people in their self care. The packs can be downloaded online.

Improving Health
Our performance in Feb

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **54%** of people completing IAPT treatment and moving into recovery
- **100%** of IAPT referrals beginning treatment within 18 weeks. **97.6%** within 6 weeks.
- **89.6%** of MH service users followed up within 72 hours of discharge from inpatient care
- **87.7%** of people with a risk assessment/staying safe plan in place within 24 hours of admission (for inpatients). This is an improving picture
- **68.4%** of people with a risk assessment/staying safe plan in place within 7 days of first contact (for community)
- **81.5%** of people died in a place of their choosing
- **4.5%** delayed transfer of care
- **74%** in CAMHS services waiting less than 18 weeks for treatment

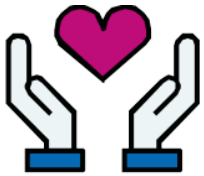
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | PQN PERINATAL QUALITY NETWORK
ACCREDITED UNTIL | 26 September 2025

Further planned industrial by junior doctors has been confirmed for Tuesday 11 April to Saturday 15 April 2023. More information is available on the intranet.

According to the latest NHS data, Barnsley's stop smoking services are the second-best nationally for helping people to successfully quit. From April 2021 to March 2022, Yorkshire Smokefree Barnsley helped 72% of local smokers who set a quit date to successfully stop smoking, making them the most successful stop smoking service across Yorkshire and Humber.

The Trust's perinatal mental health team has been accredited for its quality service by The Royal College of Psychiatrists. Following a rigorous review process, the team has successfully achieved accreditation in line with the Perinatal Quality Network (PQN) Community Standards.

Improving Care
Our performance in Feb



NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **511** inappropriate out of area bed days
- **2** young people under 18 admitted onto adult inpatient wards
- **82.6%** waiting for referral to assessment within 2 weeks
- **99.1%** waiting for assessment to treatment within 6 weeks
- **29** days is the average length of stay on adult acute mental health wards
- **58.6%** of service users on CPA offered a copy of their care plan
- **70.2%** of our mental health service users have their equality data recorded

95% of respondents in the friends and family test rated our general community services either good or very good; **85%** in our mental health services, **70%** CAMHS, **91%** for learning disability services, and **78%** for ADHD services.

Update on Patients Know Best rollout
Our Trust is aiming to rollout PKB, a new patient record system, in late May/early June 2023. There is information available on the intranet to help teams and services prepare for using PKB.

Our Trust has been working with staff, service users and carers to develop our Compassionate Principles. These can be used to make the letters and communications we send to people who use our services more friendly and reassuring. Read about our Compassionate Principles, and how you can use them, on the intranet.

Talk to the trio – a conversation with Carol, Darryl and Subha. Our executive trio invite you to have an open discussion on your thoughts and experiences. Put a date in your diary and see the Headlines for details of how to join online.

Improving Care Incidents in Feb

NHS
South West Yorkshire Partnership
NHS Foundation Trust

In February we reported:

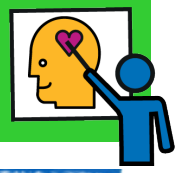
- **1,165** incidents – **761** rated green
- **342** were rated yellow and **54** rated amber
- **8** rated as red (incident severity is reviewed and may be downgraded)
- **95%** of incidents resulted in no or low **actual** harm, or were external to our care
- **30** patient safety incidents that resulted in moderate or severe harm or patient safety related death. **19** category 3 or 4 pressure ulcers, **7** serious self-harm incidents, **1** patient fall, **1** medication issue related to follow up, **1** physical violence against a patient, **1** delay in treatment.

We had **223** restraint interventions in February, slightly up from 221 in January. **87%** of prone restraints were 3 minutes or less. We continue to offer support and advice to teams around reducing restrictive interventions.

We had **49** falls in February. It was 51 last month. All falls are reviewed to identify measures required to prevent reoccurrence.

We had 45 pressure ulcers in February. Of these, 2 were identified as resulting from a lapse in care.

Learning from incidents - each year the patient safety support team look at incidents across our Trust, where we can take action and learn. A summary from 1 April 2021 -31 March 2022 is available to read on the intranet. We also have a quarterly patient safety report which is reviewed at our Trust Board.



There were **8 confidentiality breaches** in February. There were 12 in January. All of us can reduce the number of patient data or sensitive information breaches at the Trust. Please make sure you complete your IG mandatory training.

Think. Check. Share.

With **all of us** in mind.

Improving Care

All of You – Race Forward update

NHS South West Yorkshire Partnership NHS Foundation Trust

March 2023

- Steering group now meets monthly -20 March was the first meeting
- Work streams and inter dependencies identified
- Governance and reporting in place
- Driver diagram developed
- Work plan in progress

April 2023

- Visibility - All of you: Race Forward communication plan and mobilisation
- Resources - Identify tools for staff and update intranet
- Insight and data review - Staff Survey, Flair survey, Datix and WRES
- Engage staff and the REACH network and co-design next steps
- Identify intended outcomes and measures

May 2023 onwards

- Mobilise specific workstreams and reporting
- Roll out enhanced training to all senior managers
- Workforce development and recruitment, including volunteers and peer support workers

A further update will be shared in May.

With **all of us** in mind.

Improving Care
Suicide prevention strategy

We can all play our part in reducing the number of people who die by suicide.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The suicide prevention strategy has three aims, to:

- reduce the loss of life by suicide
- support those affected by suicide or suicidal expressions and actions
- work in partnership to improve the mental and physical health of the people we care for and our communities.

We have created one-page plans for action to help teams and services understand what this means in practice. These focus on **five key areas:**

- Family and communities
- Creating safe environments
- Thinking holistically
- Being here for each other
- Working together

To help people learn more about suicide prevention and the new strategy, we have:

- A one-page summary of the suicide prevention strategy
- A presentation which you can cascade through teams
- One-page plans for action.

Find all of these on the new suicide prevention intranet pages.

You can also find resources and support on the West Yorkshire Health and Care Partnership website.

Search 'suicide prevention' on the intranet or click here.

Watch the 20 minutes to save a life Zero Suicide Association film, accessed here or through ESR.

With **all of us** in mind.

Managing risk

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Corporate Organisational Risk Register (ORR) records high level risks and the controls in place to manage and mitigate them. The organisational level risks are linked to our strategic objectives; and are aligned to one of our Trust Board Committees.

Key areas of risk identified in the risk register are:

- Increased demand, acuity and complexity
- Staffing, recruitment, and access to temporary staffing where it is needed
- Staff wellbeing
- Patient safety
- Out of area bed placements
- Young people waiting for treatment and access to inpatient beds
- Confidence in our services resulting from waiting times
- IT infrastructure and cyber crime
- Health inequalities
- Inflation and cost of living pressures, including the cost of energy
- The ongoing impact of winter
- The impact of industrial action

We regularly review our risks to identify measures to mitigate them, support staff to do what is needed, and to maintain quality of care while improving services.

When the Trust identifies a risk to safety we send out urgent **Bluelight Alerts**. They are sent to all staff by email. Staff should ensure that alerts are responded to and action taken in line with the Alert recommendations. You should also ensure that any staff who do not routinely access their email have urgent sight of the alert. You can find copies of all Bluelight Alerts on the intranet.

Medicine and pharmacy related alerts are called **Greenlight Alerts**. They are distributed through the Headlines. Greenlight Alerts can also be found on the intranet.

Improving resources
Our finances in February

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Performance Indicator	Year To Date	Forecast 2022 / 23
Surplus / (Deficit)	£3.7m	£3.2m
Agency Spend	£8.9m	£9.9m
	4.4%	
Overhead Costs	15%	
Financial sustainability and efficiencies	£5.4m	£6.4m
Cash	£81.8m	£79.7m
Capital	£4.3m	£7.6m
Better Payment Practice Code	95%	

A deficit of £0.6m has been reported in February 2023. The year to date surplus is £3.7m which is £0.7m higher than planned. The full year surplus is forecast at £3.2m in line with plan.

Year to date agency cap expenditure is £8.9m which is £1.8m more than cap.

Cash in the bank remains positive for both the year to date and forecast.

The capital forecast was recently reduced following Trust Board agreement to pause a major scheme.

95% of all invoices have been paid within 30 days of receipt.

A great place to work
Our performance in Feb

South West Yorkshire Partnership NHS Foundation Trust

- **5.2%** sickness rate for the month. It is **5.3%** YTD.
- In Feb we had **70** new starters to the Trust, and **35** leavers
- We currently have **4,230 s**ubstantive members of staff
- **71.5%** of staff have a completed WorkPal appraisal
- **84.8%** of staff have completed their **IG mandatory training**.

Our Excellence award **shortlists** have been announced. We had over 220 applications this year so to be shortlisted is a great achievement. Congratulations to everyone who was entered for an award this year. The results will be announced at our celebration event on 4 May 2023.

The Government has made a pay award offer to non-medical staff (everyone on Agenda for Change terms and conditions). The offer is now subject to agreement by the unions. If it is accepted, it is likely that the uplift for 2023/24 and back pay will be paid in May or June. We will share more details about the proposed pay award as more information is released.

From 1 April, staff who have previously retired and drawn their NHS Pension will be allowed to opt back into the NHS Pension Scheme. Those who are in NEST currently will be given the option of transferring in their service from this scheme. Staff wishing to opt into the NHS Pension scheme from 1 April should email payroll@swyt.nhs.uk.

Support Muslim colleagues during Ramadan. Find out how in this guide, co-produced with the REACH staff network.

All **appraisals** should be completed in a rolling 12-month period from your previous appraisal. All staff should make sure that appraisals are booked in when needed.

'Your wellbeing' pages on the intranet have been launched following a review and re-design of staff health and wellbeing offers. We are currently designing a 'your wellbeing' button for the staff app where colleagues will be able to access health and wellbeing offers outside of work on their mobile devices.

With **all of us** in mind.

A great place to work
NHS staff survey 2022

The survey is carried out every year and was sent out between October and November.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Provides important feedback on your experience of working for the Trust

2,303 responses

50% response rate (up from 41% in 2021)

Theme results	Trust score 0-10	Average
We are compassionate and inclusive	7.6	7.5
We are recognised and rewarded	6.3	6.3
We each have a voice that counts	7.0	7.0
We are safe and healthy	6.4	6.2
We are always learning	5.6	5.7
We work flexibly	6.7	6.7
We are a team	7.1	7.1
Staff Engagement	7.1	7.0
Morale	6.2	6.0

4 themes are better than average

4 themes are average

1 theme is below average

66.5% would recommend the Trust as a place to work. An increase from 65% in 2021 and better than the national average of 63%.

68 would recommend the Trust to family and friends as a place to receive care and treatment. This is down from 70% in 2021 but better than the national average of 64%.

Results below are summarised using the ***key themes*** which have been identified by staff as being important in making the Trust a great place to work.

Developing my potential

73% of staff feel they have opportunities to improve their knowledge and skills. *This is slightly below the national average.*

70% of staff say that their immediate manager gives them clear feedback on their work.

77% of staff feel that their immediate manager encourages them at work.

78% of staff said they had an appraisal in the last 12 months

Quality of care

81% of staff say that care of patients and service users is the Trust's top priority. *This is above the national average.*

87% of staff say their role makes a difference to patients and service users. *This is in line with the national average.*

81.5% of staff say that care of patients and service users is a top priority.

Feeling safe

15% of staff said they have personally experienced violence from patients, service users or relatives. *This is in line with the national average.*

28% of staff said they had experienced bullying or harassment by service users or relatives. *This is slightly above the national average.*

7.1% of staff said they had been bullied or harassed by their line manager. *This is below the national average.*

12.6% of staff said they had been bullied or harassed by their colleagues. *This is below the national average.*

A great place to work
NHS staff survey 2022

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Positive support to keep me fit and well

63% of staff think the Trust definitely takes positive action on **health and wellbeing.**
This is slightly below the national average.

66% of staff feel there are opportunities for **flexible working.**
This is in line with the national average.

40% of staff say they have had time off work due to **work related stress.**
This is below the national average.

Working in a supportive team

79% of staff say they receive the **respect** they deserve **from colleagues.**
This is above the national average

71% say their line manager takes **effective action** for any problems they face.
This is slightly below the national average.

76% of staff feel **valued by their team.**
This is in line with the national average.

My Voice Counts

76% of staff feel able to **make suggestions to improve the work of my team or department.**
This is slightly below the national average.

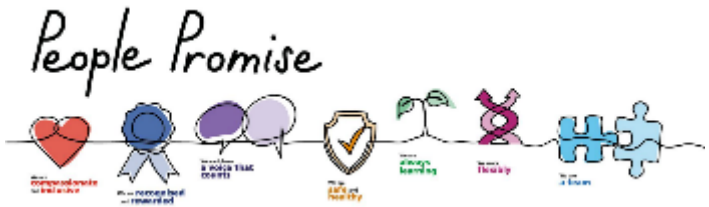
59% of staff feel able to **make improvements at work.**
This is slightly below the national average.

77% of staff feel there are **frequent opportunities to show initiative.**
This is in line with the national average.

A great place to work
NHS staff survey - next steps

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- In April, each care group/support service will receive an information pack. The pack will include key staff survey insights by service, changes since 2021 and suggested areas of focus going forward. The pack will include advice on engaging staff in conversations to understand the results, and agree action/s.
- Each service should complete a brief summary return by 30 June detailing the staff engagement that has taken place and a key action/s. This will be returned to the people experience team. Advice and support is available from the People Directorate.
- Staff Networks will also receive an information pack.
- The People Remuneration Committee will receive updates on our progress around staff engagement and action planning.
- Our comms and engagement plan will include regular updates to staff throughout 2023, and to encourage uptake of the 2023 survey.



With **all of us** in mind.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Safety comes first, always. Do everything you can to keep you and those around you safe.

Read our new suicide prevention strategy and discuss in your teams what you can do to make a difference.

Share your experiences and learning in our Talk to the Trio events.

Read our learning from incidents report and identify where you can take action.

Make sure you respond and act upon Bluelight and Greenlight Alerts when you receive them.

Discuss our NHS Staff Survey results in your teams. What can you do to make improvements?

Support your colleagues at work during Ramadan.

Make sure you prioritise your own and your colleague's wellbeing.

What do you think about The Brief? comms@swyt.nhs.uk

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 9.1

Private/Public paper:	**Public**		
Title:	**Board Assurance Framework (BAF) Quarter 4 – 2022/23**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance Andy Lister - Head of Corporate Governance		
Mission/values:	The BAF is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values.		
Purpose:	For Trust Board to be assured that a system of control is in place with appropriate mechanisms to identify potential risks to the delivery of its strategic objectives.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Board Assurance Framework allows Trust Board to monitor risks against the Trust's strategic objectives and in doing so enables them to assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnerships and Integrated Care Boards, and place-based partnerships.		
Any background papers / previously considered by:	Reviewed quarterly by Executive Management Team. Reported quarterly to Trust Board.		
Executive summary:	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. The BAF is used by Trust Board to generate the agenda for meetings, provide assurance on the management of strategic risks, and provide assurance against the delivery of the Trust's strategic objectives. The Chief Executive also uses this document to support his mid and full year review meetings with directors to ensure they are delivering against agreed objectives, and action plans are in place to address any areas of identified risk. The BAF is also used in the formulation of the Annual Governance Statement.		

In line with the Corporate / Organisational Risk Register (ORR), the BAF is aligned to the Trust's strategic objectives:

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

There are 15 strategic risks:

Improving health – 4

Improving care – 4

Improving resources – 4

Make this a great place to work – 3

On 6 April 2023, the Executive Management Team (EMT) fully reviewed the BAF to consider any changes in current circumstances which may impact on the grading of strategic risks.

EMT discussions reflected the fact that the external environment in which the Trust operates continues to evolve, often resulting in changes, each quarter, that require consideration in the review of the BAF.

The operating environment continues to be challenging including factors such as high levels of demand with increased acuity and complexity, the cost-of-living crisis, industrial action and staff sickness.

Following EMT discussion they are recommending changing the grading of Risk 1.1 from Amber to Yellow for quarter 4.

Strategic Risk Ratings	Q1 2022/ 23	Q2 2022/ 23	Q3 2022/ 23	Q4 2022 /23	↑ ↓ ↔
Red	0	0	0	0	↔
Amber	6	6	6	5	↓
Yellow	8	8	8	9	↑
Green	1	1	1	1	↔

In Quarter 4, a comprehensive review of controls, assurances and target dates for actions took place with lead directors. A summary update is included below:

Risk	Description	Q4 New Controls	Q4 New Assurances
Risk 1.1	The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place	1	0
Risk 1.2	The focus on integrated care models at place may result in unwarranted variation and differences in standards, and could potentially impact the sustainability of smaller specialist services	0	1
Risk 1.3	Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve.	1	0
Risk 1.4	Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy.	2	0
Risk 3.2	Failure to develop strong relationships with integrated care systems, places, and provider collaboratives results in services that do not meet local needs or are unsustainable	3	0
Risk 4.2	Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively	1	1

Careful consideration has been given to all strategic risks with a focus on the following:

Risk 1.1 - The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place. To move from Amber to Yellow. A discussion took place noting the context of this risk when it was established in Q1 22/23. The basis of the risk was that changes to system structures and place structures may impact on Trust service provision.

In Q4, EMT identified partnership and stakeholder working has strengthened throughout the year and is seen to be effective. The inequalities element of this risk has previously prevented movement from the amber grading, but given the original context of the risk, EMT recommend that the grading of this risk can be lowered to yellow. This results in a grading move from amber to yellow for overall assurance against strategic risks for “improving health”.

The wording of risk 1.1 has been revised for 23/24 and is presented in a separate paper to Board for review.

Risk 2.3 - Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care – To remain Amber. EMT discussed that current level of demand and complexity and levels of sickness/absence as well as the creation of new services and roles which continue to impact on supply and resources.

Risk 3.3 – **Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives** EMT acknowledged that operational pressures continue to impact on this strategic risk. It was noted there is a process for effective management of resources, capacity and changing priorities in place within the Trust. This has resulted in some work being slowed down over 22/23. The recommendation is to retain a yellow given that the majority of priorities are being delivered, and where they are off track, a plan is in place to achieve them over a longer period of time.

	Risk 4.1 - Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience and sustainability of safer staffing levels To remain amber. Month on month the Trust continues to recruit more staff. A recruitment plan for 2023/24 is in development including the Trust's role as an anchor institution and linking with local networks and education providers to recruit to vacancies and encourage diversity. A revised recruitment and marketing plan for 2023/24 has been developed. **Risk 4.3 - Failure to support the wellbeing of staff** Retain as amber. EMT agreed the Trust wellbeing offer is effective but needs to be monitored, especially with continued vacancies and sickness absence across the Trust. The 2022 staff survey results have now been released and are being reviewed against the wellbeing offer to Trust staff. The view of EMT is that the ratings of individual strategic risks for Q4 are representative of the operating environment and pressures within our services. A separate paper is presented to Trust Board to consider and review the proposed strategic risk changes for 2023/24 and an update against these new risks, once approved, will be presented to Trust Board in July 2023.
Recommendation:	**Trust Board is asked to DISCUSS this report and APPROVE the updates to the Board Assurance Framework.**

BOARD ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

South West Yorkshire Partnership NHS Foundation Trust

Our mission: we help people reach their potential and live well in their community.

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

Strategic direction: Strategic objectives And priorities as set out in our Annual Plan, underpinned by our values and linked to wider health economy and regulatory requirements.

Strategic Objectives

Approved by Trust Board and reviewed regularly

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

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

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

Strategic risks linked to strategic objectives

Controls in respect of risks and strategic objectives

Assurances in respect of the controls and strategic objectives

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

Organisational level risk register, where the risk is outside the Trusts risk appetite, mitigated in accordance with Trust risk appetite statement. Summary reports into relevant Committees of the Board.

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

Exec Management Team

Individual director/Care Group assurance

Trust Board Committees

TRUST BOARD

Closure of gaps
- Time bound responsibilities identified plus lead

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

Board Assurance Framework (BAF) – 2022/23

Overview of current assurance level:

The rationale and the individual risk RAG ratings are set out in the following pages.

Strategic objective	Strategic risk	Page ref	Assurance levels					
			2021/22		2022/23			
			Q3	Q4	Q1	Q2	Q3	Q4
Improve health	1.1 The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place		A	A	A	A	A	Y
	1.2 The focus on integrated care models at place may result in unwarranted variation and differences in standards, and could potentially impact the sustainability of smaller specialist services		Y	Y	Y	Y	Y	Y
	1.3 Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve.		Y	Y	Y	Y	Y	Y
	1.4 Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy.		A	A	A	A	A	A
Improve care	2.1 The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives		A	A	A	A	A	A
	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.		Y	Y	Y	Y	Y	Y
	2.3 Increased demand for services and acuity of service users exceeds supply and resources available leaving to a negative impact on quality of care.		A	A	A	A	A	A
	2.4 Risk of deliberate and malicious harm to the Trust including cyber-crime, arson and violence resulting in a loss of confidence in and access to the services the Trust provides.		Y	Y	Y	Y	Y	Y
Improve resources	3.1 Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively		Y	Y	Y	Y	Y	Y
	3.2 Failure to develop strong relationships with integrated care systems, places, and provider collaboratives results in services that do not meet local needs or are unsustainable		G	G	G	G	G	G
	3.3 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		Y	Y	Y	Y	Y	Y
	3.4 Failure to embed new ways of working and develop digital and creative innovations resulting in reduced ability to meet increasing demand and less efficient service provision		N/A	N/A	Y	Y	Y	Y
Make this a great place to work	4.1 Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience and the inability to sustain safer staffing levels		A	A	A	A	A	A

Strategic objective	Strategic risk	Page ref	Assurance levels					
			2021/22		2022/23			
			Q3	Q4	Q1	Q2	Q3	Q4
	4.2 Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively		Y	Y	Y	Y	Y	Y
	4.3 Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies.		A	A	A	A	A	A

Key:
Lead Directors: CEO = Chief Executive Officer, DFR = Director of Finance, Estates & Resources, CPO =Chief People Officer, DNQ = Chief Nurse and Director of Quality and Professions, CMO = Chief Medical Officer, DSC = Director of Strategy and Change, COO = Chief Operations Officer, DPD = Director of Provider Development

Committees: AC = Audit Committee, CGCS = Clinical Governance & Clinical Safety Committee, EIC = Equality, Inclusion and Involvement Committee, FIP = Finance, Investment & Performance Committee, MHA = Mental Health Act Committee, WRC = Workforce & Remuneration Committee CC = Collaborative Committee

EMT = Executive Management Team, OMG = Operational Management Group, MC = Members' Council, ORR = Organisational Risk Register

Controls and Assurance inputs: I = Internal, E = External, P = Positive, N = Negative

RAG ratings:

G	= On target to deliver within agreed timescales
Y	= On trajectory but concerns on ability / confidence to deliver actions within agreed timescales
A	= Off trajectory and concerns on ability / capacity to deliver actions within agreed timescales
R	= Actions will not be delivered within agreed timescales
B	= Action complete

Strategic objective 1: Improve health	Lead Director(s)	Monitoring and assurance	Overall assurance level											
			2021/22				2022/23							
Links to ORR (risk ID numbers): 275, 695, 773 812,1157, 1511,1624, 1689	As noted below.	EMT, CGCS, MHA, Trust Board, CC	Q3		Q4		Q1		Q2		Q3		Q4	
			Y	A	Y	A	Y	A	Y	A	Y	A	Y	

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	RAG rating
1.1	**The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place**	Y
1.2	**The focus on integrated care models at place may result in unwarranted variation and differences in standards, and could potentially impact the sustainability of smaller specialist services**	Y
1.3	**Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve.**	Y
1.4	**Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy.**	A

Rationale for current assurance level (strategic objective 1: improve health)

- Integrated Care Boards are now in place and strategy refreshes have taken place in January 2023
- NHS Long Term Plan requires integrated care boards to grow investment in mental health services faster than the NHS budget overall, aligned to specific service requirements that will be common across all districts.
- Health & Wellbeing Board place-based plans have been contributed to through board discussions, commented on and where appropriate, agreed.
- Active and full membership of Health & Wellbeing Boards.
- Care Quality Commission (CQC) visit overall rating of good including well-led review (2019), partnership working acknowledged to be strong.
- Strong and robust partnership working with local partners, through emerging integrated partnerships in Barnsley, Calderdale, Kirklees and Wakefield.
- Coordinating provider for West Yorkshire Adult Secure collaborative and South Yorkshire Adult Secure collaborative and partnering provider collaboratives regionally
- Coordinating provider for forensic child and adolescent mental health services (CAMHS) for Yorkshire and the Humber
- Mental Health Learning Disability & Autism provider collaborative established in the South Yorkshire Integrated Care System
- A range of executive and board arrangements with trusts, integrated care boards and other stakeholders in each of the places where the Trust operates.
- Trust involvement and engagement with West Yorkshire and South Yorkshire Integrated Care Systems, especially on mental health is strong.
- The Trust is involved in the development of place-based plans and priority setting.
- Involved in development of Integrated Care Partnerships in Barnsley, Calderdale, Kirklees and Wakefield (boards and committees).
- Provider collaborative established in Calderdale led by CHFT
- Mental health offer well regarded with the establishment of Mental Health Provider Alliance in Wakefield. A similar approach has been developed in Kirklees. The Trust is also a member of the mental health partnership in Barnsley and has a formal alliance agreement in place with Barnsley primary care via the Barnsley Healthcare Federation to strengthen the joined-up community offer
- Stakeholder engagement plans in place.
- Friends and Family Test feedback from service users continues with noted variance in areas of low returns and low scores are being explored. Results continue to be triangulated with other feedback. Insight report, and Healthwatch.
- Work is taking place in CAMHS to gather and enhance service user feedback
- The Trust insight report now feeds the Executive Management Team meeting and Equality, Inclusion and Involvement Committee
- Integrated Performance Report (IPR) summary metrics month 11 out of area beds – red, children and young people accommodated on an adult inpatient ward – 2 service users, learning disability referrals with completed assessment, care package and commenced delivery within 18 weeks – red, delayed transfers of care – green.

Rationale for current assurance level (strategic objective 1: improve health)
• Transformation and priority programmes, including the measurement and impact on strategic risks, reported to Trust Board through the Integrated Performance Report (IPR), Clinical Governance & Clinical Safety Committee, and Audit Committee through the triangulation report. • Internal audit reports. • Patient experience and engagement toolkit in place. • Trust website rated good on Accessible Information Standard. • Covid-19 pandemic highlighted the disproportionate impact upon protected characteristics and specifically people with a learning disability and from the black, Asian, minority ethnic (BAME) community. Eight priority actions are being monitored through the Equality, Inclusion, and Involvement Committee • Trust health inequalities approach developed drawing on the Kings Fund framework and relevant aspects of Core 20 plus 5 • Trust engagement with Barnsley place through place partnership forums and community networks • Clear value proposition for our social prescribing offer in our places. • Additional capacity secured to support the development of insight using the new inequalities and data interactive tool to inform the inequalities plan • Comprehensive creative and cultural offer through Creative Minds and recovery colleges in each of our places to diverse communities. • The Trust is playing a key role in developing the West Yorkshire Integrated Care System creative health hub. • Compliance with the public sector equality duty. • A standard approach is in place to support involvement plans which include previous insight that has been gathered • Approach developed and implemented with Voluntary Community Sector partners in each of our places to strengthen insight involvement and co-production • Equalities interactive data and insight tool and approach developed • Process and approach in place to support formal consultation which is used when required • Mandatory training in place for all staff on equality and diversity. The Trust is currently conducting a review of mandatory training in respect of equality and diversity. • All services have a baseline Equality Impact Assessment (EIA) in place. • Deliver and report on compliance with Equality Delivery System (EDS2) annually. • Introduced mandatory Freedom to speak up training for all staff and managers to ensure that any service line issues are raised and addressed early. • Work on waiting lists across the Trust is being carried out with a focus on health inequalities • Chief allied health professional recruited and in place for January 2023, this provides enhanced governance and oversight of Allied Health Professional roles. • The Trust is working with partners across all of our places to reduce health inequalities

Strategic objective 2: Improve care	Lead Director(s)	Monitoring and assurance	Overall assurance level											
			2020/21				2021/22							
Links to ORR (risk ID numbers): 275, 695, 773, 852, 905, 1078, 1080, 1132, 1159, 1424, 1522, 1530, 1531,1568, 1649, 1758	As noted below.	EMT, CGCS, WRC, Trust Board	Q3			Q4		Q1		Q2		Q3		Q4	
			Y	A		Y	A	Y	A	Y	A	Y	A	Y	A

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	RAG rating
2.1	**The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives**	A
2.2	**Failure to create a learning environment leading to lack of innovation and to repeat incidents.**	Y
2.3	**Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care.**	A
2.4	**Risk of deliberate and malicious harm to the Trust including cyber-crime, arson and violence resulting in a loss of confidence in and access to the services the Trust provides.**	Y

Rationale for current assurance level (strategic objective 2: improve care)
• Enhanced Infection prevention and control processes in place to manage covid-19 outbreaks • Covid-19 outbreak data is monitored through the IPR • Incidents of outbreaks of Covid-19 on inpatient wards and within clinical teams continue to be monitored with an established process in place. • A band 7 Speech and Language Therapist has been established to take a lead role in our approach to dysphagia • Business intelligence development plan is being aligned to Trust strategic objectives and priority programmes including health intelligence data and reporting. • Trust developing overarching operational data quality improvement plan which will be monitored by Improving Clinical Information Group (ICIG) and Operational Management Group (OMG) • Focused information provided for out of area bed review to support improvement • Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 11 shows: Friends & Family (F&F) Test MH – Green F&F Test Community – Green, safer staff fill rates – green, IG confidentiality breaches – Red. • Ongoing improvement work around the FIRM risk assessment and care planning continues. A task and finish group has been established to focus on risk assessment and care planning. • Waiting list management in SystmOne is being prioritised for roll out. • Investment in Estates and Facilities and IT infrastructure. The Trust estates strategy is in the process of being updated. • Clinical services monitor OPEL levels to guide our emergency responses Partnership arrangements are at different stages of development in each of the places in which we provide services. • Data quality and waiting list management project progressing

Rationale for current assurance level (strategic objective 2: improve care)
• Staff commitment to the Trust values is evidenced through the excellence awards and regularly reviewed as part of the Trust appraisal and supervision process. • Quality Improvement (QI) culture is becoming embedded with a particular emphasis on our learning from QI approach and application in practice of our IHI training including a focus on spreading best practice from sexual safety collaborative • In the main, positive Friends and Family Test feedback from service users. Noted variance in areas of low returns and low scores are being explored. Results continue to be triangulated with other feedback. Insight report, and Healthwatch. • Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery • Regular analysis and reporting of incidents through clinical risk panel • Development of trust wide arrangements for learning and improving standards, recognised by CQC and NHSE • The Trust has processes in place to capture learning from innovation and change • Internal audit reports – Serious Incident Action planning, Formulation Informed Risk Management (FIRM) risk assessments, System Partnership working: place governance, pay expenditure and Sustainability all received significant assurance, DSPT (2021-2) substantial assurance. These all contribute the Head of Internal Audit Opinion which is currently on track to maintain the high Trust standard. • 98% compliance with internal audit actions. • Care Quality Commission (CQC) assessment overall rating of good, CQC conducted a well-led review in 2019 which contributed to the overall rating provided. • Bed occupancy and patient acuity has been consistently high, particularly in adult acute, psychiatric intensive care units (PICU) and medium secure forensic services. • Testing and support for service users in response to Covid-19 continues • Support for staff in response to Covid-19 continues • Freedom to speak up audit completed which received limited assurance. All actions complete and in order to give further independence the role has been moved from the People Directorate to Corporate Governance. • Cyber awareness tested with staff by means of a survey and phishing exercise. E-mail accreditation in place with action plan for 22/23. • Reducing restrictive practices and interventions (RRPI) and trauma informed organisation steering group has been launched with piloted with identified teams – senior responsible owners are the chief people officer and chief nurse and director of quality and professions • A new report “the care group quality and safety report” is being presented to all CGCS meetings to provide assurance on the quality impact of operational pressures in care groups.

Strategic objective 3: Improve resources	Lead Director(s)	Monitoring and assurance	Overall assurance level					
			2020/21		2021/22			
Links to ORR (risk ID numbers): 275, 812, 852, 905, 1080, 1114, 1217, 1319, 1368, 1432, 1585	As noted below.	EMT, AC, WRC, Trust Board, FIP	Q3	Q4	Q1	Q2	Q3	Q4
			Y	Y	Y	Y	Y	Y

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	RAG rating
3.1	**Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively.**	Y
3.2	**Failure to develop strong relationships with integrated care systems, places, and provider collaboratives results in services that do not meet local needs or are unsustainable.**	G
3.3	**Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.**	Y
3.4	**Failure to embed new ways of working and develop digital and creative innovations resulting in reduced inability to meet increasing demand and less efficient service provision.**	Y

Rationale for current assurance level (strategic objective 3: improve resources)
• Financial arrangements are in place for 2023/24 and will remain predominantly on a block basis. Longer term planning due to commence shortly and anticipated to be two years in detail and three years at high level • Financial arrangements for adult secure lead provider collaboratives in South and West Yorkshire are on a cost per case and cost and volume basis. Taking a year view this presents a medium level of risk to the Trust • The Trust has submitted a break even plan with a 3.2% efficiency requirement • There has been a sustained increase in acuity and demand leading to an increase in out of area bed placements and costs, this was a considered management decision to manage demand and pressure on inpatient staffing Targets are in place to reduce this out of area usage during 2023/24 however, the Trust is continuing to manage high levels of demand and acuity as a result of which OOA placements may not reduce in line with plans. • Internal audit reports – Serious Incident Action planning, Formulation Informed Risk Management (FIRM) risk assessments, System Partnership working: place governance, pay expenditure and Sustainability all received – significant assurance, with 98% follow up completion rate for actions. • Head of internal audit opinion for 21/22 was significant assurance • Integrated Performance Report (IPR) summary metrics will be updated to reflect the new strategic priorities for 23/24 in Q1 • Closing cash balance at the end of 2022/23 was £74.6m. • Partnership arrangements are established within each place. • Positive well-led results following Care Quality Commission (CQC) review (2019), with revised preparation for the next inspection taking place • Lead provider collaboratives for forensics, CAMHS and eating disorders in West Yorkshire have gone live from 1st October 2021. Board approval was sanctioned to take on lead provider of the South Yorkshire collaborative in May 2022 and is now live. The Board has approved the Trust to be coordinating provider for forensic CAMHS for Yorkshire and Humber region go live for 1 April 2023. • Mental health investment standard and other recent income growth continues to support our financial position. At present, all places continue to invest to a level compliant with MHIS. The Trust is in the process of agreeing final contracts as a provider. • Inflationary pressures are challenging for revenue and capital planning . Reviews are under way to consider mitigating actions. • Updated priority programmes for 2023-24 are aligned to strategic objectives and will be monitored as part of the IPR reporting. • Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes.

Rationale for current assurance level (strategic objective 3: improve resources)
• The Trust has an approved digital strategy with the most recent update being presented to Trust Board in November 2022 and approved. • Capacity has been obtained to progress Digital dictation in the Trust and phase 1 will be complete for July 2023. Phase 2 will be the implementation phase and there is an ongoing capacity risk within care groups to support implementation in regards to training. • New standing financial instructions and scheme of delegation approved by Trust Board (January 2023) and Members Council (February 2023)

Strategic objective 4: Make this a great place to work	Lead Director(s)	Monitoring and assurance	Overall assurance level					
			2020/21		2021/22			
Links to ORR (risk ID numbers): 1151, 1157, 1614, 1729	As noted below.	EMT, WRC, Trust Board	Q3	Q4	Q1	Q2	Q3	Q4
			A	A	A	A	A	A

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	RAG rating
4.1	**Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience and the inability to sustain safer staffing levels**	A
4.2	**Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively**	Y
4.3	**Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies.**	A

Rationale for current assurance level (strategic objective 4: make this a great place to work)
• Vacancies in key areas – high vacancy levels across clinical functions • Use of bank agency and medical locums to manage current level of vacancies • Staff turnover rates have stabilised but vary between care groups and service lines with turnover in inpatient areas presenting the highest numbers. • Care Quality Commission (CQC) visit overall rating of good (2019). • Changes to the Integrated Performance Report (IPR) to improve oversight and compliance at both Board and Board Committee level • Staff survey results for 2022 have been received and the Trust in comparison to similar local organisations is in a relatively positive position. Action plans are in development Positive progress resulting from workforce actions including increased international recruitment, implementation of new roles and entry level roles across the Trust. • The internal audit of Trust exit process for leavers is now complete and has been reported to Audit Committee. Action plan delivery on track • The Trust now has a full and substantive board including both executive and non-executive roles. • The Trust has a comprehensive development programme across all levels of leadership and management. • Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. • Support to staff continues in the form of, health and wellbeing offer, and is under constant review. • A range of staff networks are in place including REACH Race, Equality and Cultural Heritage (formerly BAME), LGBT+, disabilities, staff side and working carers. Staff networks attend at Board on rotation and all network meeting are attended by the Chief People Officer • Full-time lead Freedom to Speak up Guardian is in post and progression against internal audit report action plan being monitored by PRC. • A freedom to speak up steering group has been developed that will now report into PRC. • Introduced mandatory Freedom to speak up training for all staff and managers to ensure that any service line issues are raised and addressed early. • Clear roles communications are in place for Equity guardians, FTSU champions, Staff Side champions and RESPECT champions • The Trust continues to work in a positive relationship with Staff side, including fortnightly formal meetings with the People Director and bi-monthly trust partnership forums including members of EMT. • Open and just culture approach has resulted in reduced disciplinary and other formal casework across the Trust. • Financial year April 2022 to March 2023 the Trust grew by over one hundred and forty net full time equivalent members of staff . • The inclusive leadership programme has been commissioned to start in February 2023 and will be rolled out through the course of the year. This will support the Trust culture and diversity agendas including Board discussion in May • The Trust has successfully recruited to a full time diversity and inclusion lead to start in January 2023 to support diversity and inclusion across the Trust. • Outbreaks of Covid-19 on wards have reduced leading to less Covid related absence. • Staffing levels are being maintained through the real time monitoring and deployment of staff across functions to ensure safety for all services • A change in the appraisal window has been introduced to ensure more effective monitoring of appraisal rates across the organisation. • Values based recruitment and appraisal processes are embedded within the Trust • Regular engagement between the chief people officer and staff governors to ensure staff voice is represented and gather insight into staff experience • Successful recruitment of full time OD and wellbeing facilitator to support and improve staff experience within the Trust • Board development programme now in place for 23/24 which is driven by Trust values and recognises the Boards duty to lead and role model behaviours and culture • Trust values are embedded in appraisal and leadership development programmes across the Trust. • Trust Board discussions are consistently linked to the Trusts values, and all Board members are encouraged to challenge themselves and each other to lead through values, and model Trust behaviours

Strategic risk 1.1 The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place			
Controls (strategic risk 1.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DFR	1.1, 1.2, 1.4
C02	Operational Management Group (OMG) meetings identify and rectify performance issues and learn from good practices in other areas. (I)	COO	1.1, 1.2, 1.4, 2.2, 2.3
C03	Senior representation on West Yorkshire and South Yorkshire mental health, learning disability and autism collaborative and associated workstreams. (I, E)	DPD	1.1, 1.4
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DSC/DPD	1.1, 1.4, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR/DPD	1.1, 1.2, 2.3, 3.1, 3.2
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C07	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	DSC	1.1, 1.2, 1.3
C08	Formal contract negotiation meetings with integrated care boards, NHSE boards, NHSE and provider collaboratives underpinned by national agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with integrated care boards to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets are in place for 2023/24(I, E)	DNQ	1.1, 1.4, 3.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO/DPD	1.1, 1.3, 2.3
C11	Governors' engagement and involvement on Members' Council and working groups, holding Non-Executive Directors (NEDs) to account. (I)	CEO	1.1
C12	Partnership Fora established with staff side organisations to facilitate necessary change. (I)	CPO	1.1
C13	Priority programmes supported through programme/CHANGE management approach. (I)	DSC	1.1
C14	Project Boards for change programmes and work streams established, with appropriate membership skills and competencies, project initiation documents (PIDs), project plans, project governance, risk registers for key projects in place. (I)	DSC	1.1, 1.2
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C16	Operational leadership arrangements provide a link to each place and have oversight of service pathways to minimise unwarranted variation . (E)	COO	1.1
C17	Member of South Yorkshire & Bassetlaw mental health, learning disability and autism programme board. Partner in SYB provide alliance. (I, E)	DSC	1.1, 1.4
C18	Meetings with Healthwatch organisations in each place. (E)	DSC	1.1
C19	Process and approach in place to support formal consultation on the Trust's strategic direction. (I, E)	DSC	1.1
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via MHA, Clinical Governance Clinical Safety Committee (CGCS) and Equality, Inclusion, and Involvement Committee. (E, I)	DSC / DNQ / CMO	1.1, 1.2, 1.3, 1.4
C123	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P, I)	CEO	1.1, 1.2
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	CEO	1.1, 1,2, 1.3
C126	Commissioning intentions are factored into operating plans as part of the planning process aligned to national guidance. (P, I)	DFR, COO	1.1, 1.2, 1.4, 3.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through quality improvement and assurance team in line with Trust agreed priorities (P, N, I).	DNQ	1.1, 1.2, 1.3
C145	Service user survey results reported annually to Trust Board and action plans produced as applicable. (P, N, I).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I).	COO	1.1, 1.2, 3.1, 3.2
C168	The Executive Management Team (EMT) have reviewed key internal and external meetings to make sure the Trust has effective representation as required. (I, E, P)	DSC	1.1
C181	Operational and Care Group structures have been updated around care pathways (I,P)	COO	1.1

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Impact of local place-based arrangements and solutions and Integrated Care System initiatives – recognition that elements of this are not fully within our control, however we continue to play our part and help shape developments in all places and influence across the two ICSs and working in partnership to reduce health inequalities and improve mental and physical health in line with national guidance. (Linked to ORR Risk ID 812) Following go live of the Health and Social Care Act on 1 July 2022 work continues to establish governance routes in	July 2023	DSC / DPD

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
place. Governance structures and systems have been implemented in each place, these will be subject to regular review until they become fully embedded and established. Governance arrangements are now in each place and are being reviewed when necessary to assess effectiveness. Review further in July 2023.		
A provider collaborative in South Yorkshire is in development for mental health, learning disability and autism. Progress to be reviewed at the end of Q4. Reviewed in April 2023 still in progress review further July 2023	July 2023	DSC / DPD
Levels of engagement with primary care networks could differ by place and lead to inconsistent development of services. The Trust is working in partnership to develop the detail of the local transformation development plan. Continue to work with primary care networks in each of our places to harness the benefits of the Additional Roles Reimbursement Scheme (ARRS) mental health practitioners implemented in each place. This is within the context of mental health community transformation in each place. Regional and national conversations are taking place regarding modelling and implementation. The Trust will continue to engage with primary care through the community transformation programme and place based integrated care forums. Still in development review July 2023.	July 2023	DSC/DPD
Further develop and embed the approach to using insight and data to address service access and experience in relation to health inequalities. The Trust continues to embed the approach and testing in identified areas is underway. Progress is being made but further work required. Review further in July 2023	July 2023	DSC/DPD/COO

Assurance (strategic risk 1.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re. quality impact. (I) (P)	DSC	1.1, 1.2, 1.3, 2.3, 3.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality monitoring structure. Reports on these visits are provided to the EMT, Clinical Governance &Clinical Safety Committee (CGCS) Trust Board and Members' Council.	Annual unannounced and planned visits programme in place and annual report is now received directly by the Clinical Governance Clinical Safety Committee (CGCS). Quality monitoring visits for 2023/24have started and will be reported into CGCS Committee in due course. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Calderdale, Kirklees, and Barnsley for 23-24. (P) (I) (E)	DFR	1.1, 3.1, 3.2
A16	Update reports on WY and SY ICS progress.	Routine report into EMT and Board. (P) (I)	DSC/DPD	1.1
A17	Reports from Barnsley, Calderdale, Kirklees, and Wakefield Partnership Board and Health and Wellbeing.	Update reports into EMT and Board. (P, N) (I)	DSC / DPD	1.1, 1.2
A19	Proactively involved as a partner in integrated care partnership arrangements in each place.	Meeting minutes and papers provided and circulated to Trust Board (P) (I, E)	DPD / DSC	1.1
A20	Reports are reviewed by EIIC, CGCS and MHA Committee on service access and experience. Mental Health Act visits on a regular basis.	Patient experience reports & integrated performance report (IPR) data on access & waiting times included in the new Equality & Inclusion interactive tool. (P) (I)	DNQ	1.1, 1.2, 1.3, 1.4

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Impact of local place-based arrangements and solutions and Integrated Care System initiatives – recognition that elements of this are not fully within our control, however we continue to play our part and help shape developments in all places and influence across the two ICSs and working in partnership to reduce health inequalities and improve mental and physical health in line with national guidance. (Linked to ORR Risk ID 812) Following go live of the Health and Social Care Act on 1 July 2022 work continues to establish governance routes in place. Governance structures and systems have been implemented in each place, these will be subject to regular review until they become fully embedded and established. Governance arrangements are now in each place and are being reviewed when necessary to assess effectiveness. Review further in July 2023.	July 2023	DSC / DPD

Strategic risk 1.2 The focus on integrated care models at place may result in unwarranted variation and differences in standards, and could potentially impact the sustainability of smaller specialist services

Controls (strategic risk 1.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments.. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DFR	1.1, 1.2, 1.4
C02	Care Group performance and Operational Management Group (OMG) meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	COO	1.1, 1.2, 1.4, 2.2, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C07	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	DSC	1.1, 1.2, 1.3
C14	Project Boards for change programmes and work streams established, with appropriate membership skills and competencies, project initiation documents (PIDs), project plans, project governance, risk registers for key projects in place. (I)	DSC	1.1, 1.2
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via MHA, Clinical Governance Clinical Safety Committee (CGCS) and Equality, Inclusion, and Involvement Committee and clinical risk panel. (E, I)	DSC / DNQ / CMO	1.1, 1.2, 1.3, 1.4
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed, and acted upon. (I, E)	DNQ	1.2, 1.4, 2.3
C22	Operations management structure reflects an approach to ensuring consistent delivery of services. (I)	COO	1.2
C123	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P, I)	CEO	1.1, 1.2
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	CEO	1.1, 1,2, 1.3
C126	Commissioning intentions are factored into operating plans as part of the planning process. This is focussed on a place-based planning approach overseen by the introduction of integrated care board (ICBs) (P, E, I)	DFR, COO	1.1, 1.2, 1.4, 3.2
C140	The Trust is registered with the CQC and assurance processes are in place through the DNQ to ensure continued compliance – monthly meeting with CQC local relationship manager and quarterly engagement meetings between DNQ & CQC. (P) (I)	DNQ	1.1 1.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meeting take place between Chief Executive and Directors. (P) (I)	CEO	All
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through quality improvement and assurance team in line with Trust agreed priorities. (P, N, I).	DNQ	1.1, 1.2, 1.3
C145	Service user survey results reported annually to Trust Board and action plans produced as applicable. (P, N, I).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I).	COO	1.1, 1.2, 3.1, 3.2
C149	Revised operational structure includes oversight of pathways across the organisation that reach into each place (P, N, I).	DSC	1.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Alignment of our plans with Integrated Care Boards. Alignment of operational and quality plans are being developed through place governance structures. Work is expected to be completed by May 2023 update further July 2023	July 2023	DPD/COO/DFR
Place based plans and other system transformation programmes are developing and the Trust is participating in developing place based plans across all places with an expected date of completion of April 2023. Work expected to be completed by May 2023 and will update further in July 2023	July 2023	DPD
The Trust continues to embed and further develop the Barnsley Integrated Health and Care Alliance with partners, delivering on agreed plans and priorities. Business plan and priorities for 23/24 are now being developed. Update further in July 2023.	July 2023	DSC/COO

Assurance (strategic risk 1.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2

Assurance (strategic risk 1.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A09	Transformation changes and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re. quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality monitoring structure. Reports on these visits are provided to the EMT, Clinical Governance &Clinical Safety Committee (CGCS) Trust Board and Members' Council.	Annual unannounced and planned visits programme in place and annual report is now received directly by the Clinical Governance Clinical Safety Committee (CGCS). Quality monitoring visits for 2023/24have started and will be reported into CGCS Committee in due course. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A17	Reports from Barnsley, Calderdale, Kirklees, and Wakefield Partnership Board.	Update reports into EMT. (P, N) (I)	DSC/DPD	1.1, 1.2
A20	Reports are reviewed by EIIC, CGCS and MHA Committee on service access and experience. Mental Health Act visits on a regular basis.	Patient experience reports & integrated performance report (IPR) data on access & waiting times included in the new Equality & Inclusion interactive tool. (P) (I)	DNQ	1.1, 1.2, 1.3, 1.4
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A22	Serious incidents from across the organisation reviewed through the Clinical Risk Panel including the undertaking proportionate analysis investigations and dissemination of lessons learnt and good clinical practice across the organisation. We are currently embedded the principles of the patient safety incident review framework. (PSIRF)	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to OMG, EMT, Clinical Governance & Clinical Safety Committee and Trust Board. "Our Learning Journey Report" (P, N) (I)	DNQ	1.2, 2.2
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR	1.2, 3.1, 3.2, 3.3
A24	Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN quality performance is monitored through Clinical Governance Group (CGG)	Monthly Integrated Performance reporting (IPR) to CGG, EMT, Finance, Investment & Performance Committee and CGCS and Trust Board. (P, N) (I).	DNQ	1.2, 3.1, 3.3
A26	Great place to work strategy completed in line with national people plan in April 2021	Signed off by Trust Board in April 2021. Update reports into EMT and Workforce & Remuneration Committee. (P) (I)	CPO	1.2
A85	The delivery plan for the Great Place to Work strategy including the OD agenda has presented to and approved by PRC for 23/24.	Updates on delivery of the plan will be provided at every PRC meeting and will be provided to Trust Board through the triple A report (P,N,I)	CPO	1.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
The planning process for 23/24 is complete and the Trust will now begin to look at longer term planning for years two and three for 24/25 and 25/26. This will take into account such factors as the aims and intentions of the NHS long term plan, the development of integrated care systems, local place plans, workforce planning, financial sustainability, longer-term impact of the pandemic including recovery and restoration, inequalities, and capital planning. Finance is working up a three-year long term financial plan (LTFP) which will come back through FIP and Board. Reviewed regularly through FIP and an annual update was provided to Board in Jan 23. Currently it is anticipated that the Trust will have a LTFP in place by Q3/Q4 , this will be subject to national planning guidance timelines.	September 2023	DFR
The new people directorate structure and great place to work strategy in place but vacancies within the people directorate could pose a risk to both achievement of outcome and timescales	July 2023	CPO

Strategic risk 1.3 Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve.

Controls (strategic risk 1.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C07	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	DSC	1.1, 1.2, 1.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO/DPD	1.1, 1.3, 2.3
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C23	Strategic priorities and underpinning programmes supported through robust programme and change management approaches and in line with the Integrated Change Framework. (I)	DSC	1.3
C24	All non-training grade senior medical staff participate in a job planning process which reviews and restates priority areas of work for these senior clinical leaders. (I)	CMO	1.3
C25	Participate in national benchmarking activity for mental and community health services and act on areas of significant variance. (I)	DFR	1.3
C26	Community reporting used as a tool to enable people to talk to members of their own community about their experience and approach developed and implemented with VCS partners in each of our places to strengthen insight involvement and co-production (I,E)	DSC	1.3, 1.4
C27	Governors supported to involve people at a locality level, Toolkit in place. (I, E)	DSC	1.3, 1.4
C28	Toolkit in place to capture patient stories. (I)	DSC	1.3, 1.4
C29	Process in place to demonstrate compliance with the public sector equality duty. (I)	DSC	1.3
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Equality, Inclusion, and Involvement Committee. (I)	DSC	1.3, 1.4
C31	Joint Needs Assessment (JNA) data reflected in all service EIAs. (I)	DSC	1.3, 1.4
C32	JNA data used to identify involvement approaches. (I)	DSC	1.3
C33	Service line equality data used to identify the existing target audience to ensure methods and approaches meet the needs of those audiences. (I)	DSC	1.3
C34	Provision of information, leaflets, and posters which meet the Accessible Information Standard. (I)	DSC	1.3
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.3
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	DFR	1.1, 1,2, 1.3
C127	Communication leads network established in places and across ICSs (P, I, E)	DSC	1.3
C128	Senior level representation at Health & Wellbeing Boards in each place. (P, E)	DSC	1.3
C129	Ongoing meetings with Healthwatch organisations in each place. (P, I, E)	DSC	1.3
C130	Working with partners such as Healthwatch, public sector colleagues and ICSs to collectively capture and share insight and intelligence and avoid duplication. (P, I, E,)	DSC	1.3
C131	Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) process integrated and used at gateways in transformation and change programmes. (P, I)	DSC	1.3
C138	Trust wide Equality Impact Assessment together with the inequalities data developing systemic analysis and plans to address Trust inequality priorities (P, I)	DSC	1.3
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C143	Trustwide Benchmarking Group established. This is chaired by Director of Finance, Estates and Resources and reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. (P, E, I)	DFR	1.3, 2.1
C144	Audit of compliance with policies and procedures in line with approved plan co-ordinated through quality improvement and assurance team in line with Trust agreed priorities. (P, N, I, E).	DNQ	1.1, 1.2, 1.3
C145	Service user survey results reported annually to Trust Board and action plans produced as applicable. (P, N, I, E).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
C147	Trust website rated as good on Accessible Information Standard. (P, N I, E)	DSC	1.3
C162	CHATpad is a tablet available on every Trust ward which allows for communication with a loved one, carer, friend, staff member or advocate via zoom and is used to capture patient views using an online survey. The use of tablets is promoted to patients, visitors, carers and advocacy services to retain contact and improve communication. (P, I)	DSC	1.3
C163	Approach to capturing insight and service user feedback from a range of stakeholders in place (insight report) (P, E, I)	DSC	1.3
C164	The EIA tools have been created, including the Trust wide EIA and literature (P, I)	DSC	1.3
C170	Data collection is in line with local and regional direction including Core20plus5 and the NHSE toolkit. An equality interactive tool dashboard has been established and continues to develop insight and ensure this is used to inform improvements and service change including the development of Equality Impact Assessments (EIA's)	DSC	1.3
C171	Health Intelligence support role now in place	DSC	1.3
C184	Targeted programmes are being delivered through linked charities	DSC	1.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Impact of local place-based arrangements and solutions and Integrated Care System initiatives – recognition that elements of this are not fully within our control, however we continue to play our part and help shape developments in all places and influence across the two ICSs and working in partnership to reduce health inequalities and improve mental and physical health in line with national guidance. (Linked to ORR Risk ID 812) Following go live of the Health and Social Care Act on 1 July 2022 work continues to establish governance routes in place.	July 2023	DSC/DPD

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Governance structures and systems have been implemented in each place, these will be subject to regular review until they become fully embedded and established. Governance arrangements are now in each place and are being reviewed when necessary to assess effectiveness. Review further in July 2023.		
Data collection is in line with local and regional direction including Core20plus5 and the NHSE toolkit. An equality interactive tool dashboard has been established and continues to develop insight and ensure this is used to inform improvements and service change including the development of EIA's. This approach now needs to be embedded across clinical and non-clinical services. Dashboard is in place, but work continues to further evolve this. Review further in July 2023	July 2023	DSC

Assurance (strategic risk 1.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to Audit Committee and CG&CS Committee re. quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A20	Reports are reviewed by EIIC, CGCS and MHA Committee on service access and experience. Mental Health Act visits on a regular basis.	Patient experience reports & integrated performance report (IPR) data on access & waiting times included in the new Equality & Inclusion interactive tool. (P) (I)	DNQ	1.1, 1.2, 1.3, 1.4
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Building capacity and capability through EIA and equality and inclusion themed development sessions and diversity training. Training to be rolled out over the next twelve months. EIA training continues. Review further in July 2023	July 2023	DSC
Continuing to evolve the use of the dashboard and the Business Intelligence tools to address health inequalities. Staff commenced in post mid November 2022, progress to be reviewed in July 2023.	July 2023	DSC

Strategic risk 1.4
Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy.

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DFR	1.1, 1.2, 1.4
C02	Operational Management Group (OMG) meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	COO	1.1, 1.2, 1.4, 2.2, 2.3
C03	Senior representation on West Yorkshire and South Yorkshire mental health collaborative and associated workstreams. (I, E)	DPD	1.1, 1.4
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DSC	1.1, 1.4, 2.3
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C08	Formal contract negotiation meetings with integrated care boards, NHSE and provider collaboratives underpinned by national agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with integrated care boards to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets are in place for 2022/23 (I, E)	COO	1.1, 1.4, 3.3
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC/CPO	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C17	Member of South Yorkshire & Bassetlaw mental health, learning disability and autism programme board. Partner in emerging SYB provide alliance. (I, E)	DSC	1.1, 1.4
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via MHA, Clinical Governance Clinical Safety Committee (CGCS) and Equality, Inclusion, and Involvement Committee. (E, I)	DSC / DNQ / CMO	1.1, 1.2, 1.3, 1.4
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed, and acted upon. (I, E)	DNQ	1.2, 1.4, 2.3

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C26	Community reporting used as a tool to enable people to talk to members of their own community about their experience and approach developed and implemented with VCS partners in each of our places to strengthen insight involvement and co-production (I, E)	DSC	1.3, 1.4
C27	Governors supported to involve people at a locality level, toolkit in place. (I, E)	DSC	1.3, 1.4
C28	Toolkit in place to capture patient stories. (I)	DSC	1.3, 1.4
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Equality, Inclusion, and Involvement Committee (I)	DSC	1.3, 1.4
C31	JNA data reflected in all service EIAs. (I)	DSC	1.3, 1.4
C37	Equality, Inclusion and Involvement Committee and sub-committee in place. (I)	DSC	1.4
C38	Trust website rated good on Accessible Information Standard. (I)	DSC	1.4
C39	Translation and interpretation service in place. (I)	DSC	1.4
C40	Photo symbol package available to staff. (I)	DSC	1.4
C41	Patient experience and engagement toolkit in place. (I)	DSC	1.4
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, COO	1.1, 1.2, 1.4, 3.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C145	Service user survey results reported annually to Trust Board and action plans produced as applicable. (P, N, I, E).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
C148	All services have a baseline Equality Impact Assessment (EIA) in place. (P) (I)	DSC	1.4
C185	Improving access to care priority programme established (P, I)	DSC	1.4
C186	Dashboard and business intelligence tools in place to help address health inequalities	DSC	1.4

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Continuing to evolve the use of the dashboard and the Business Intelligence tools to address health inequalities Staff commenced in post mid November 2022, progress to be reviewed in July 2023.	July 2023	DSC / DNQ

Assurance (strategic risk 1.4)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A20	Reports are reviewed by EIIC, CGCS and MHA Committee on service access and experience. Mental Health Act visits on a regular basis.	Patient experience reports & integrated performance report (IPR) data on access & waiting times included in the new Equality & Inclusion interactive tool. (P) (I)	DNQ	1.1, 1.2, 1.3, 1.4
A24	Investment Appraisal report – covers bids and tenders' activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A33	Patient experience service reports to Trust Board (annual) and CGCS Committee.	Annual reports to Board / EMT and quarterly into CGCS. (P, N) (I)	DNQ	1.4, 2.3
A34	Quality strategy review updates report into CG&CS Committee.	Routine reports into CG&CS via IPR and annual report scheduled in 2021/22 work plan. Quality strategy currently under review, with a planned publication of September 2022 (P) (I)	DNQ	1.4, 2.3
A35	Equality interactive tool presented to Equality, Inclusion, and Involvement Committee	Regular reports and papers provided. (P) (I)	DSC	1.4

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 2.1 The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives

Controls (strategic risk 2.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C42	Access to the model hospital to enable effective national benchmarking and support decision making. (E, I)	DFR	2.1
C43	Development of data warehouse and business intelligence tool supporting improved decision making. (I)	DFR	2.1
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and half yearly report to Trust Board. (I)	DFR	2.1
C45	Risk assessment and action plan for data quality assurance in place. (I)	DFR	2.1
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C47	Weekly incident risk scan where all red, amber, staffing related and incidents related to protected characteristics are reviewed for immediate learning. (I)	DNQ / CMO	2.1, 2.3, 4.1
C48	Improving Clinical Information & Information Governance Group (ICIG) reviews clinical information systems and data quality. (I)	DNQ / DFR	2.1
C49	Internal process to impact assess / review potential new systems from a technical and information governance (IG) standpoint. (I)	DFR	2.1
C50	Change control process in place for operational / service level requests / changes, for system-wide changes and developments. (I)	DFR	2.1
C51	National benchmarking data is reviewed at the benchmarking group and then analysed and taken to OMG, EMT and Finance, Investment & Performance Committee. (I)	DFR	2.1
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C143	Trustwide Benchmarking Group established. This is chaired by Chief Operating Officer and reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. (P, E, I)	DOF	1.3, 2.1
C172	Data quality and waiting list management project lead in post from December 2021 (I, P)	DFR	2.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The waiting list project is ongoing and funding has now been extended to September 2023. The project is now linked into the access to care groups to determine areas of priority. Reviewed in April 2023 and to review further in July 2023	July 2023	DFR

Assurance (strategic risk 2.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A37	Data quality improvement plan monitored through Executive Management Team (EMT) deviations identified and remedial plans requested.	Included in monthly IPR to OMG, EMT and Trust Board. Regular reports to Audit Committee. (P) (I)	DNQ/DFR	2.1
A38	Progress against SystmOne optimisation reviewed by Clinical Safety Design Group, EMT and Trust Board.	Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT and Trust Board. (P) (I)	DNQ	2.1
A39	Quarterly Board Assurance Framework and Risk Register report to Board providing assurances on actions being taken.	Quarterly risk register reports to Board. Triangulation of risk, performance, and governance present to each Audit Committee. (P) (I)	DFR	2.1
A40	Data quality focus at OMG and ICIG and in the Brief	Regular agenda items and reporting of at ICIG and OMG. (P, N) (I)	DNQ/COO	2.1
A41	Benchmarking reviews and deep dives conducted at Finance, Investment and Performance Committee.	Reports provided regularly. (P) (I)	COO / DFR	2.1
A42	OMG management processes.	OMG minutes taken into EMT, summary of finance and performance reviews into EMT monthly. (I) (P)	COO	2.1

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Continuing to evolve the use of the dashboard and the Business Intelligence tools to address health inequalities Staff commenced in post mid November 2022, progress to be reviewed in July 2023	July 2023	DSC

Strategic risk 2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.

Controls (strategic risk 2.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C02	Care Group performance and Operational Management Group (OMG) meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	COO	1.1, 1.2, 1.4, 2.2, 2.3
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C52	Patient experience reporting includes learning from complaints and concerns. (I)	DNQ	2.2, 4.1
C53	Patient Safety Strategy developed to reduce harm through listening and learning. (I)	DNQ	2.2, 4.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.2, 4.1
C55	Quality Strategy achieving balance between assurance and improvement. (I)	DNQ	2.2
C56	Quality improvement approach and methodology. (I)	DNQ	2.2, 2.3
C57	Leadership and management arrangements established and embedded at Care Group and service line level with key focus on clinical engagement and delivery of services. (I)	COO	2.2, 4.1
C58	Learning lessons reports, Care Groups, post incident reviews. (I)	DNQ	2.2
C59	Risk Management Governance Framework in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training. (I)	CEO/DFR	2.2
C60	Weekly serious incident summaries to Executive Management Team (EMT) supported by monthly reports to OMG, quarterly reports to Clinical Governance & Clinical Safety Committee and Trust Board. (I)	DNQ	2.2
C61	I-hub platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate, and improve. (I)	DSC	2.2
C62	Peer lead worker role in place and training toolkit developed. (I)	DSC	2.2
C139	Process established for the use of improvement case studies which are then shared by the communications team and published on the Trust website. (P, I)	DSC	2.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C161	Learning from innovation process through use of SBAR structure to create short learning case studies which are shared with all staff via the Trust headlines (P, I)	DSC	2.2
C173	The use of external experts to for serious incident investigations and reviews when appropriate (P, N, I, E)	DNQ	2.2
C174	Internal audit report received demonstrating significant assurance against SI action planning (November 2022) (P,I,E)	DNQ	2.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Following receipt of significant assurance on the Trusts SI action planning, clinical governance and clinical safety committee (CGCS) and the clinical governance group continue to monitor the embedding of learning and the evidence to support this. Progress against this to be assessed in April 2023. CGCS are overseeing the learning from SI action plans clear evidence of learning is the gap – committee will continue to monitor. July 2023	July 2023	DNQ

Assurance (strategic risk 2.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A22	Serious incidents from across the organisation reviewed through the Clinical Risk Panel including the undertaking proportionate investigations and dissemination of lessons learnt and good clinical practice across the organisation. We are currently embedded the principles of the patient safety incident review framework. (PSIRF)	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to OMG, EMT, Clinical Governance & Clinical Safety Committee and Trust Board. "Our Learning Journey Report" (P, N) (I)	DNQ	1.2, 2.2
A44	Risk scan update into each EMT meeting.	Risk scan update into EMT meeting. (P, N) (I)	DNQ	2.2
A45	Assurance reports to CG&CS Committee covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place.	Routine report to each CG&CS Committee of risks aligned to the committee for review. (P) (I)	DNQ	2.2
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P) (I)	DSC	2.2, 4.1

Assurance (strategic risk 2.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A47	Examples of co-production in recovery colleges and Creative Minds	Reports to CFC and to Corporate Trustee for Charitable Funds. Creative Minds produce reports that go to CFC and recovery colleges report into OMG. (P, I)	DSC	2.2
A48	Inpatient structure provides assurance of operational grip in relation to record keeping.	Routine matron checks reported through Care Group governance groups and in governance report to CG&CS. (P) (I)	COO	2.2
A51	Action planning from the assurance paper in relation to the Panorama and Dispatches	Reports go into the clinical governance group and then clinical governance clinical safety committee (CG & CS)	DNQ	2.2
A57	Learning from the East Kent review of maternity services is being incorporated into broader patient safety structures	Reported via the Care Group Quality and Safety Report into (CG & CS)	DNQ	2.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Impact of information governance (IG) training and action plan on IG hotspots. (Linked to ORR risk 852). Bespoke and ad-hoc training has been re-introduced in January 2023. Comms campaigns, action plans and thematic reviews continue. Fluctuating numbers of incidents are being reported this year with no real trend identified. The cause of most incidents continues to be information disclosed due to human error and a comms campaign is running to address this. Due to low compliance with mandatory Data Security Awareness training, delivery of sessions to increase compliance is currently being prioritised over training for teams reporting the highest numbers of incidents. Reviewed in April 2023 and further review to take place in July 2023	To review in July 2023	DFR
Work on the inpatient priority programme is underway and is using learning to improve safe and effective care delivery. Expected date of completion April 2023. Part of the priority programme for 23/24 in line with national and regional inpatient Quality Transformation Programme for Mental Health, Learning Disabilities & Autism transformation	March 2024	COO
A Trustwide approach to shared decision making and co-production is being developed to support the delivery of personalised care and innovation in response to NICE guidance. Update April 2023 - with regards to Shared decision making (NICE guideline [NG197]), baseline assessment is underway, further update available in July 2023.	July 2023	DSC/DNQ

Strategic risk 2.3 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care.			
Controls (strategic risk 2.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C02	Care Group performance and Operational Management Group (OMG) meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	COO	1.1, 1.2, 1.4, 2.2, 2.3
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DSC/DPD	1.1, 1.4, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DSC/CEO/DPD	1.1, 1.3, 2.3
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC/CPO	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed, and acted upon. (I, E)	DNQ	1.2, 1.4, 2.3
C47	Weekly incident risk scan where all red, amber, staffing related and incidents related to protected characteristics are reviewed for immediate learning. (I)	DNQ / CMO	2.1, 2.3, 4.1
C56	Quality improvement approach and methodology. (I)	DNQ	2.2, 2.3
C63	Care Closer to Home Partnership Meeting and governance process. (I)	COO	2.3
C64	Care closer to home programme incorporating whole system actions with out of area bed reduction reported against trajectory. (I, E)	COO	2.3
C65	Safer staffing policies and procedures in place to respond to changes in need. (I)	DNQ	2.3
C66	TRIO management system monitoring quality, performance, and activity on a routine basis. (I)	COO	2.3
C67	Use of trained and appropriately qualified temporary staffing through bank and agency system. (I)	CPO	2.3
C68	Targeted improvement support in place to deliver waiting list management improvement plans to support people awaiting a service / treatment. A new workstream Improving Access to Care is established and is focussing on improving the way that we reduce waits, increase access and reduce inequalites. This reports through the priority programmes. (I) (ORR 1078, 1132)	COO	2.3
C69	Process to manage the CQC action plan. (I)	DNQ	2.3
C134	Workforce strategic groups established and is being reviewed alongside the new operational model and people directorate structure. (P, I)	CPO	2.3, 3.3
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C142	Health Watch provide external assurance on standards and quality of care. (E)(P)	DNQ	2.3

Controls (strategic risk 2.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C145	Service user survey results reported annually to Trust Board and action plans produced as applicable. (P, N, I).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
C160	The operations management team have implemented frequent staffing meeting to ensure inpatient wards are staffed safely and staff redeployed according to need (P, I)	COO	2.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Continuing to evolve the use of the dashboard and the Business Intelligence tools to address health inequalities Staff commenced in post mid November 2022, progress to be reviewed in July 2023.	July 2023	DSC/DFR
Safer staffing establishment being developed for community services as part of community serviced transformation programme. Update to be included in the six monthly safer staffing paper that will go to April Board. Reviewed in April 2023 to be reviewed further in July 2023.	July 2023	/DNQ/COO

Assurance (strategic risk 2.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A09	Transformation changes and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re: quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality monitoring structure. Reports on these visits are provided to the EMT, Clinical Governance &Clinical Safety Committee (CGCS) Trust Board and Members' Council.	Annual unannounced and planned visits programme in place and annual report is now received directly by the Clinical Governance Clinical Safety Committee (CGCS). Quality monitoring visits for 2023/24have started and will be reported into CGCS Committee in due course. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A33	Patient experience service reports to Trust Board (annual) and CGCS Committee.	Annual reports to Board / EMT and quarterly into CGCS. (P, N) (I)	DNQ	1.4, 2.3
A34	Quality strategy review updates report into CG&CS Committee.	Routine reports into CG&CS via IPR and annual report scheduled in 2021/22 work plan. (P) (I)	DNQ	1.4, 2.3
A49	CQC self-assessment process.	Reviewed by EMT as part of preparation for CQC inspection process. (I)	DNQ	2.3
A80	Healthcare inequalities dashboard	OMG, EMT and EIIC and EIIC sub committee reviewed also included in IPR. Reviewed by Improving access to care group to focus on activity but allows trends over time to be identified (I) (P)	DCS	2.3
A81	CAMHS referral monitoring	CAMHS governance group monitors referrals numbers to monitor pressure on core CAMHS services (P) (N) (I) (E)	COO	2.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
The Care Closer to Home work continues, with renewed focus on patient flow and discharge, including the national one hundred day discharge challenge which reports through the ICS. Spikes in demand are still present and these are closely managed, and patients are repatriated to their local areas where possible. Complaints and incidents are monitored by the service line which is Trust wide. Thus, acuity and turnover has increased, adding significant pressure to the delivery system on inpatient wards. Additional funding to support discharge packages continues to be available in each place. The use of out of area remains over trajectory with a plan to reduce usage over 2023/24, review further in July 2023.	July 2023	COO
Specific demand for children's neurodevelopmental (ADHD.ASD) assessments in Calderdale and Kirklees exceeds capacity. Resources have recently been agreed with commissioners to improve the position. Implementation of agreed waiting list initiatives has commenced, increasing capacity internally and working with an external partner. The situation is correct as at January 2023. By the end of Q2 23/24 it is anticipated that demand and capacity will be stabilised. This will need to be monitored to ensure it remains on track before confirming the gap in assurance is addressed.	July 2023	COO
Continuing to evolve the use of the dashboard an the Business Intelligence tools to address health inequalities Staff commenced in post mid November 2022, progress to be reviewed in July 2023	July 2023	DSC/DFR/

Strategic risk 2.4 Risk of deliberate and malicious harm to the Trust including cyber-crime, arson and violence resulting in a loss of confidence in and access to the services the Trust provides.

Controls (strategic risk 2.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C70	Anti-virus, encryption, and security systems in place for IT devices, servers, and networks. (linked to ORR1080) (I)	DFR	2.4
C71	Annual infrastructure, server, and client penetration test. Further investment in firewall defences concluded in March 2022 (E)	DFR	2.4
C72	Data protection policies and business continuity plans in place. (I)	DFR	2.4
C73	Data Security and Protection Toolkit compliance process (I, E)	DFR	2.4
C74	Weekly fire risk scans and any issues escalated in line with the policies in place. (Linked to ORR 1159) (I)	DFR	2.4
C75	Trust smoking policies. (I)	CMO	2.4
C76	Use of sprinklers and other fire suppressant systems within our estate. (I)	DFR	2.4
C77	Staff mandatory fire training. (I)	CPO	2.4
C78	Capital prioritisation process to ensure funds are allocated to support IT security and safety of estate. (I)	DFR	2.4
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meeting's take place between Chief Executive and Directors. (P) (I)	CEO	All

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Not all Trust estate has sprinklers in place. There is a roll out system based on risk assessments for existing estate. All new buildings have sprinkler systems and fire risk assessments for all estate are completed on an annual basis.	July 2023	DFR

Assurance (strategic risk 2.4)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A52	Annual report on compliance with Data Security and Protection Toolkit	Report to Improving Clinical Information & Information Governance Group, Audit Committee and Trust Board (P)(I)	DFR	2.4
A53	Monthly / quarterly reports on fire / operational fire / unwanted fire activation.	Fire Safety Advisor produces reports with review by EFM senior managers and Estates TAG.(P) (I)	CEO	2.4
A54	Twice yearly reports on actions to maintain and promote cyber security to the Audit Committee.	Reported to the Audit Committee bi-annually (P) (I)	DFR	2.4
A55	Regular reports on health & safety to Clinical Governance & Clinical Safety Committee and annual report to Trust Board.	Reported periodically to CGCS and annually to Trust Board (P) (I)	CEO	2.4
A56	Cyber awareness tested with staff by means of a survey and phishing exercise. E-mail accreditation in place with action plan complete for 22/23.	Reported in Audit Committee through DSPT and Trust Board and action plans monitored accordingly P, N) (I)	DFR	2.4

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 3.1 Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively

Controls (strategic risk 3.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C79	Finance managers aligned to Care Groups acting as integral part of local management teams. (I)	DFR	3.1
C80	Standardised process in place for producing business cases supporting full benefits realisation. (I)	DFR	3.1

Controls (strategic risk 3.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C81	Standing Orders, Standing Financial Instructions, Scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities. (I)	DFR	3.1
C82	Annual financial planning process, cost improvement programmes (CIP) and Quality Impact Assessment (QIA) process. (I)	DFR, DNQ	3.1
C83	Financial control and financial reporting processes. (I)	DFR	3.1
C84	Regular financial reviews at Executive Management Team (EMT). (I)	DFR	3.1
C85	Service line reporting / service line management approach. (I), Implementation of patient level costing	DFR	3.1
C86	Weekly Operational Management Group (OMG) chaired by Chief Operating Officer providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. (I)	COO	3.1, 3.3
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director. (I)	DFR	3.1, 3.3
C133	Annual strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats. Strategic business and risk analysis reviewed by Trust Board. (P) (I)	DSC	3.1, 3.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I, E).	COO	1.1, 1.2, 3.1, 3.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Trust has previously not fully achieved its recurrent CIP targets (Linked to ORR risk 1076). The Trust needs to have a fully developed CIP plan for 23/24 including QIA. CIP challenge for 23/24 is currently expected partially through non-recurrent measures. Plans need to progress to identify further recurrent schemes.	July 2023	DFR / COO

Assurance (strategic risk 3.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Calderdale, Kirklees, and Barnsley for 23-24. (P) (I) (E)	DFR	1.1, 3.1, 3.2
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR/	1.2, 3.1, 3.2, 3.3
A24	Investment Appraisal report – covers bids and tenders' activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN performance monitored through Operational Management Group (OMG)	Monthly Integrated Performance reporting (IPR) to OMG, EMT, Finance, Investment & Performance Committee and Trust Board. (P, N) (I).	COO	1.2, 3.1, 3.3
A58	Monthly focus of key financial issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG).	Standing agenda item for OMG and Finance, Investment & Performance Committee. (P, N) (I)	COO	3.1, 3.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
The Care Closer to Home work continues, with renewed focus on patient flow and discharge, including the national one hundred day discharge challenge which reports through the ICS. Spikes in demand are still present and these are closely managed, and patients are repatriated to their local areas where possible. Complaints and incidents are monitored by the service	July 2023	COO

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
line which is Trust wide. Thus, acuity and turnover has increased, adding significant pressure to the delivery system on inpatient wards. Additional funding to support discharge packages continues to be available in each place. The use of out of area remains over trajectory with a plan to reduce usage over 2023/24, review further in July 2023.		
Increasing expenditure on staffing in inpatient wards with spend higher than income. This remains an issue as we progress through 23/24 due to the Trust maintaining safety and quality on inpatient wards where acuity and demand remains high. Reviewed in April 2023, to be reviewed further in July 2023.	July 2023	DFR

Strategic risk 3.2

Failure to develop strong relationships with integrated care systems, places, and provider collaboratives results in services that do not meet local needs or are unsustainable

Controls (strategic risk 3.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C08	Formal contract negotiation meetings with integrated care boards, NHSE and provider collaboratives underpinned by national agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C88	Clear plans for each place to provide direction for service development. (I)	DSC	3.2
C89	Forums in place with commissioners to monitor performance and identify service development. (I, E)	COO	3.2
C90	Annual review of the strategic stakeholder engagement plan and action plans. (I, E)	DSC	3.2
C91	Strategic Business and Risk Report including PESTEL / SWOT and threat of new entrants / substitution, partner / buyer power. (I)	DSC	3.2
C92	Quality Impact Assessment (QIA) process in place. (I)	DNQ	3.2
C93	Partnership agreements in place or being developed in the systems in which we provide services. (I, E)	DSC / DPD	3.2
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, COO	1.1, 1.2, 1.4, 3.2
C133	Annual strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats. Strategic business and risk analysis reviewed by Trust Board. (P) (I)	DSC	3.1, 3.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C146	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework. (P, N, I, E).	COO	1.1, 1.2, 3.1, 3.2
C175	Capital plans are developed within the Trust to meet requirements. Plans are clearly articulated into the ICB ensuring they are managed within the wider ICB financial allocation in any given year. Strong relationships facilitate this.	DFR	3.2
C176	West Yorkshire adult secure provider collaborative have a board that provides oversight of all provider collaboratives, there is also a financial risk share in place with NHS providers in West Yorkshire	DFR	3.2
C177	West Yorkshire finance forum of finance directors provides the ability to develop strong relations hips with integrated care system and places through development of financial strategy, financial planning peer review and in year performance management.	DFR	3.2
C187	South Yorkshire adult secure provider collaborative have a board that provides oversight of all provider collaboratives. The financial risk share in in development with NHS providers in South Yorkshire.	DFR	3.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Work is being carried to out to validate service waiting times in a consistent manner. We expect there will be different levels of access at service level, locality level and variation in health inequalities. This is being monitored by the improving access to care group, supported by the waiting list project. Reviewed in April 2023 review again in July 2023	To be reviewed in July 2023	COO/DFR
South Yorkshire adult secure provider collaborative, at this time, does not have a risk share agreement between providers, negotiations are taking place, updated position to be presented in April 2023. Reviewed April 2023 and update in July.	July2023	DFR

Assurance (strategic risk 3.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2

Assurance (strategic risk 3.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Calderdale, Kirklees, and Barnsley for 23-24. (P) (I) (E)	DFR	1.1, 3.1, 3.2
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR/COO	1.2, 3.1, 3.2, 3.3
A24	Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A60	Current contracts reflect growth in line with mental health investment standard as well as some specific service pressures.	The investment for 23/24 is aligned to the long-term plan and aligned to the MHIS. (P) (I, E)	DFR	3.2
A61	Attendance at external stakeholder meetings including Health & Wellbeing boards.	Minutes and issues arising reported to Trust Board meeting on a monthly basis. (P, N) (I, E)	CEO	3.2
A62	Documented update of progress made against Equality, Involvement, Communication and Membership Strategy.	Monthly IPR to Executive Management Team (EMT) and Trust Board. Quarterly report to EIC. (P, N) (I)	DSC	3.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
Community forensic services are under review to develop a more consistent approach in West Yorkshire and provide further capacity enhancement in South Yorkshire. South Yorkshire are on track to complete this in line with their commissioning intentions for April 2023. Review July 2023 West Yorkshire are in the design phase, and a paper is to be presented to Collaborative Committee in September 2023.	July 2023 September 2023	DFR DFR
Impact of local place-based arrangements and solutions and Integrated Care System initiatives – recognition that elements of this are not fully within our control, however we continue to play our part and help shape developments in all places and influence across the two ICSs and working in partnership to reduce health inequalities and improve mental and physical health in line with national guidance. (Linked to ORR Risk ID 812) Following go live of the Health and Social Care Act on 1 July 2022 work continues to establish governance routes in place. Governance structures and systems have been implemented in each place, these will be subject to regular review until they become fully embedded and established. Governance arrangements are now in each place and are being reviewed when necessary to assess effectiveness. Review further in July 2023.	July 2023	DSC

Strategic risk 3.3
Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.

Controls (strategic risk 3.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with integrated care boards to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets are back in place for 2022/23 (I, E)	COO	1.1, 1.4, 3.3
C86	Weekly Operational Management Group (OMG) chaired by Chief Operating Officer providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. (I)	COO	3.1, 3.3
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director. (I)	DFR	3.1, 3.3
C94	Agreed Trust workforce plan in place which identifies staffing resources required to meet current and revised service offers. Also describe how we meet statutory requirements re training, equality, and diversity. (P, N), (I)	CPO	3.3
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	3.3
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DSC	3.3
C97	Integrated Change Team in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities. (P), (I)	DSC	3.3
C98	Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks. (P), (I)	DFR/DPD	3.3
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2022-23 priorities. (P), (I)	DSC	3.3
C100	Integrated Change framework contains process for adding to strategic priorities within year which includes consideration as to whether a new programme becomes an additional priority or whether it replaces a current priority. (P), (I)	DSC	3.3

Controls (strategic risk 3.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C134	Workforce strategic groups were established reviewed alongside the new operational model and people directorate structure. New agency group established as a result of this process. (P, I)	CPO	2.3, 3.3
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C151	Integrated Change Framework includes escalation process for issues / risks to be brought to the attention of the Executive Management Team. (P,I)	DSC	3.3
C152	Integrated Change Framework includes gateway reviews at key points and post implementation reviews. Capacity and resources are considered at these key points. (P, I)	DSC	3.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
The Trust is to review its workforce plan over 2023/24 aligned to joint work between Finance and People directorates to review establishment. As part of the work for the 23/24 operational and finance plan the finance, operations and people leads will work to develop a revised plan for 23/24 to mitigate this risk. Ongoing July 2023	July 2023	CPO/COO/D FR

Assurance (strategic risk 3.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re: quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR/COO	1.2, 3.1, 3.2, 3.3
A24	Investment Appraisal report – covers bids and tenders' activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to Trust Board. (P, N) (I) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee and are received at Board half yearly. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN performance monitored through Operational Management Group (OMG)	Monthly Integrated Performance reporting (IPR) to OMG, EMT, Finance, Investment & Performance Committee and Trust Board. (P, N) (I).	COO	1.2, 3.1, 3.3
A58	Monthly focus of key financial issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG).	Standing agenda item for OMG and Finance, Investment & Performance Committee. (P, N) (I)	COO	3.1, 3.3
A65	Strategic priority programmes report into CG&CS Committee and Audit Committee on regular basis to provide assurance on risk and quality issues.	Strategic priority programmes report into CG&CS Committee and Audit Committee. (P) (I)	DSC	3.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

Strategic risk 3.4 Failure to embed new ways of working and develop digital and creative innovations resulting in reduced ability to meet increasing demand and less efficient service provision.

Controls (strategic risk 3.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C36	Improving access group and improving equalities groups are in place to ensure services are inclusively locking in innovation.	DSC/DPD/COO	1.4,3.4
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and half yearly report to Trust Board. (I)	DFR	2.1,3.4
C61	I-hub platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate, and improve. (I)	DSC	2.2,3,4
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	3.3,3.4
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DSC	3.3,3.4
C97	Integrated Change Team in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities. (P), (I)	DSC	3.3,3.4
C98	Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks. (P), (I)	DFR	3.3,3.4
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2020-22 priorities. (P), (I)	DSC	3.3,3.4
C100	Integrated Change framework contains process for adding to strategic priorities within year which includes consideration as to whether a new programme becomes an additional priority or whether it replaces a current priority. (P), (I)	DSC	3.3,3.4
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	CEO	1.1, 1.2, 1.3. 3.4
C134	Workforce strategic groups established and is being reviewed alongside the new operational model and people directorate structure. (P, I)	DHR	2.3, 3.4
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C151	Integrated Change Framework includes escalation process for issues / risks to be brought to the attention of the Executive Management Team. (P, I)	DSC	3.3, 3.4
C152	Integrated Change Framework includes gateway reviews at key points and post implementation reviews. Capacity and resources are considered at these key points. (P,I)	DSC	3.3, 3.4
C169	Digital Strategy and Innovation Group meets quarterly to assess potential new and emerging digital opportunities (P, I)	DSC	3.4

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Digital solutions are being considered to manage waiting list issues to improve access to care. Creative health app is in development and the first phase working app will be ready by the end of June 2023. Funding has been confirmed and identified for the second phase.	July 2023	DSC
Inpatient improvement programme includes a range of actions to enhance the use of creativity and creative practitioner roles and this is expected to be in place by October 2023.	October 2023	DSC

Assurance (strategic risk 3.4)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re: quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR/COO	1.2, 3.1, 3.2, 3.3
A75	Digital Strategy updates presented to Trust Board	Reports into Trust Board half yearly (P, I)	DFR	3.4
A79	EMT assurance against the Trust position and actions relating to emerging national priorities and digital maturity in line with Trust Digital Strategy	Reports presented to EMT and OMG, as required, through 22-23 (P,I,E)	DFR	3.4

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Digital and creative innovations are currently behind schedule and progress is being monitored by the Digital Strategy Group and a revised timeline is being established. Digital dictation work- additional resource and capacity secured and plans are being mobilised for delivery July 2023.	July 2023	DFR/DSC

Strategic risk 4.1

Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience and the inability to sustain safer staffing levels

Controls (strategic risk 4.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C47	Weekly incident risk scan where all red, amber, staffing related and incidents related to protected characteristics are reviewed for immediate learning. (I)	DNQ / CMO	2.1, 2.3, 4.1
C52	Patient Experience reporting includes learning from complaints and concerns. (I)	DNQ	2.2, 4.1
C53	Patient Safety Strategy developed to reduce harm through listening and learning. (I)	DNQ	2.2, 4.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.2, 4.1
C57	Leadership and management arrangements established and embedded at Care Group and service line level with key focus on clinical engagement and delivery of services. (I)	COO	2.2, 4.1
C101	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme. (I)	CPO	4.1, 4.2
C102	Annual learning needs analysis undertaken linked to service and financial plans. (I)	CPO	4.1
C103	Established education and training governance group agrees and monitors annual training plans. (I)	CPO	4.1, 4.2
C104	Human Resources processes in place ensuring defined job description, roles, and competencies to meet needs of service, pre-employment checks done re qualifications, DBS and work permits. (I)	CPO	4.1
C105	Mandatory clinical supervision and training standards set and monitored for service lines. (I)	CPO	4.1
C106	Medical leadership programme in place with external facilitation as and when required. (I)	CMO	4.1
C107	Great place to work strategy annual delivery plan approved by PRC (March 2023)	CPO	4.1
C110	Values-based appraisal process in place with revised monitoring arrangements in place and monitored through Key Performance Indicators (KPIs). (I)	CPO	4.1, 4.3
C111	Values-based Trust Welcome Event in place covering mission, vision, values, key policies, and procedures. (I)	CPO	4.1
C112	Trust Workforce plan in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements regarding training, equality, and diversity. (I)	CPO	4.1
C113	Good partnership working with a range of Higher Education Institutions (HEI'S) to discuss undergraduate and post graduate programmes. (E)	CPO / DNQ	4.1
C114	Appraisal process to discuss individuals' intentions regarding future career development with a view to maximise opportunities within the Trust and promote staff retention. Improved exit questionnaire process implemented. (I)	CPO	4.1
C135	International recruitment process in place, and the development of new roles with a view to increasing workforce supply (P) (E)	CPO	4.1
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C165	Medical director is a general medical council sponsor for international fellows. (P, E, I)	CMO	4.1
C178	Agency scrutiny group established which is chaired by the head of people resourcing to ensure agency standards are fully adhered to (P,I)	CPO	4.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Mental Health Investment Standard funding in 22/23 created significant new opportunities across the West and South Yorkshire systems. The great place to work strategy delivery plan is introducing a greater focus on workforce redesign and new roles which is helping to mitigate this risk. However, Mental Health Investment Standard plans for 23/24 are still be established and may create further pressure	July 2023	CPO
The impact of growth in budget and establishment is likely to result in growth in vacancies in Q4. A revised recruitment and marketing plan for 2023 has been developed focussing on the Trust role as an anchor institution and linking with local networks and education providers to recruit to vacancies and encourage diversity. Consideration of these issues is being addressed through the planning process for 23/24 and a change is expected to be visible in Q1 23/24.	July 2023	CPO
Recruitment process is in place for a replacement band 8a leadership and management development lead. The delivery of leadership activity throughout the Trust is reduced in the interim period until this vacancy is filled. An appointment is hoped to be complete by July 2023	July 2023	CPO

Assurance (strategic risk 4.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P) (I)	DSC	2.2, 4.1
A66	Annual Mandatory Training report goes to PRC and CG&CS Committee.	CG&CS Committee receive annual report (P) (I)	CPO	4.1
A67	Appraisal uptake included in IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	CPO	4.1
A68	ESR competency framework for all clinical posts.	Monitored through mandatory training report. (P) (I)	CPO	4.1
A69	Mandatory training compliance is part of the IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	CPO	4.1
A70	Recruitment and Retention performance dashboard.	Quarterly report to the Workforce and Remuneration Committee. (P, N) (I)	CPO	4.1
A71	Safer staffing reports included in IPR and reported to CG&CS Committee. (ORR 905,1158)	Monthly IPR goes to the Trust Board and EMT six monthly report to Trust Board. (P)	DNQ	4.1
A72	Workforce Strategy implementation dashboard.	Quarterly report to the WRC Committee. (P) (I)	CPO	4.1
A73	Annual appraisal and, objective setting cycle in place	Included as part of the IPR to EMT and Trust Board. (P) (I)	CPO	4.1, 4.3
A74	Staff wellbeing survey results reported to Trust Board and / or People & Remuneration Committee and action plans produced as applicable.	Results will be reported when available. (P, N) (I)	CPO	4.1, 4.2, 4.3
A78	Continuing international recruitment and the development of new roles as part of increasing workforce supply. Virtual international recruitment portal signed off by EMT. Establishment of new roles group to look at development of new clinical roles.	Reported into PRC Committee (P,I)	CPO	4.1
A83	Agency scrutiny group report providing details of spend, governance arrangements, trends, hotspots and quality assurance	Reported into PRC and FIP (P,N,I)	CPO/DFR	4.1

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
Supply of a range of professions including doctors and nurses is insufficient to meet demand. (Linked to ORR 1151). Recruitment and retention group established to address local based recruitment actions. Working with MHLDA group across the West Yorkshire MHLDA programme and a renewed focus on retention. Reviewed in January and April and progress on medical and nursing recruitment has been positive in certain areas of the Trust over the last four quarters, however, severe national and global challenges remain and achievement of full establishment is a long term ambition. In view of this to be reviewed in October given context of national and global issues.	October 2023	CPO

Strategic risk 4.2

Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively

Controls (strategic risk 4.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C101	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme. (I)	CPO	4.1, 4.2
C103	Education and training governance group established to agree and monitor annual training plans. (I)	CPO	4.1, 4.2
C115	Appointment of diversity and inclusion lead and BAME talent pool established as part of the Trust's overall leadership and management development arrangements. (I)	CPO	4.2
C136	Inclusive Leadership Board Development (ILDB) programme on inequalities completed March 2022 with future board development programme being established.	CPO	4.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C154	Regular and consistent updates and communications throughout the Trust via the View and the Brief (P, I)	DSC	4.2
C155	Trust Board engagement with staff networks (P, I)	DSC	4.2
C156	Appointment of Freedom to Speak up Guardian, Equity Guardian and diversity and inclusion lead roles (P, I)	CPO	4.2
C157	Values based recruitment processes in place (P, I)	CPO	4.2
C158	Values based appraisal system (I, E,P,N)	CPO	4.2
C159	Leadership and development programme to support talent management approach (I, E, P, N)	CPO	4.2

Controls (strategic risk 4.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C166	Shadow Board programme and the development of future leaders and succession planning (P, I)	CPO	4.2
C167	Insight programme – developing future Board members from diverse backgrounds (P, I, E)	CPO	4.2
C179	Developed internal transfer system which is now to be promoted and embedded (P) (I)	CPO	4.2
C188	The great place to work strategy acknowledges the diversity challenge in senior roles across the Trust, with an action plan in place for 23/24	CPO	4.2
C189	Trust Board development programme in place for 23/24 led by the Chief People Officer building on the leadership through a values-based culture and strengthening delivery of the Trusts strategic objectives	CPO	4.2

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
WRES and WDES are in place but there is not an LGBT equivalent, and this is being considered by the People directorate and will be reported into People and Remuneration Committee in May 2023	May 2023	CPO

Assurance (strategic risk 4.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A74	Staff wellbeing survey results reported to Trust Board and / or People & Remuneration Committee and action plans produced as applicable.	Results will be reported when available. (P, N) (I)	CPO	4.1, 4.2, 4.3
A86	The priority inpatient recruitment task and finish group is reviewing a range of options to support creative recruitment.	Reported in PRC quarterly (P) (N) (I)	CPO	4.2
A87	Flair survey completed to provide insight into staff experience of inclusion and diversity matters in a timely fashion	Analysis and actions to be monitored by PRC (P,N,I)	CPO	4.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
On Boarding system is in place which will give insight into lead time and areas where efficiencies can be made. This is being monitored through PRC and efficiencies being realised by October 2023.	October 2023	CPO
Internal audit report on the leavers process completed and now action plan Action plan in place and updates into PRC. October 2023	October 2023	CPO

Strategic risk 4.3
Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies.

Controls (strategic risk 4.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Annual action plans developed, and ongoing processes established for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C110	Values-based appraisal process in place and monitored through Key Performance Indicators (KPIs). (I)	CPO	4.1, 4.3
C116	Provision of appropriate personal protective equipment (PPE) in line with national guidance. (I)	DNQ	4.3
C117	Access to wellbeing apps. (I)	CPO	4.3
C118	Comprehensive Occupational Health Service offer.	CPO	4.3
C119	Integrated care system Workforce Support Hub established. (I)	CPO	4.3
C121	Promotion and accessible offer of flu vaccination programme for all staff within the Trust with clear targets. (I)	CPO	4.3
C122	The Trust continues to promote and encourage lateral flow Covid-19 testing by staff to protect staff and service users, in situations of clinical vulnerability. (I)	DNQ	4.3
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C180	Recruitment of a diversity, inclusion and belonging lead (P) (I)	CPO	4.3

Controls (strategic risk 4.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C182	Wellbeing is to be embedded in recruitment, induction and onboarding initiatives (P) (I) (E)	CPO	4.3
C183	Wellbeing capacity within the Organisational Development (OD) team has been expanded (P, I)	CPO	4.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Staff sickness rates have increased over the winter period. The people directorate continues to work closely with line managers to help support staff and work in partnership with trade unions to ensure the staff wellbeing offer is effective and make adjustments as necessary. To review in July 2023	July 2023	CPO

Assurance (strategic risk 4.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A73	Annual appraisal, objective setting and PDP timelines are in place for 2022/23	Included as part of the IPR to EMT and Trust Board. (P) (I)	CPO	4.1, 4.3
A74	Staff wellbeing survey results reported to Trust Board and / or Workforce & Remuneration Committee and action plans produced as applicable.	Results will be reported when available. (P, N) (I)	CPO	4.1, 4.2, 4.3
A76	Routine scan of national guidance as part of horizon scanning	Discussed fortnightly at people leadership team (PLT). (P, I, E)	CPO	4.3
A77	Review of hotspots in relation to support to staff / staffing levels	Discussed fortnightly at people leadership team (PLT). (P, I)	CPO	4.3
A78	Review of workforce information by the People & Remuneration Committee and Trust Board.	Reported to Trust Board through IPR. (I)	CPO	4.3
A82	Robertson Cooper survey is an internal review of Trust staff in relation to physical and mental health to highlight hotspots	Annual report to the People and Remuneration Committee and EMT (P) (I)	CPO	4.3
A84	Health inequalities data and support from staff network groups to be used to improve understanding of staff groups	Part of WRES and WDES (P) (I) (E)	CPO	4.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Wellbeing champions are to be appointed to each of the Trusts clinical areas. An OD & wellbeing practitioner has now been appointed and is driving work to support services with the implementation of health & wellbeing champions and is scoping out current gaps across the Trust. Reviewed in April 2023 and being monitored for further update in July 2023.	July 2023	COO/CPO

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 9.2

Private/Public paper:	**Public**		
Title:	**Board Assurance Framework (BAF) Strategic Risks for 2023/24 and updated schematic for approval**		
Paper presented by:	Adrian Snarr – Director of Finance, Estates and Resources		
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance Andy Lister - Head of Corporate Governance		
Mission/values:	The BAF is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values.		
Purpose:	For Trust Board to review the updating of the Trust's strategic risks for 2023/24 to use in the Board Assurance Framework (BAF).		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Board Assurance Framework allows Trust Board to monitor risks against the Trusts strategic objectives and in doing so enables them to assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnerships and Integrated Care Boards, and place-based partnerships.		
Any background papers / previously considered by:	Regular quarterly reports to Trust Board regarding the Board Assurance Framework Trust Board members are involved annually in the determination and agreement of strategic risks The Executive Management Team (EMT) have reviewed the existing strategic objectives in conjunction with the current operating landscape and suggested some draft strategic objectives for 2023-24		
Executive summary:	The Board Assurance Framework (BAF) provides the Trust Board with a simple but comprehensive method for the effective and focused management of the risks to meeting the Trust's strategic objectives. Strategic risks are reviewed and updated annually by the Trust Board and today's paper recognises that following discussions with the Executive		

	Management Team and a representation of non-executive directors there are considerations for some changes to the strategic risks for 2023-24. The attached paper provides EMT's views on an initial set of strategic risks for this new financial year with the appropriate rationale. In determining the proposed risks, consideration has been given to the status of existing risks and changes in the operating landscape in which we work. In March 2023 the Director of Finance, Estates and Resources shared an initial draft of the proposed 2023-24 strategic risks with a group of non-executive directors for consultation and input. The non-executive directors were supportive of the strategic risks proposed for 2023/24 andthey asked for consideration to be given to the following: Risk 3.4 – Has the risk of access to services posed to those who are unable to access through digital channels been truly reflected. EMT agreed this would be addressed in the BAF through gaps in control/assurance as an action. Risk 4.2 – is organisational development work adequately reflected and whereabouts in the BAF would this feature. There was also an ask as to whether there is a need for more emphasis in the risk if we cannot demonstrate diverse leadership. EMT agreed this would be addressed in the BAF through gaps in control/assurance as an action. The non -executive director discussion raised the point of race equality and there was a suggestion a new risk should be considered for inclusion in the BAF. Following EMT on the 6 April 2023, it was agreed that a broader risk covering all discrimination should be included and a new risk has been developed (see below) which it is proposed will sit within the Improve Care strategic objective, this is because it relates to both staff and service users. **Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience** Non-executive directors also asked for consideration to be to the climate emergency as a strategic risk noting the Trust has a suite of strategies to support this work. EMT discussed the global climate emergency in relation to our Board Assurance Framework (BAF). They acknowledged the issue of climate change and the potential impact to the organisation but did not feel this should be identified as a strategic risk in our BAF at the present time, but rather the wider system. The Trust's reflects our contribution to addressing this through the our Social Responsibility and Sustainability Strategy which is included as

	a golden thread across all strategic priorities.. The work of the Trust feeds into the integrated care system goal to tackle the climate emergency across both West and South Yorkshire. The attached paper provides greater detail of the initially proposed risks for 2023-24 along with the rational for any changes. In line with the Corporate / Organisational Risk Register (ORR), the BAF and associated strategic risks are aligned to the Trust's strategic objectives: **Our four strategic objectives** **Improving health** | **Improving care** **Improving resources** | **Making SWYPFT a great place to work** <u>BAF schematic update</u> On 11 April 2023 Audit Committee received a review of the BAF schematic that features on the front page of the BAF. The key updates as part of the review are: • Adherence with the NHSE Code of Governance for NHS Provider Trusts has been added to the cycle. • The new title of the risk management governance framework has been updated. • The Operations Context of the Board Assurance Framework has been updated to include the Care Quality Commission Well Led framework. • The Audit Committee has been added, as this Committee provides annual oversight and assurance of the effectiveness of other Board committees. • The Audit Committee risk triangulation report has been referenced as this report triangulates information from performance, risk and governance. • The Trust Board Committee, alert, advise, assure reports have also been added a key form of Board assurance. On 11 April 2023, the Audit Committee recommended the revised schematic to the Board for approval.
Recommendation:	**Trust Board is asked to DISCUSS this report and APPROVE the updates to the strategic risks to be included in the Board Assurance Framework for 2023/24 and APPROVE the updated schematic as recommended by the Audit Committee**

Board Assurance Framework

Strategic Risks – 2023/24

Introduction

The purpose of this paper is to enable Trust Board to discuss the Trust's strategic risks for 2023/24 as recommended by the Executive Management Team. The strategic risks form the basis of the Trust's Board Assurance Framework (BAF). The table below provides details of the strategic risks as articulated in 2022/23 along with suggested changes to the BAF risks for 2023/24 with rationale.

Objective	Ref	Current	Comments	23/24 Proposed
Improving Health	1.1	The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place	New ICS landscape increasingly embedded and the Trust is working well with partners. Changing financial landscape may lead to different pressures.	Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place
Improving Health	1.2	The focus on integrated care models at place may result in unwarranted variation and differences in standards, could potentially impact the sustainability of smaller specialist services	To be updated to reflect unwarranted variation in place covering our influence to the system and how we provide services	Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision
Improving Health	1.3	Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve.	Recognise the need for co-production, engagement, and involvement	Lack of or ineffective co-production, involvement and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve
Improving Health	1.4	Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy	Recognise potential inequality in health outcomes or life expectancy	Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to inequality

				in health outcomes or life expectancy
Improving Care	2.1	The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives	Risk remains valid	The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives
Improving Care	2.2	Failure to create a learning environment leading to lack of innovation and to repeat incidents.	Risk remains valid	Failure to create a learning environment leading to lack of innovation and to repeat incidents.
Improving Care	2.3	Increased demand for services and acuity of service users exceeds supply and resources available leaving to a negative impact on quality of care.	Risk remains valid	Increased demand for services and acuity of service users exceeds supply and resources available leaving to a negative impact on quality of care.
Improving Care	2.4	Risk of deliberate and malicious harm to the Trust including cyber-crime, arson and violence resulting in a loss of confidence in and access to the services the Trust provides	Viewed more as an ongoing risk to be managed operationally. Recommend this risk drops off the BAF and is included in the ORR.	
Improving Care	2.4	Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience	New risk for 23/24	
Improve Resources	3.1	Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively		Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively

Improve Resources	3.2	Failure to develop strong relationships with integrated care systems, places, and provider collaboratives results in services that do not meet local needs or are unsustainable	Good relationships in place with partners. Recommend this risk drops off the BAF	
Improve Resources	3.3	Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives	Risk remains valid	Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives
Improve Resources	3.4	Failure to embed new ways of working and develop digital and creative innovations resulting in reduced inability to meet increasing demand and less efficient service provision	To be slightly updated to also include accessibility of services	Failure to embed new ways of working and develop digital and creative innovations resulting in reduced inability to meet increasing demand, reduced accessibility to services and less efficient service provision
GPTW	4.1	Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience and the inability to sustain safer staffing levels	Wording to be updated to also include staff experience	Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user and staff experience and the inability to sustain safer staffing levels
GPTW	4.2	Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively	Risk remains valid	Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively
GPTW	4.3	Failure to support the wellbeing of staff resulting in an increase in sickness/absence	Risk remains valid	Failure to support the wellbeing of staff resulting in an increase in sickness/absence

		staff turnover and vacancies.		staff turnover and vacancies

Board Assurance Framework – Structure and Process

Our mission: we help people reach their potential and live well in their community.

The Operational Context of the Board Assurance Framework (BAF)
Purpose: to provide a comprehensive method for the effective and focused management of the principal risks to achieving the delivery of strategic objectives.
Provides direct evidence for: Annual Governance Statement, the Head of Internal Audit Opinion and Care Quality Commission Well Led Framework

Strategic direction:
Strategic objectives and priorities are set out in the Trust's Annual Plan, and include the Board's duty to ensure the Trust's vision, values and strategy, align with the Integrated Care Partnership's integrated care strategy.

Strategic Objectives

Approved by Trust Board and reviewed

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

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

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

Strategic risks to the achievement of strategic objectives

Controls in respect of risks and strategic objectives

Assurances in respect of the controls and strategic objectives

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

Adherence with the NHSE Corporate Governance Code for NHS Provider Trusts

Organisational level risk register, where the risk is outside the Trusts risk appetite, mitigated in accordance with Trust risk appetite statement. Summary reports into relevant Committees of the Board.

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

Exec Management Team

Individual director/Care Group assurance

Audit Committee
Annual report
Quarterly Risk Triangulation Report

Trust Board Committee
Advise, Alert, Assure reports

Closure of gaps
- Time bound responsibilities identified plus lead

TRUST BOARD

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 9.3

Private/Public paper:	**Public**		
Title:	**Quarter 4 Corporate / Organisational Risk Register 2022/23**		
Paper presented by:	Adrian Snarr – Director of Finance, Estates and Resources		
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance Asma Sacha - Corporate Governance Manager		
Mission/values:	The ORR is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values.		
Purpose:	For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives and have controls and actions in place to mitigate those risks.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	References to the Board Assurance Framework are included in the ORR where applicable		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Trust risk management structure ensures a consistent, systemic and integrated approach to the identification, management and mitigation of organisational risk to ensure the Trust can deliver safe and effective services to the integrated care systems in which the Trust operates.		
Any background papers / previously considered by:	Previous quarterly reports to Trust Board. Standing agenda item at each Board Committee meeting.		
Executive summary:	**Corporate / Organisational Risk Register** The Corporate/ Organisational Risk Register (ORR) provides Trust Board with oversight of organisational risks that are significant in nature and have been escalated by the Executive Management Team (EMT). Risks that could have an impact across the Trust are reported to the Executive Management Team (EMT) monthly as per the Risk Management Framework. Risks on the ORR are aligned to the Trust's strategic objectives:		

Our four strategic objectives	
Improve health	Improve care
Improve resources	Making SWYPFT a great place to work

All organisational risks are assigned to relevant Board Committees for discussion and oversight, and they report to Board through the individual committees triple A report (Alert, Advise, Assure).

The full corporate/ organisational risk register is reviewed on a quarterly basis by EMT, and individual risks are reviewed monthly by the responsible director with the corporate governance team.

At each review controls, actions, risk scores and completion dates are considered and updated as required.

Emergent risks

The following risk is currently being assessed and scored and will be presented to EMT for consideration for inclusion in the ORR to Trust Board in Q1 2023/24.

- Delayed Transfers of Care (DToC) in acute mental health inpatient services and learning disability services mean that service users stay in hospital longer than they need to. This can have a negative impact on their recovery and wellbeing and has an impact on bed capacity for other people.

New Risks:

Risk ID	Risk Owner	Description
New risk	Chief Operating Officer/ Chief Nurse and Director of Quality and Professions / Chief Medical Officer/ Chief People Officer	There is a risk that the cumulative impact of staff shortages, high turnover of staff, high use of temporary staffing, low supervision rates, opportunity to release staff for training and high acuity, could have a detrimental impact on the culture of a team which could then lead to patient harm.

A new risk has been developed to consider the cumulative impact of challenges with staffing issues which could have a detrimental impact on the culture of a team leading to patient harm. The executive directors have graded this risk at 9 amber (consequence 3 moderate x likelihood 3 possible). This risk

will be reviewed by the Clinical Governance and Clinical Safety Committee and the People and Remuneration Committee.

Risk ID	Risk Owner	Description
New risk	Chief Nurse and Director of Quality and Professions / Director of Finance, Estates and Resources	Failure to implement a comprehensive system to monitor, manage and maintain medical devices in line with relevant legislation may lead to patient harm.

This new risk has been developed in relation to the maintenance of medical devices. The risk has been graded as 12 amber (consequence 4 major x likelihood 3 possible). This risk will be reviewed by the Clinical Governance and Clinical Safety Committee.

Risk 15+

Risk ID	Risk Owner	Description
1758	Chief People Officer / Chief Operating Officer	The risk of disruption to services and reduction in staff due to industrial action and our inability to deliver care.

The Chief People Officer and Chief Operating Officer have reviewed the risk score and are recommending an increase in likelihood from 3 possible to 4 likely in light of recent staff industrial action. The overall risk score will increase from 12 amber to 16 red.

Risk less than 15, outside of risk appetite

Risk ID	Risk Owner	Description
1614	Chief Nurse and Director of Quality and Professions	National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.

This risk is currently monitored by the Clinical Governance and Clinical Safety Committee. A recommendation is being made for this risk to be monitored by the People and Remuneration Committee as well in light of the staffing challenges.

Risk ID	Risk Owner	Description
1689	Director of strategy and change	Risk that the Trust cannot evidence that it has mitigated against or addressed health inequalities in both the provision and restoration of services.

The Director of strategy and change has reviewed the risk grading and is providing assurance that the risk actions and control measures are in place to show we are mitigating against addressing health inequalities, therefore is recommending a decrease of likelihood from 4 likely to 3 possible. The risk score will reduce from 12 amber to 9 amber.

Risk ID	Risk Owner	Description
1511	Director of Finance, Estates and Resources	Risk that carrying out the role of lead provider for adult secure services across West and/ or South Yorkshire will result in financial, clinical, and other risk to the Trust.

The Director of Finance, Estates and Resources is recommending an increase in likelihood from 2 unlikely to 3 possible with an increase in risk score from 8 amber to 12 amber. This is in relation to ongoing dialogue with NHS England to resolve contractual position in relation to South Yorkshire provider.

Risk ID	Risk Owner	Description
1568	Chief Operating Officer	Risk that a seclusion room will not be available due to damage that occurred placing staff and service users at an increased risk of harm.

The Chief Operating Officer is recommending to increase the risk grading of the likelihood from 3 possible to 4 likely due to high acuity and damage to the seclusion room in Forensics. The overall risk score will increase from 12 amber to 16 red.

Risk ID	Risk Owner	Description
1368	Chief Operating Officer	Risk that given demand and capacity issues across South & West Yorkshire and nationally, children and younger people requiring admission to hospital will be unable to access a CAMHS bed. This could result in quality of care being compromised and places additional pressure on staff when young people are cared for on adult wards in the secure CAMHS estate or in acute hospitals supported by the Trust's CAMHS service

The Chief Operating Officer is recommending to increase the risk grading of the likelihood from 3 possible to 4 likely which would result in the risk score to increase from 12 amber to 16 red. This is due to increase in acuity and challenges impacting upon capacity.

Risk ID	Risk Owner	Description
1649	Chief Nurse and director of Quality and Professions/ Chief Medical Officer	The current inconsistency in SALT provision could compromise the quality of care available in response to choking incident.

The Chief Nurse and director of Quality and Professions and the Chief Medical Officer have reviewed the risk score and recommend that the risk score remains at 9 amber due to the vulnerabilities of the population.

Risk ID	Risk Owner	Description

1545	Chief Medical Officer	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic or as a result of the public inquiry.

This risk has been reviewed by the Chief Medical Officer and Assistant Director of Legal Services. The current IPC guidance in relation to public health legislation will be continuously reviewed by the IPC and Moving Forward Group, this is in relation to the impact of an outbreak of Covid 19 on Section 17 leave. The risk actions and control measures have been reviewed and updated.

Heat map

Appendix 1 shows the heatmap of the organisational / corporate risk register.

A summary of findings are below:

- The number of risks has decreased slightly from 32 to **31 in total.**
- The **highest number of risks** are aligned to the Trust objective, Improving Care
- The **lowest number of risks** are aligned to the Trust objective, Making this a great place to work
- There are 2 red risks aligned to Improving Care, 1 red risk aligned to Improving Resources and 1 red risk aligned to Making this a great place to work
- The accumulative risk score as at 31 March 2023 is **330** with an average score of **10.6** (amber)

Risk Appetite:	The ORR supports the Trust in providing safe, high-quality services within available resources, in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to REVIEW and COMMENT on the risk register and to confirm they are ASSURED that current risk levels are appropriate, considering the Trust risk appetite, and given the current operating environment.** **In addition, Trust Board is asked to:** • **AGREE to add the new risk in relation to the culture of a team** • **AGREE to add the new risk in relation to medical devices** • **AGREE to increase the risk score for risk 1758** • **AGREE to the addition in monitoring and assurance for risk 1614** • **AGREE to the reduction in risk score for risk 1689** • **AGREE to an increase in risk score for risk 1568** • **AGREE to an increase in risk score for risk 1368**

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk appetite:
Clinical risks (1-6): 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 (8-12): 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 (1-6): 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 (1-6): Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.
Strategic risks (8-12): 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.

Risk appetite	Application
Minimal / low - Cautious / moderate (1-6)	• Risks to service user/public safety. • Risks to staff safety • Risks to meeting statutory and mandatory training requirements, within limits set by the Board. • Risk of failing to comply with Monitor requirements impacting on license • Risk of failing to comply with CQC standards and potential of compliance action • Risk of failing to comply with health and safety legislation • Meeting its statutory duties of maintain expenditure within limits agreed by the Board. • 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.
Open / high (8-12)	• Reputational risks, negative impact on perceptions of service users, staff, commissioners. • Risks to recruiting and retaining the best staff. • Delivering transformational change whilst ensuring a safe place to receive services and a safe place to work. • Developing partnerships that enhance Trusts current and future services.

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

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

Our four strategic objectives	
Improve health	Improve care
Improve resources	Making this a great place to work

KEY:
CE = Chief Executive
DFR = Executive director of Finance, estates and resources
CPO = Chief People Officer
DNQ = Chief nurse and director of quality and professions
CMO = Chief medical officer
DS = Deputy CE/ Executive director of strategy and change
COO = Chief Operating Officer
DPD = Executive director of provider development

AC = Audit Committee
CG&CSC = Clinical Governance & Clinical Safety Committee
FIP = Finance, Investment & Performance Committee
MHA = Mental Health Act Committee
PRC = People & Remuneration Committee
EIIC = Equality, Inclusion, and Involvement Committee
CC = Collaborative Committee

Corporate/ Organisational Risk Register Quarter 4 2022/23 (January 2023 – April 2023)

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

New Risk

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
New risk	**Risk outside of risk appetite <15**	There is a risk that the cumulative impact of staff shortages, high turnover of staff, high use of temporary staffing, low supervision rates, opportunity to release staff for training and high acuity, could have a detrimental impact on the culture of a team which could then lead to patient harm.	**COO/ CMO/ DNQ/ CPO**	CG & CSC PRC	• Meeting terms of reference for Care Groups and OMG set out escalation processes for areas of concern. • Weekly review of all amber and red incidents, all staffing incidents, and all incidents related to protected characteristics at Clinical Risk Panel • Seclusion and Segregation oversight group • OMG and PRC receive detailed reports re: Blanket restrictions process of oversight • Medicines management to review use of rapid tranquilisation • MHAC maintains oversight of the reading of service user's rights • Safer Staffing reporting into monthly IPR • Incident and quality monitoring in Care Group Quality and Governance Groups, and then centrally at the Clinical Governance Group • Quality Monitoring Visits, as both a regular oversight function and also used purposefully when concerns are present • Freedom to Speak up Guardians, Equity Guardians and Dignity and Respect Guardians in place • Open relationship reported by our regulators through informal contact via email and formal meetings • Visibility and direct team contact by the Executive TRIO and other Board members	3 moderate	3 possible	9	1-6 Clinical risk	• Develop a process to improve triangulation with regard to such as incidents / grievances / workforce issues, to identify potentially poorly performing units (DNQ, May 2023) • To deliver the improvement plan relating to Quality and Safety within Mental Health, Learning Disability and Autism Inpatient services (DNQ, To review monthly, May 2023) • Work has commenced on practice and reporting of supervision (DNQ, May 2023) • Explore additional options of how we might enhance visibility of senior colleagues in clinical teams and communicate this out to services (TRIO, May 2023) • Progress the complaints improvement programme (DNQ, May 2023) • Leadership development activity will focus on culture with a plan agreed across the year for sessions in care groups and OMG by May 2023 (CPO, May 2023) • Work commenced with external partner (Leadership and Talent Development Coach) to support inclusive culture with a plan agreed across the year for sessions in care groups and the OMG. (CPO and TRIO, phase 1 to be delivered by end of July 2023) • Appointment of three new People Business Partners to support the development of inclusive action plans using workforce data to drive change (CPO, June 2023) • Developing an approach and policy to adopt just and learning principles across our employee relations (CPO, review June 2023) • An agency scrutiny group has been set up to look reducing agency workers and increase bank recruitment (CPO, review June 2023) • A recruitment and retention strategy is being developed (CPO, estimated sign off date, May 2023)	31 July 2023	OMG EMT CGG CG&CGC PRC Trust Board	3	New risk for approval Note: OMG time out on 11 January 2023 focused on leading a positive culture.	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					• Accompanying improvement group • Care Group quality and safety report provided by the TRIO to clinical governance and clinical safety committee (monthly) • Quality Monitoring Visits consider evidence of compassion and kindness • Strong relationship with staff side groups and trade unions through Trust partnership forum • Established bank forums to discuss any areas of concern and good practice • Diversity, Inclusion and Belonging Lead now in post who will focus on the development of actions from the Race Forward Group (CPO) • Quality Monitoring Visits action plan progress has been added to the agenda to have oversight within clinical governance group • TRIO Talks have been established for the year and will include references to culture in each session, TRIO					• Use of staff survey feedback and data to identify hotspots and actions to address (CPO, review June 2023) • To explore new and innovative ways to deliver learning and development to enable staff to be released in shorter periods (Ongoing, CPO)					
New risk **Linked to ID 1757**	**Risk outside of risk appetite <15**	Failure to fully maintain and monitor medical devices to the Trust agreed standards and in line with relevant legislation may lead to patient harm.	**DNQ/ DFR**	CG&CSC	• Re-done equipment approval • The EBME contract has just been reviewed and awarded, part of the new contract. • COO has circulated comms to Managers • In an attempt to increase servicing rates, areas and have been contacted to instigate compliance and prompt services to service their devices. • Equipment register in place • Purchasing process	4 major	3 possible	12	Clinical risk 1 - 6	• Comms to be circulated via management structure (TRIO) (TRIO, April/ May 2023) • A bluelight comms to be circulated (TRIO, May 2023) • Review Medical devices workload and review business case for trust wide medical devices officer (DNQ and DFR, end of May 2023,) • Full review of the electrical Biomedical Medical Engineering / Equipment EBME list (DNQ and DFR, Ongoing review fortnightly,) • There is a wider piece of scoping work being undertaken to review other servicing contracts for medical	29 September 2023	Clinical governance / care group clinical governance CG&CSC Safety and resilience TAG OMG Medical Devices TAG	2	New risk for approval Notes: Identified recurrent budget issue There are linked risks to the incident: Health and Safety at Work Act 1974	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					• Appointment of project manager extended to the end of June 2023 • Raised awareness in the Care Group governance meetings and the CG&CSC (see assurance and monitoring column) •					devices e.g. scales, bladder scanners etc (DNQ and DFR, Review monthly) • To define liaison with Mid Yorkshire NHS Trust (DNQ and DFR, May 2023) • Continue with the servicing programme (Trust wide) (DNQ and DFR, To review on an ongoing basis) • To review and cleanse the asset register data for medical devices (DNQ and DFR, weekly review, ongoing) • Medical Devices Policy under review (DNQ, To be completed by Sept 2023) • Medical devices requisition and approval process under review (DNQ End of May 2023)		EMT Trust Board		Medicines & Healthcare products Regulatory Agency (MHRA) bulletin, Device Bulletin - Managing Medical Devices, Guidance for Healthcare and Social Services Organisations DB2006(05)	

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk level 15+

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1758	**To be confirmed**	The risk of disruption to services and reduction in staff due to industrial action and our inability to deliver care.	**CPO/ COO**	PRC	• Active business continuity and emergency planning processes in place • Established good partnership working with staff side and trade unions • Mutual aid arrangements in place with our two ICSs • Joint Information Cell Task & Finish Group to work through implications on service delivery and identify priority areas i.e., crisis service, PICU, A&E liaison and inpatients where we need to maintain staffing levels established and meeting weekly with agreed TOR representatives from staff-side organisations and trade unions included. • Regular reporting to OMG and EMT established. • High level comms messages agreed. • Stepping down procedure agreed by JLNC	4 major	4 Likely	16	8 – 12 Strategic Risk	• Follow national guidance issued by NHS England and NHS Employers as it emerges (CPO, Ongoing) • Maintain good communication and engagement with staff side through the people/staff side fortnightly meetings (CPO, Ongoing) • People directorate to communicate with staff side/unions to understand numbers of staff who are part of a union (CPO, Ongoing) • Understanding the potential numbers of staff taking industrial action through information provided by the unions to enable us to assess the impact on services (CPO, Ongoing – as more ballots and information emerges) • Ensure payroll are recording any absence through industrial action (CPO, Ongoing) • Continue to develop comms messages to staff (supportive and asking for support to maintain essential services. Comms to communicate before, during and after industrial action (DS, Ongoing as information emerges) • Silver command meetings have been re-established to manage the industrial action (CPO / COO May 2023) • A separate strike committee was set up to manage and consult with the BMA on the terms of conditions for those doctors striking, stood down with learning to take place for any future industrial action) This group will be reconvened as needed (CPO, ongoing review) • Further consultative ballot there is now a ballot for full strike action by Consultants, likely to hear outcome in May 2023 (CPO, May 2023)	30 June 2023	PRC OMG EMT Joint Information Cell Task and Finish Group Trust partnership forum Trust Board	9	BAF ref: SO 2 Recommending a change in risk score from 12 to 16, with an increase in likelihood from 3 possible to 4 likely.	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1151	**Risk level > 15+**	Risk of being unable to recruit and retain clinical staff due to national shortages and growth in mental health investment/ commissioning which could impact on the safety and quality of current services and future development.	**CPO**	CG & CSC PRC	• Safer staffing levels for inpatient services agreed and monitored. • Agreed turnover and stability rates part of IPR. • Weekly risk scan by DNQ and CMO to identify any emerging issues, reported weekly to EMT. • Reporting to the Board through IPR. • Datix reporting on staffing levels. • Strong links with Universities. • New students supported whilst on placement. • Regular advertising. • Workforce plans incorporated into new business cases. • Workforce strategy action plan. • Retention plan developed. • Working in partnership across West Yorkshire on international recruitment. • Inpatient ward workforce review with revised skill mix. • Marketing of the Trust as an employer of choice. • Established work group to look at development of new clinical roles. (CPO/DNQ) • Development of updated workforce plans • Appointed interim Head of Resources and Recruitment • Internal staff transfer report to understand internal turnover in more detail • The priority inpatient recruitment task and finish group has ended and future development of a Trust wide group will be led by the Head of	4 Major	4 Likely	16	1-6	• Proposal for On Boarding System to include recruitment/career Microsite development is ongoing with the view to complete testing and roll out (CPO, June 2023) See comments • Incentive measures adopted to increase filling of shifts (CPO/COO, June 2023) • Exploring use of recruitment and retention premia in inpatient settings, paper to EMT (CPO ongoing discussion at EMT) See comments • Collaborative recruitment initiatives with West Yorkshire Mental Health and Learning Disabilities and Autism Collaborative (ongoing, CPO) • In partnership with Just R recruitment specialists to deliver recruitment initiatives for qualified and unqualified staff (CPO, June 2023) • A new Recruitment and Resourcing Lead appointed, starts end of March 2023 and who will lead on recruitment and retention initiatives (CPO, Ongoing) • Review of entry level qualifications in support worker roles is continuing and a number of unintended consequences have occurred, it needs more testing to ensure the new process is robust, (CPO, June 2023) • Developed internal transfer system which now needs further promoting and embedding (CPO Ongoing 2023) • Applicant Tracking System now agreed, project plan in place to be fully delivered by Sept 2023, CPO • Working with the limitations within NHS Jobs 3 and continue to try to mitigate those as much as possible whilst waiting for the ATS system to be implemented (Sept 2023, CPO) •	30 June 2023	Care Group (weekly) CG&CSC PRC EMT (monthly) Trust Board	9	Risk appetite: Financial / commercial risk target 1 – 6 BAF Ref, SO 3, 4 <u>Comments in relation to risk actions:</u> Proposal for on boarding has been delayed due to technical issues and a further decision to include the applicant tracking system as part of the overall system following the issues with NHS Jobs. There is now a strong commitment to have this developed June 2023. Exploring use of recruitment and retention premia in inpatient settings, paper to EMT. This has been delayed due to ongoing	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					Recruitment and Resourcing (CPO) • Review of recruitment, operational resourcing and structure has started and new Senior posts have now been appointed to from early February 2023 (CPO) • Internal audit report on the leavers process complete and actions addressed (CPO)									discussions at EMT and between CPO and DoF about the proposed model, expenditure and return on investment ongoing exploration of this in EMT	
1530	**Risk level > 15+**	Risk that demand continues to rise placing further pressure on access to services and waiting lists	**COO**	CG & CSG	• Planning process. • Working as a key partner in each of the Integrated Care Systems. • Members of the place-based partnerships and integrated care boards • Health and wellbeing boards. • Digital and telephone solutions are part of the standard offer for service users. • Service delivery is prioritised to meet need, manage risk and promote safety with cross service and care group support utilised. • Where demand exceeds capacity, this is escalated through the Operational Management Group with bespoke arrangements put in place. • Business continuity plans remain responsive and are updated to reflect changes in context • Quality impact of increased demand is overseen in the Clinical Governance Group • Care pathways are designed to be flexed in	4 Major	4 Likely	16	1-6	• Continue to work with partners in each place to monitor and manage changes in demand and hotspots. (Review May 2023, COO/DPD) • Where the need for additional capacity is identified work with commissioners to agree the required changes (COO, ongoing, review May 2023) • Full review of demand is underway and will be discussed in the Improving Access to Care group in February 2023 (COO, May 2023)	31 May 2023	CG&CSC EMT (monthly) OMG Trust Board	4	BAF ref SO 2	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					order to respond to changes in demand.										
1080	**Risk level >15+**	Risk that the Trust's IT infrastructure and information systems could be compromised by cyber-crime leading to a) theft of personal data b) Key system downtime and/or c) Inability to provide safe and high-quality care.	**DFR**	AC	• Microsoft Windows Defender in place including advanced threat protection (ATP), • The Trust's computer estate is all Windows 10 • Security patching regime covering all servers, client machines and network devices with ongoing updates • Annual penetration testing in place and ongoing regular cyber health checks. • Appropriately skilled and experienced staff in post • Disaster recovery and business continuity plans which are tested annually. • Data retention policy in place with regular backups • NHS Digital Care Cert reviewed and applied as applicable • Cyber security is included in mandatory Information Governance training. • Key messages and communications issued to staff regarding potential cyber security risks on a regular basis. • Remediation plans from the Penetration test conducted in January 2022 • Phishing campaign was completed in March 2022 • Schedule of ongoing communications and education on cyber awareness for all staff to continue via Trust standard communication channels. • DSPT Cyber and Information Governance	5 Catastrophic	3 Possible	15	8-12	• Review business continuity plans with frontline services following the cyber-attack on Advanced (NHS IT system provider). (DFR, Q1, 2023/24) • Digital TAG and ICIG to continue to receive reports and assess the cyber risk and escalate where necessary to EMT and Trust Board. (DFR, Ongoing) • 6-monthly cyber security update reports provided to Audit Committee (DFR, ongoing) • Cyber security phase 2 enhancements to support move towards advanced monitoring capabilities business case to be readied for EMT/Trust Board consideration/approval in Q1 2023/24 (DFR) • Cyber campaign and communications schedule for imparting key messages raising staff awareness of heightened cyber security situation, especially given ongoing situation in Ukraine/Russia. (DFR, ongoing) • Phishing campaign to be scheduled to raise/monitor staff awareness (DFR, Ongoing 2023/24) • Develop Trust action plan following recent Advanced cyber security incident, once lessons learned and recommendations become available, (DFR, Q1/Q2 2023/24 • Initial testing of Windows 11 commencing with a view to wider rollout ahead of Windows 10 going End of Life in 2025. (DFR, 2025) • Business case for the introduction of proactive cyber security technologies (SIEM-IPS) presented to EMT for consideration and approval (DFR, 2023/24)	Review 31 July 2023	IM&T Managers Meeting (Monthly) Digital TAG (Quarterly) EMT/Trust Board (Six monthly update as part of Digital Strategy Update) AC (Monthly) IT Services Department service management meetings (Trust / Daisy) (Monthly)	10	Risk appetite: Financial risk target 1 – 6 and Commercial Risk 8-12 BAF Ref, SO 2 & 3	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					met (substantial) and includes additional resilience to mitigate the risk presented by the Ukraine conflict • Cyber security enhancements to support move towards advanced monitoring capabilities, Phase 1 business case approved by EMT January 2022, hardware ordered, and implementation activities completed in 21/22 as planned. • Cyber Essentials Plus re-accreditation complete • Key systems availability (uptime) is continuously monitored by IT Services and form part of routine service management activities with KPIs established. • Immutable backup functionality implemented, which is new backup technology which provides additional safeguards against cyber threats. • Annual cyber table top exercise complete (DFR) • Annual Penetration Test completed in March 2023 • Cyber security resilience assurance provided as part of DSPT baseline and final submission. • Implementation of Multi-Factor Authentication (MFA) across the Trust completed in March 2023 • Introducing Digital Technology Assessment Criteria (DTAC) requirements which includes cyber security considerations into Trust procurement/tendering processes for digital/IT solutions/services –									

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					complete - December 2022 • Cyber Essentials Plus re-accreditation achieved in March 2023 •										
905	**Risk level >15+**	Risk of a negative impact on quality of care due to low staffing levels and insufficient access to temporary staffing.	**COO DNQ**	CG & CSC	• Recruitment and retention plan agreed • Monthly safer staffing reports to Board and OMG via IPR with appropriate escalation arrangements in place. • Biannual safer staffing report to Board and Commissioners including care hours per patient per day • Daily staff absence report. • Medical staff bank established. • Allied Health Professionals master agency contract in place. • Staffing levels monitored locally by matrons and / or service managers with actions taken to increase staffing levels above establishment in accordance with presenting need. • Risk panel monitors the occasions where newly qualified nurses undergoing preceptorship are asked to take charge of a shift. • Care Group meetings review safer staffing and take action to prioritise redeployment of staff to maintain safe staffing levels. • Staff redeployment process in place as part of business continuity planning • Regular review of staff testing capacity through NQP business meeting to minimise staff absence	4 Major	4 Likely	16	1-6	• Additional funding requests with commissioners will be maintained throughout contract negotiations for (COO/ DFR 2023/2024) • International nurse recruitment activity taking place. (CPO, Ongoing) • Roll out of Safe care ongoing throughout 2022/23(DNQ, Apr – May 2023) • Work with partners across ICS as part of the inpatient service improvement programme continues to consider how inpatient services can be promoted as an area of expertise and staff can be recognised and rewarded appropriately (COO/ CPO, to review in May 2023) • The intense programme of work to focus on recruitment to inpatient areas continues (CPO, review monthly, May 2023) • A full review of inpatient ward establishments is underway and reporting through the inpatient service improvement programme (May 2023, DNQ)	31 May 2023	EMT (monthly) OMG Safer staffing inpatient and community group CG&CSC Trust Board	6	Risk appetite: Clinical risk target 1 – 6 BAF Ref, SO 2 & 3	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					with Covid-19 symptoms. (DNQ) • Clinical Risk Panel monitors all staffing incidents to ensure appropriate actions to be taken • Alternative staffing arrangements continue to be reviewed by DNQ and reported to risk panel via Datix. • Overtime is available as part of a range of temporary staffing options • Safer staffing project manager in place with appropriate medium- and longer-term plans including recruitment drive and centralisation of the bank • Bank recruitment now embedded within the broader people directorate recruitment function • Processes are in place to guide staff decision making when staffing is challenged • New roles group continues to lead on the development of a range of options including ACP (Advanced Clinical Practitioner)									

Risk level <15 Risks outside the risk appetite

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1729	**Risk level <15 risk outside the risk appetite**	Staff wellbeing may deteriorate which could exacerbate staffing challenges leading to a delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.	**CPO**	PRC EIIC	• Occupational health service • Health and wellbeing support centre as part of the Workforce Support Hub. • Process for testing all staff established in line with the national model • Self help guide for managers to support their own and teams wellbeing and resilience. • Managers and team leaders coaching to support wellbeing and resilience. • Healthy team's self-help guidance. • Staff counselling availability. • Link to the national health and wellbeing offer. • assessments and health and wellbeing . • Health lifestyle support on Stop Smoking and weight management. • Support and engagement from all staff networks. • Equality Impact Assessment of staff health and wellbeing offer and occupational health. • Comprehensive occupational health offer • Effective supervision practices • Data analysis and hot spot reporting Trust wide • Communications brief with well being messages for all staff • Support to vaccine hesitant members of staff is now mainly through positive comms messages and offers of support from IPC/OH and pharmacy as	3 Moderate	4 Likely	12	1-6	• Targeted communication and engagement with staff network groups. (CPO/DNQ, Quarterly 2023/24) • Wellbeing champions in each of the clinical areas (CPO/COO, Ongoing, review June 2023) • Wellbeing embedded in recruitment, induction and onboarding initiatives (CPO, June 2023) • Health inequalities data and support from staff network groups (CPO, Ongoing, review June 2023) • Planning for 2023-24 vaccination programme due to commence in April 2023 (CPO, Review in 2023/24) • Further actions being developed to enhance our financial wellbeing offers to address the cost of living for our staff including subsidised meals and working in collaboration with other partners (CPO, Sept 2023) • Developing ways to measure and gain feedback and take up of offers across all staff groups (CPO Ongoing) • Ensuring our managers are confident to have financial wellbeing conversations with their staff and are included in all appropriate Occupational Health discussions. (CPO ongoing, review Dec 2023) • Staff survey results currently being analysed and action plans being developed, paper due for PRC and Trust Board in June 2023 (CPO, June 2023)	29 September 2023	Safer staffing reports (monthly) Moving forward group PRC EIIC OMG EMT Trust Board	9	BAF Ref: SO 4 Comment from CPO: Annual vaccination programme drawing to a close, has seen a reduction in uptake compared to last year although this is a national trend. Trust performance benchmarks well compared to local peers.	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					and when requested (CPO) • Financial wellbeing offers and support available to staff • Wage-stream available to all staff to draw down earned pay (i.e. overtime and bank shifts) before usual pay date • Wellbeing and OD practitioner resource in place (CPO) • Financial wellbeing leaflet has been developed for staff and is available on the intranet (CPO) • Moving Forward IPC group meetings now established (every 2 weeks) to look at risk assessments, latest guidance for staff on living with Covid-19										
1614	**Risk level > 15, outside of risk appetite**	National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially reduced quality, unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.	**DNQ**	CG&CSC PRC	• All Datix which relate to staffing issues are presented to the weekly clinical risk panel and escalated to EMT as appropriate. • Review of inpatient services – priority programme • Waiting list reports • Length of stay reports and monitoring • Safety and quality relayed clinical incidents • Staff survey • Clinical risk and care plan improvement project in place • Clinical risk assessment completion and care planning • Complaints, concerns and compliments reporting in place • Quality Monitoring Visits • Bank and agency staffing • Critical incident de briefs	4 Major	3 possible	12	1-6	• New roles being explored across the WY Mental Health Collaborative (DNQ, May 2023) • Review of pilot regarding robust handover processes (DNQ, Review April/ May 2023) • 'Tendable' (outcome monitoring tool) is in place in Mental Health Inpatients which has been well received and there is a plan for a further roll out (DNQ, May 2023) • Safecare is being piloted in Forensics with a plan to roll out to Barnsley mental health Inpatient in 2023 (DNQ Review Nov 2023)	30 November 2023	OMG EMT Trust Board CG&CSC PRC Trust Board	6	BAF Ref SO4 A new approach to capture and report staffing challenges in Forensics has not progressed due to existing pressures on staff workload and the introduction of safe care. (DNQ) Recommendation to link this risk to PRC as well.	May 2023

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					• Safer staffing groups for inpatient and community mental health • Freedom to speak up guardians in place • Quality focused updates from in-patient areas to the Clinical Governance Group • Protocol is in place to support safe practice during seclusion and restraint when working with reduced substantive staff										
1689	**Risks outside of risk appetite <15**	Risk that the Trust cannot evidence that it has mitigated against or addressed health inequalities in both the provision and restoration of services.	**DS**	EIIC	• JSNA in each place • SystmOne data • Integrated strategy and associated action plans • Workforce data including WRES and WDES • Equality Impact Assessments • Intranet resources to support access to equality data • Annual Equality Report • Equality Involvement and Inclusion Committee and sub-committee • Using existing insight and capturing feedback in each place, including analysis of insight by protected group • Internal audit and assurance • Equality dashboard • Annual action plans in place and governance approach established. • Making Data Count Change Manager recruited (DS) • Improving access to care priority programme established (COO) • An excel tracker for EIA and actions are in place (DS)	3 Moderate	3 possible	9	1-6	• Campaign to improve data quality for recording of equality data in place including Develop Making Data Count approach (DS, Review end of Q1 2023/24) • Building capacity and capability through EIA and equality and inclusion themed development sessions and diversity training (DS, May 2023) • Further work underway to embed the use of dashboard as part of routine monitoring (waiting times and access) (DFR/ COO, May 2023) • Triangulation of information from Trust systems, patient experience and involvement/engagement are now being implemented and to embed approach in priority programme (DS, Review end of May 2023) • Developments of narratives and case studies to demonstrate impact and continuous improvement (DS, May 2023) Ongoing action. • Involvement in place-based health inequalities programmes and contribute to these (DS/DPD/COO, May 2023) • Deliver targeted programmes through linked charities (DS, End of May 2023) • Key priority programmes incorporate health inequality actions (DS, May 2023)	31 July 2023	Recovery and reset monthly EMT EIIC (monthly) quarterly meeting and bi-monthly sub-committee EMT Trust Board	6	BAF Ref SO 1 Note: Recommendation to reduce this risk from 4 likely to 3 possible, with a reduction in score from 12 to 9. The risk actions and control measures are in place to show we are mitigating against and addressing health inequalities	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					• Health Intelligence support roles focusing on inequality data established • EIA digital administration tool to disaggregate data and actions being taken is now in place (DS) • EDS 2022/23 • Training and awareness sessions in place • Working with partners in each place to address inequalities through place partnerships					• Embed the EIIC and inequalities priorities within workplans for care group equalities (DS/ COO, May 2023)					
275	**Risks outside of risk appetite <15**	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	**DS/ COO /DPD /DFR**	CG&CSC	• Agreed joint arrangements for management and monitoring delivery of integrated teams. • Weekly risk scan by Chief Nursing Officer and Chief Medical Officer • Care Group / commissioner forums – monitoring of performance. • Monthly review through performance monitoring governance structure via EMT of key indicators and regular review at OMG of key indicators. • Regular ongoing review of contracts with local authorities. • New organisational change policy includes further support for the transfer and redeployment of staff. • Attendance at and minutes from Health & Wellbeing board meetings. • Attendance and monitoring at contract forums. • Annual planning process. • Active involvement in both West and South Yorkshire integrated care systems. • Engagement in each place with local authority partners through meetings and joint working. (COO)	4 Major	3 Possible	12	1-6	• Kirklees Place has in May 2022 placed itself in formal financial recovery process – Trust to contribute to recovery actions (DFR, Review Ongoing, monthly review) • To work with partners in all places to address in year specific financial challenges (DFR/ DPD year-end review, May 2023) •	30 June 2023	Care Group (monthly) EMT (monthly) OMG (regular) CG&CSC Trust Board (each meeting through integrated performance report) Annual review of contracts and annual plan at EMT and Trust Board	6	Risk appetite: Clinical risk target 1 – 6 BAF Ref: SO 1, 2 and 3 Exec team to review the risk score in Q1 2023/24	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					• Calderdale is captured in the Calderdale Cares document and delivery is overseen through the Health and Wellbeing Board. (DNQ) • Kirklees Delivery Collaborative in place chaired by DPD • Barnsley – part of the Integrated Care Delivery Group • Wakefield – active involvement in the mental health provider alliance and Wakefield Provider Collaborative. (DPD) • Contribute routinely to the development of Place based plans and priorities in each place • Winter plans are in place in each district (COO/ DPD) • Clinical and quality Trust representation now established in all place based quality committees										
1624	**Risks outside of risk appetite <15**	Service pressures mean that we are not always able to consistently accept a referral to all three of our 136 suites. This impacts upon the quality of service we can offer to someone who may have a mental health need in our local community.	**COO**	CG & CSC	• Coordinated approach to staffing the 136 unit between IHBTT and inpatient areas • Bed management processes • Staff rotas • There is a multi-agency 136 group (regular meeting) • Joined up work with the police is in place in all areas regarding Section 136. • Agreed process for ensuring that when a person is delayed in the 136 suite waiting for a bed, their care is delivered in line with the inpatient pathway and admission to a ward is actively progressed.	3 Moderate	3 Possible	9	1-6	• Work is progressing across both ICS to review 136 access and pathways across Calderdale, Barnsley, Kirklees and Wakefield with a view to optimising resources and facilitating admissions to local areas wherever possible. (COO, Review May 2023) • Participation in a Barnsley inter-agency working group with work-strands on 136 continues (COO, Review May 2023) • Additional capacity for staffing model in the West suites being negotiated with commissioners (COO, May 2023) Additional police liaison capacity being negotiated in each place which may avert further 136 presentations (COO, May 2023)	31 May 2023	OMG CG&CSC EMT Trust Board (each meeting through integrated performance report)	3	BAF ref SO1 Work with partners is progressing well with joint arrangements being discussed. This will be reviewed again in May 2023 Additional capacity has been secured for Barnsley 136 suite and therefore staffing has been	May 2023

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					• Datix reports • Funding agreed in Barnsley for additional staffing capacity									confirmed as a control. Staffing for the west is still being negotiated.	
1511	**Risks outside of risk appetite <15**	Risk that carrying out the role of lead provider for adult secure services across West and/ or South Yorkshire will result in financial, clinical, and other risk to the Trust.	**DFR**	CC	• Partnership agreement in place with all partners and risk share arrangements in place with NHS providers for West Yorkshire • Commissioning Hubs established in SY and WY with all staff in post • Financial management and control processes in place, including monthly analysis of financial position, and reporting to Provider Collaborative Boards in WY and SY • Quarterly contract meetings in place with sub-contracted partners to ensure oversight of any financial, quality and clinical mitigations • Monthly Patient Safety and Quality Meeting (WY) and Clinical governance meeting (SYB) in place to ensure oversight of any quality and clinical risks and mitigations • Clinical Lead roles in place WY and Clinical Director in place for SYB • Focus and clinical oversight of patient repatriation plans in place Risk register maintained for the programme Quality assurance processes and monitoring in place across the Collaboratives, which continues to develop • Trust Provider Collaborative Committee established with work plan in place	4 Major	3 possible	12	1-6	• Partnership agreement and risk share in South Yorkshire – discussions ongoing (DFR, May 2023) • Benchmarking work across the WY providers (DFR, May 2023) • Progress sub-contracts to signature completed for WY, still outstanding for SY (DFR, end of April/ May 2023) • Ongoing dialogue with NHSE to resolve contractual position in relation to South Yorkshire provider (DFR, review end of May 2023)	31 May 2023	CC EMT (monthly) Trust Board	4	BAF ref SO1 Recommendation to increase the likelihood from 2 unlikely to 3 possible with an increase in risk score from 8 to 12.	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					• Process and governance structures developed and agreed for South Yorkshire AS PC										
1078	**Risks outside of risk appetite <15**	Risk that young people will suffer serious harm as a result of waiting for treatment.	**COO**	CG & CSC	• Incidents are reported on Datix and reviewed through risk panel • First point of contact is in place in all areas • Children waiting for a neurodevelopmental assessment with mental health needs are supported by core CAMHS • Emergency response process is in place for those on the waiting list. • Routine wellbeing checks and support is offered to children who are waiting. This is reviewed on an ongoing basis by the CAMHS Governance Group and concerns are through the assurance process • New pathways are in place for Neurodevelopmental services in Calderdale and Kirklees • 'Clock stop' processes are embedded and include meaningful contacts across video/telephone/face to face. The processes also include provision for the clock not to stop for welfare checks and pathways requiring specific interventions. • Waiting list initiatives have been agreed in all areas and are reported to Clinical Governance & Clinical Safety Committee routinely. • CAMHS performance dashboard for each place	4 Major	2 Unlikely	8	1-6	• Waiting list initiatives are in place with the Trust and a private provider which will partially address demand for Calderdale and Kirklees neurodevelopmental pathways (COO, July 2023) • Changes to delivery system to manage recent increase in demand on crisis and eating disorder pathway remain in place and continue to be monitored (COO, July 2023) • Actions relating to access to CAMHS services and reducing inequalities are being implemented as part of the Improving Access priority workstream (COO, Review May 2023) • Additional work is underway to improve the waiting list report and further roll out of equality monitoring as part of the report (COO, May 2023)	31 July 2023	OMG CG&CSC EMT - monthly Individual district performance reports reviewed by care group Trust Board	6	Risk appetite: Clinical risk target 1 – 6 BAF Ref SO 2 Further improvement work is taking place to improve equality monitoring – review date extended Demand continues to outstrip commissioned capacity – waiting list initiatives are having an impact but this will be seen through Q1 2023/4.	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

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					• Consistent approach to care pathways and activity and outcome recording data. • Active participation in ICS CAMHS work • Ethnicity monitoring is now in place. • Technological solutions are now embedded. • CAMHS Improvement Group established with identified change leadership across each of the pathways • The Improving Access to Care Priority Programme reports to OMG monthly										
1132	**Risks outside of risk appetite <15**	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	**COO**	CG & CSC	• Feedback is reported through insight reports, customer service contacts and friends and family tests • Waiting lists are reported through the care group business meetings with a regular report to OMG. • Alternative services are offered as appropriate. • People waiting are offered contact information if they need to contact someone urgently or their needs escalate • Individual bespoke arrangements are in place within services and reported through the care group business meetings. • Review of impact and ongoing risk presented to CG&CS Committee. • Bespoke arrangements are in place where waiting times have an impact on carers. • Waiting list initiatives have been agreed in all areas. • Work has taken place with commissioners to agree	4 Major	3 Possible	12	1-6	• Waiting list initiatives agreed with ICB. Demand will be reported via contract meetings and planning discussions for 2023/24 will incorporate actions to address predicted demand. (DFR, 2023/24) Waiting list reports are being developed on SystmOne (COO/ DFR, review June 2023) • Hidden waits are being identified and will continue to be included as the waiting list reports develop (COO, June 2023) • Further improvement work is underway on the operational waiting list report to include inequalities and capture the impact of the wait for all areas (COO, June 2023) • Actions relating to access to services and reducing inequalities are being developed as part of the Improving Access priority workstream (COO, June 2023) • The executive TRIO are reviewing the clinical assessment processes to ensure that clinical risk is informed by any inequality issues (TRIO, June 2023)	30 June 2023	Performance reporting to OMG CG&CSC EMT monthly. Assurance report to CG&CS Committee (CAMHS). Individual district performance reports reviewed by Care Group. Trust Board	6	Risk appetite: Clinical risk target 1 – 6 BAF Ref SO 2 Comments from COO: Further improvement work is taking place The Trio's work on the clinical assessment has been moved to June 2023 to enable further work on the data and to better align.	May 2023

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					additional capacity in specific services. • Ethnicity monitoring is now in place to monitor whether there is a disproportionate impact for specific communities or groups. • Priority programmes report to Board, EMT and OMG										
1159	**Risks outside of risk appetite <15**	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	**DFR**	AC	• Fire Safety Advisor produces monthly / quarterly Fire Report and Operational Fire / Unwanted Fire Activation for review / action by EFM Senior Managers. • Quarterly review undertaken by Estates TAG. • Weekly risk scans are completed by the Trust's Fire Safety Advisor • Adherence to standards for the provision, installation, testing and planned maintenance of fire safety equipment and systems. • The identification of standards for the control of combustible, flammable or explosive materials • Delivery of fire safety awareness training • Fire safety training compliance measured monthly at OMG. • Emergency procedures in place to ensure early recovery from unforeseen incident involving fire. • Use of sprinklers across all Trust buildings reviewed as part of the capital programme. • New inpatient builds and major developments fitted with sprinklers. • Reinforcement of rules and fire safety message in	4 Major	3 Possible	12	1-6	• The smoke free policy is being further reviewed due for completion by the end of April/ early May 2023 (DNQ) • A further review of the approved vape is being undertaken as part of the smoke free policy (CMO April/ May 2023) • The rollout programme reviews of the sprinkler system at the Estates TAG and fire risk assessment takes place yearly (Yearly, DFR, Nov 2023) • Annual fire risk assessments to be completed annually by March every year (once a year, March, the next one will be March 2024 (DFR) • The 23/24 fire alarm programme will commence from April 2023. (DFR, March 2024) • Fire training target achieved for 2022/23 (88.4%) (exceeded target of 80%) monitoring will continue until 31 March 2024 (DFR, March 2024)	31 March 2024	EMT Estates TAG (monthly) Safety TAG (Quarterly) OMG (monthly) AC Trust Board	6	Risk appetite: Clinical risk target 1 – 6 BAF Ref, SO 2 Note: A new sprinkler system has been ordered for the priority ward, which will be rolled out in the coming year 2023/24.	May 2023

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					locations where additional oxygen could be used. • Health and Safety annual report submitted annually to Trust Board. • CGCS and the Audit Committee are updated (AAA report) at each committee meeting as part of routine sub-committee updates (monthly, DNQ) • The use of vapes on acute wards to support the smoke free policy has been agreed and a specific manufacturer has been identified with supplies only being available through the Trust, this has been approved by the Fire Officer. • The annual statement of fire safety compliance approved at EMT on 23 March 2023. • Investing in upgraded fire alarms. 22/23 programme has been completed (DFR) • A further fire safety officer appointed • Fire training sessions are being scheduled on a rolling basis									
1424	**Risks outside of risk appetite <15**	Risk of serious harm occurring from known patient safety. risks, with a specific focus on: • Inpatient ligature risks • Learning from deaths & complaints • Clinical risk assessment • Suicide prevention	**DNQ CMO**	CG & CSC	• Clear policies and procedures, and reporting in place, providing framework for the identification and mitigation of patient safety risks. • Weekly risk scan of all red and amber patient safety incidents for any immediate actions required. • Appropriate OMG, Clinical Governance Group and CGCSC escalation arrangements in place.	4 Major	2 Unlikely	8	1-6	• Recent Learning Disability Mortality Review (LeDeR) reports identifying Covid-19 impact on learning disability community are being reviewed for organisational learning opportunities and reported into EMT. (DNQ, April/May 2023) • Complaints policy and metrics subject to further review with regards to quality and response times. Revised proposal agreed and under implementation. (DNQ, April/ May 2023, further to agreement in EMT) • We have a task and finish group focused on an enhancing consistency of oversight of serious incidents and	31 May 2023	Performance & monitoring via EMT CG&CSC OMG & TB reports e.g. quarterly Patient Safety report &	6	Risk appetite: Clinical risk target 1 – 6 BAF ref SO 2	May 2023

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		• Restraint reduction • Covid-19.			• Reducing restrictive practice and intervention (RRPI) improvement plan implementation. • Relevant support from legal team • Formulation of informed risk management (FIRM) assessment training. (DNQ) • New group established focused on improving performance in clinical risk assessment and care plan performance • Clinical Risk Panel monitors all staffing incidents to ensure appropriate actions to be taken • The Clinical Environmental Safety Group oversees ligature risk, • Patient Safety Specialist Roles in place and overseeing our implementation of the Patient Safety Incident Review Framework • Trust wide learning forum, (SI) facilitated by the Nursing Directorate. Quarterly meetings are held to ensure continual learning • The RRPI team support learning with front line colleagues and benchmark practice against other providers. • RRPI Team are supporting a shared approach to the Collaborative Bank (DNQ) • Quality Priorities have now been agreed (DNQ) • There are now regular Patient safety learning events (DNQ) • A new risk identified and actions developed in relation to organisational culture and safety					serious incident action completion across care groups, care group governance group agendas are being reviewed to ensure consistency (DNQ, April/ May 2023)		incident report as well as monthly reporting in the IPR Trust Board			

ORGANISATIONAL LEVEL RISK REPORT

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					• Quality strategy has been approved in March 2023										
1568	**To be confirmed**	Risk that a seclusion room will not be available due to damage that occurred placing staff and service users at an increased risk of harm.	**COO**	CG & CSG	• The leadership team monitor the use of seclusion across all areas and can provide immediate advice on the availability of seclusion in each area. • Seclusion rooms on different wards within acute / medium and low secure can be accessed if available and provide the appropriate level of security • The seclusion policy supports the use of bedrooms / other rooms if safe and appropriate for seclusion. • Incidents are monitored through risk panel with actions escalated as appropriate. • Completion of risk assessments for each individual case to determine whether seclusion can be implemented safely and appropriately in other available spaces. • Issues regarding access to seclusion are reported via Datix and reviewed by the risk panel and escalated to the executive trio if required • Process in place for the Estates Team to respond to urgent requests for repair • A set of standards for seclusion agreed based on available guidance, learning from incidents and knowledge of the current position.	4 Major	4 Likely	16	1-6	• Estates have agreed to accelerate the improvement plan and are working with operational teams to confirm the specific programme (COO, May 2023) • The oversight group will review the incidents where seclusion has been unavailable and make a recommendation for changes to the likelihood score (DNQ May 2023) • Urgent work will be carried out to make available the damaged seclusion rooms in forensic services by removing the vinyl during April 2023 (COO) • The clinical environment clinical safety group will review the urgent solution to remove the vinyl and make a recommendation for an appropriate solution (DNQ, May 2023)	31 May 2023	CG&CSC EMT monthly OMG (regular updates) Clinical Environment clinical safety group Trust Board	4	BAF Ref SO 2 A costed plan is in place to bring each seclusion room up to the required standard. Note: There is a recommendation to increase the risk score due to high acuity and damaged seclusion rooms in Forensics and an issue found with current vinyl on floor and walls. Recommendation to increase the likelihood from 3 possible to 4 likely, which will change risk score from 12 to 16.	May 2023

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					• A costed plan is in place to bring each seclusion room up to the required standard • Seclusion and segregation oversight group reports to the clinical governance group. • The Clinical Environment clinical safety group review this risk and make recommendations for scoring change based on the controls in place •										
852	**Risks outside of risk appetite <15**	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	**DFR**	AC	• Trust maintains access to information governance training for all staff and has track record of achieving the mandatory training target of 95%. • Trust employs appropriate skills and capacity to advise on policies, procedures and training for Information Governance. • Trust has appropriate policies and procedures that are compliant with GDPR. • Improving Clinical Information and Governance group in place which is the governance group with oversight of IG issues. • Monthly report of IG issues to EMT. • Internal audit perform annual review of IG as part of DSPT Toolkit. • Use of blue light system to highlight specific breaches. • Communications and awareness plan • Data protection impact assessment process • Targeted approach to advice and support from IG Manager through	4 Major	3 Possible	12	1-6	• Increase in training available to teams including additional e-learning and self-assessment using workbooks. (DFR, end of June 2023) • Bespoke team training in relation to IG incidents will be rolled out over 2023/24 (DFR, Sept 2023) • Currently working on improving processes for capturing positive consent to share using a digital solution (DFR, End of June 2023, See comments • Working on ensuring services are aware of processes for ensuring differences between addresses on SystmOne and the NHS Spine are actioned (DFR, review June 2023)	31 Sept 2023	ICIG OMG EMT AC Trust Board	4	Risk appetite: Financial risk target 1 – 6 BAF Ref, SO2 DFR and IG Manager agree that we cannot consider a reduction in risk scoring due to outstanding risk actions. A digital solution to capturing positive consent to share has been developed is almost ready for live testing. To support implementation of this, further awareness and communicati	May 2023

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					proactive monitoring of incidents and 'hot-spot-areas. • Formal decision logs are maintained for any temporary changes to policies as a result of wider incidents. • Confidentiality clause in staff contracts plus data protection included in managers' induction checklists • Processes in place for rectifying inaccurate or incomplete data and for erasing erroneous or inaccurate data • ICIG has overseen a piece of work to develop an action plan to reduce the number of IG incidents, including how we target areas of most concern									on about asking patients and recording their consent to share preferences will be taking place. (DFR, End of June 2023	
1319	Risks outside of risk appetite <15	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for PICU or mental health adult inpatient treatment and therefore they will need to be admitted to an out of area bed. The distance from home will mean that their quality of care will be compromised.	COO	CG & CSC	• Bed management process. • Ongoing partnership work with commissioners • Agreed governance structure, with meetings in place, with commissioners in relation to the monitoring and management out of area cessation plans. • Workstreams in place to address specific areas reporting to a service wide meeting • Routine reviews of care whilst out of area are in place. • Pathway for people with trauma informed emotionally unstable personality disorder is in place with a programme of training ongoing. • Barriers to discharge reports link into place-based delays in discharges.	3 Moderate	4 Likely	12	1-6	• Review the actions in place that aimed to reduce admissions and reduce length of stay with a focus on effective discharge from hospital to determine whether they remain in place and or whether they are still fit for purpose for both acute care and PICU . (COO, May 2023) • Participate in the revised plans to review PICU access and care across WYMHLD collaborative (CCO, review May 2023) • Continue to work with local places to address barriers to discharge. (COO, July 2023) • Use the secondary care pathways work to revisit the work as part of West Yorkshire ICS to develop and implement a system wide approach to management of out of area beds to manage peaks in demand. (COO, July 2023) • Additional funding to support discharge packages is still available. Teams continue to work with partners across the ICS to make best use of	31 July 2023	OMG CG&CSC EMT Trust Board	4	Risk appetite: Clinical risk target 1 – 6 BAF ref, SO 3 100 day discharge initiative for mental health has commenced. ,	May 2023

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										the available resources. (COO, May 2023) • Work is underway to achieve the 10 initiatives in the NHS England 100 day discharge initiative for mental health (COO, May 2023) • Scope out the opportunity to block purchase beds, using the continuity of care principles, to support demand through 2023/24 (COO May 2023)					
1368	To be confirmed	Risk that given demand and capacity issues across South & West Yorkshire and nationally, children and younger people requiring admission to hospital will be unable to access a CAMHS bed. This could result in quality of care being compromised and places additional pressure on staff when young people are cared for on adult wards in the secure CAMHS estate or in acute hospitals supported by the Trust's CAMHS service	COO	CG & CSC	• Bed management processes are in place as part of the new care model for Tier 4. • All community options are explored. • Protocol in place for admission of children and younger people on to adult wards. • The most appropriate beds identified for temporary use. • CAMHS in-reach arrange to the ward to support care planning. • CAMHS in-reach is also provided to acute hospitals where younger children are waiting for a tier 4 bed. • Regular report to board • Safeguarding team provides scrutiny of all under 18 admissions. • Red Kite View is now open as the resource for West Yorkshire • Leeds and York Partnership FT have established the care collaborative board to lead work across the system to manage access to inpatient beds and to reduce demand on inpatient care. • System-wide panels take place to review the demand and take action to address delays in	4 major	4 Likely	16	1-6	• Wrap around CAMHS support continues to be provided to children waiting for a bed in the acute Trust and/or in an adult bed. (COO, Ongoing action – review June 2023) ▪ The collaborative is exploring further out of hospital support to children to avoid hospital admission (COO, July 2023) ▪ The executive trio ensure appropriate escalation to partners where an appropriate solution for a child is not available (TRIO review May 2023)	31 July 2023	CG&CSC (regular) EMT (monthly) OMG Trust Board (each meeting through integrated performance report)	4	Risk appetite: Clinical risk target 1 – 6 BAF ref: SO 3 Note: Due to increased acuity and issues in the current inpatient service, the collaborative have not yet reviewed the out of hospital support so the date has been moved. A recommendation to increase the likelihood from 3 possible to 4 likely due to challenges in Red Kite View impacting upon capacity. The risk score will	May 2023

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					discharges of young people to release inpatient capacity. • Care, Education, Treatment Reviews (CETR) are in place for children with learning disability and autism. • An operational cell has been developed as part of the Provider Collaborative in West Yorkshire and a similar tactical group in South Yorkshire. • Management and clinical supervision are in place to support and monitor the impact on CAMHS staff who are working with very high risk children in an unsuitable environment.									increase from 12 to 16.	
1585	**Risks outside of risk appetite <15**	The current NHS capital regime could result in the Trust not having sufficient allocation to complete all its capital plans in any one year adversely impacting on ability to meet its strategic objectives and priorities.	**DFR**	FIP	• Detailed internal capital planning and prioritisation process. • ICS capital allocation process. • Internal cash availability. • Approved updated digital strategy. • System capital planning process. • Effective communication of Trust capital priorities to West and South Yorkshire ICS partners. • Capital allocation for 22/23 meets out needs • The overarching ICB capital allocation and their tracking of system wide expenditure against it • Current refresh of estates strategy	3 Moderate	3 possible	9	1-6	• Updated estates strategy currently being developed (DFR, May 2023) • Consider the emerging cost pressure inflation risk in relation to construction costs and the impact on our capital plan (DFR, ongoing review for each scheme within the capital plan, 2023/24) • Consider the potential increase of the Bretton costs will likely reduce the funding remaining for other capital developments (DFR, April / May 2023) • Separate opportunities to bid for national hospital funds bid process has been launched and our response is underway (DFR, Review May 2023)	31 July 2023	EMT (monthly) FIP (monthly) Trust Board	4	BAF ref: SO 3	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

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1157	**Risks outside of risk appetite <15**	Risk that the Trust does not have a diverse and representative workforce at all levels which reflects all protected characteristics to enable it to deliver services which the meet the needs of the population served and fails to achieve national requirements linked to EDS2, WRES and WDES.	**CPO**	EIIC	• Strategy and involvement approach • Annual Equality Report. • Equality Impact Assessment. • Staff Partnership Forum. • Development and delivery of joint WRES, WDES and EDS2 action plan. • Focus development programmes. • Review of recruitment with staff networks as and when needed. • Links with Universities on widening access. • Policy for bullying and harassment between colleagues. • Full time freedom to speak up guardian structure, resources, and associated policies • Workforce Strategy 2021-2024 supporting SWYPFT as a Great Place to Work • Establishment of staff disability network and LGBT network. • Working Carers Staff network established • Civility and Respect Guardians in place to support cultural change and staff experience decision-making groups are. (CPO) • Career conversations, coaching mentoring programmes are reflective of our diverse communities. • IPC control measures in place in respect the impact of diverse groups • National review of EDS with local implementation actions being developed (CPO) • Reciprocal mentoring and shadow board programme in place	3 Moderate	3 Possible	9	1-6	• Launch of Equity Guardians roles to be further developed and embedded across services. (CPO and DNQ, June 2023) • Race Forward action plan to tackle harassment and bullying from service users and families, this will be co-produced with the Race Forward Group and taken forward by the newly appointed Diversity, Inclusion and Belonging Lead (DNQ, review June 2023) • Develop our approach to diversity and leadership including our approach to talent management (review July 2023, CPO) • Work commenced with external partner (Leadership and Talent Development Coach) to support inclusive culture (CPO, phase 1 to be delivered by end of July 2023) • Use of staff survey data to improve staff experience with a focus on feedback from all diverse groups (CPO, June 2023) • FLAIR survey concluded and currently being analysed (CPO, May 2023) • Appointment of three new People Business Partners to support the development of inclusive action plans using workforce data to drive change (CPO, June 2023) • New Leadership and Management Lead to be appointed to support inclusive leadership appointments (CPO July 2023) • Developing the allyship model (CPO, June 2023) • Development of equality dashboards for EIIC to track data, progress and improvements (CPO, ongoing, review June 2023) • A discussion on the options for improving diversity in leadership roles to be presented in EMT, May 2023 (CPO)	31 July 2023	EMT (quarterly) EIIC Committee (quarterly) Trust Board	6	BAF ref, SO 1 and 4	May 2023

ORGANISATIONAL LEVEL RISK REPORT

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					• Internal review panels in place for disciplinary and grievance cases related to discrimination on the grounds of race. • Race Forward programme has been relaunched with a series of meetings now in place (DNQ) • strategic resourcing and recruitment lead now in post (CPO) • Group has been set up to manage the implementation of EDS2 (CPO) • Ongoing engagement with regional partners and our regional lead from NHSE with regards to disparity in ethnicity representation across nurse bandings										

Organisational level risks within the risk appetite

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
695	Organisational risk within risk appetite	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy	DS	CG & CSG	• OMG, board and EMT. • Service quality metrics in place highlighting potential hotspots and areas for action to be taken as appropriate. • Post implementation review process. • Active engagement in West Yorkshire and South Yorkshire Integrated Care Systems/ • Regular review and update of the strategy by Trust Board. • Review by the CG&CS Committee on QIAs and post implementation reviews updated at gateway review stages of the integrated change framework. • QIA process in place for all significant change. • EQIA trust wide in place for Covid-19 response. • EQIA processes in place for all service changes. • Recovery toolkit that includes EIA / EQIA in place for service recovery and reset. • Annual objectives and priorities and programmes in place (DS) • Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives. (DS / DPD / COO) • Involvement in joint bids and projects to develop strategic partnerships which will facilitate the	3 Moderate	2 Unlikely	6	1-6	• Close involvement in Barnsley plan to monitor potential impact and take measures to mitigate. (DS and COO May 2023) • To ensure digital innovations that support modernisation of clinical services are tested and developed with clinical teams (DFR/ DS/ COO Ongoing) • To further embed creative and cultural approaches in clinical services and integrated pathways (DS/ COO, May 2023) • To deliver priorities within the sustainability strategy, (DS, March 2024) • Develop and introduce sustainability impact assessments (DS, March 2024) • Develop measures to monitor the impact of the headline initiative from the social responsibility and sustainability strategy for responsive and reclusive services (DS, End of May 2023)	29 March 2024	EMT (monthly) Transformation board (monthly) OMG (weekly) CG&CSC Trust Board	6	Risk appetite: Clinical risk target 1 – 3 BAF Ref, SO1 & 2	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					transition to new models of care and sustainable services. (DS and DPD) • Active engagement in place-based plans. (DS / DPD / COO) • Place based plans that impact on clinical services will be governed and managed through the Trust-wide integrated change process at EMT and discussed at Trust Board. (DS / DPD / COO) • Focus on working towards the strategic ambitions of the Trust. (EMT) • Internal place integration group now established (DPD) • Stakeholder engagement plans reviewed and in place.										
812	Organisational risk within risk appetite	Risk the creation of local place-based solutions which change clinical pathways and financial flows could impact adversely on the quality and sustainability of other services.	DS	CG & CSG	• Progress on system and service transformation reviewed by Board and EMT. • Quality Impact Assessment process for CIP and QIPP savings in place. • Alignment of contracting and business development functions to support a pro-active approach to retention of contract income and growth of new income streams. • Bi-annual EMT and Trust Board investment appraisal report • Regular review and update of strategy by Trust Board. • Active engagement in West Yorkshire and South Yorkshire Integrated Care System (ICS) / CEO leads the West Yorkshire ICS. • Financial control process to maximise contribution.	3 Moderate	2 Unlikely	6	8-12	• Alignment of our plans with ICBs, (DPD/ COO/ DFR, end of April/ May 2023) • Place based plans and other system transformation programmes developing and ensuring Trust participation. (DS, May 2023) • To continue to develop Barnsley Integrated Health and Care Alliance with partners delivering on agreed plans and priorities (DS/COO, May 2023)	31 May 2023	CG&CSC EMT (monthly) Trust Board	6	BAF Ref, SO 1 & 3	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					• WY MHLDA specialised services board • Active commensurate role in strategic partnership working in each of our places, including West Yorkshire and South Yorkshire Integrated Care Systems, to plan and deliver stabilisation and recovery priorities. • Active involvement in place based communications and engagement groups • Approach to collating and reporting insight from stakeholders place. • Horizon scanning for new business opportunities. (DS / DFR) • Review of CQUIN income attainment by EMT & OMG with action plan to improve. (DFR) • Review of commissioning intentions by EMT and contract negotiation stances and meetings in place to progress agreements of contracts. (DFR) • Trusts pro-active involvement and influence in system transformation programmes, which are led by commissioners and includes new models of care. (DPD / COO) • Internal groups established to co-ordinate contribution and involvement in each place in both West and South Yorkshire integrated care systems. Individuals identified supporting any key work streams from an operational perspective. (DS / DPD / COO) Internal place integration group established (DPD)									

ORGANISATIONAL LEVEL RISK REPORT

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					• Proactively involved in all places including the developments of mental health and wellbeing alliances and working in partnership to reduce health inequalities in line with national guidance. (DS / DPD) • Clinical and quality Trust representation in place and ICS level quality boards (DNQ/CMO)										
773	**Organisational risk within risk appetite**	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.	**DS**	CG & CSG	• Transformation projects required to include engagement with external partners to ensure alignment. • Use of workshops with external stakeholders to co-produce changes. • Communications through contract meetings and other working groups to ensure appropriate sharing of information. • Regular team-to-team meetings with commissioner organisations to ensure strategic alignment. • Quarterly Partnership Board meetings. • Active participation at all levels in ICSs and other place-based planning initiatives. • Represented on place based integrated care partnerships or equivalent. • Equality, Involvement, Communication and Membership strategy. • Stakeholder plan developed with regular review through EMT • Trust prospectus used as part of ongoing engagement in place • Business cases approved by Calderdale, Kirklees	3 Moderate	2 Unlikely	6	8-12	• Proactive development of relationships with GP Federations to identify opportunities for collaboration and alignment is underway. (DPD/ COO, May 2023) • For ongoing stronger links with national bodies to influence local and national systems thinking in relation to mental health and community services. (DS/ CE, Ongoing, review in May 2023) • Alignment of priorities through provider alliances and integrated care partnership (DPD/ DS, May 2023) • Alignment of Trust transformation and significant change plans for all services with commissioner's plans as set out in local ICS place-based plans. (DS/ DPD/ COO, May 2023 • The Equality, Involvement, Communication and Membership strategy is in place with action plans agreed. Delivery of key actions ongoing. (DS, review March 2024)	29 March 2024	Bi-monthly focus by EMT on transformation. CG&CSC Trust Board reports as appropriate	6	BAF Ref, SO 1 & 2	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					and Wakefield commissioners • Stakeholder plans in place • Involvement in the Overview and Scrutiny Committees (OSCs) regarding transformation proposals as required. (DS/ DPD/ DNQ) • The prospectus that sets our Trust Offer has been reviewed and refreshed (DS)										
1649	**Organisational risk within risk appetite**	The current inconsistency in SALT provision could compromise the quality of care available in response to choking incident.	**DNQ CMO**	CG & CSG	• SBAR issued communicating importance of identifying choking risks and actions required • Choking awareness training slide pack produced and circulated • Systemic approach to MDT choking risk assessment for all inpatient areas established • The Trust secured the services of an independent SLT provider to deliver additional SLT resource in Barnsley and in Wakefield inpatient services to support the dysphagia offer • An E-learning programme on ESR has now been rolled out essential to job role • A learning event from the thematic review is also available to watch on the Trust intranet (information regarding choking) DNQ • All wards are delivering protected mealtimes. • A Process and structure for choking risk assessment is in place with governance checks that the tool is being completed and subsequent choking	3 Moderate	3 Possible	9	8-12	• Following a review of provision, business case for substantive SALT provision is very close to completion by Business and SALT colleagues (DNQ, May 2023) • Audit planned regarding compliance and quality improvement for the choking screening tool (DNQ, May 2023) • Review of process/es for staff when patients are on escorted and unescorted leave and have an existing choking need (May 2023, DNQ) • Establishment of Trust central resource for SALT, focusing on capacity / demand and completion of a robust business case (May 2023, DNQ)	31 May 2023	CG&CSC OMG EMT (monthly) Trust Board	6	BAF Ref: SO 2 Risk scoring discussed, due to vulnerabilities of our population, this risk remains moderate / possible, no change.	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					care plans are in place (DNQ) • Adult Dysphagia and Choking Policy has been approved by EMT • The IPC walk around now includes checking that posters are in place (DNQ) • All choking incidents and the progress of the choking action plan is reported to each Trust Board as part of the Complex Serious Incident Report										
1650	**Organisational risk within risk appetite**	Inpatient areas with gardens that have access to single storey buildings present an increased risk of absconding and/or falling resulting in physical injury.	**COO**	CG & CSC	• We have anti-climb measures in each garden worked through with estates • Induction / update for staff includes access to garden areas • FIRM risk assessments identify clinical risks and safety plans • Safe and supportive observation of patients at risk policy is in place to manage individual risks. • Ward security checks are in place in each area and safety systems and alarms are part of this • The Oakwell/Willow ward risk assessments have been completed (DNQ) • Blanket restrictions are now in place where necessary as there are gaps under the fence where contraband can be placed under or through • Improvement work in the garden area at the Dales is complete.	4 Major	3 Possible	12	8-12	• Where necessary to maintain safety, a blanket restriction is applied in order to manage an immediate risk. This will be for the shortest time possible and within the guidance. (COO/DNQ, Review quarterly, June 2023) • Each area will maintain a risk assessment to understand the potential climb risks. (COO, ongoing, review quarterly June 2023) • Where appropriate supervised access to garden areas is maintained. (ongoing, review quarterly (COO, June 2023) • The clinical environment safety group meeting will review this risk and make a recommendation regarding future actions (DNQ, Review every 6 months) • Following an incident, Forensic Care Group are working with Estates to scope further preventative measures (June 2023, COO)	30 June 2023	CG&CSC Clinical Environment Safety Group EMT (monthly) Trust Board	6	BAF ref: SO 2 Feedback from COO and DNQ: Risk assessments have been reviewed by the care groups and dates updated.	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1217	Organisational risk within risk appetite	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.	DS	AC	• Programme prioritisation processes. • Overall priority progress reports via monthly IPR. • Individual priority programmes via governance groups of change and partnership board, OMG and EMT. • Resources established aligned to programmes. • Annual planning process. • Leadership framework to build capability and to include change competencies. • Quality strategy approved and implementation plan established. • Integrated Change and Improvement Network established to develop critical mass across the organisation. • Development and implementation of interim executive leadership arrangements now in place • Additional capacity aligned to the Trust to support Alliance and partnership work in Wakefield, Kirklees and Barnsley • Additional capacity secured for identified programmes (DS) • The new Quality Strategy was approved by Trust Board in March 2023	3 Moderate	3 Possible	9	8-12	• Agree resource availability to support system-wide programmes of work. (Annually, as needed, in line with business planning and priority programme setting) (EMT, ongoing review) • Review prioritisation and include stopping some activities based on risk assessment. (DS, in line with quarterly review of programmes and capacity, May 2023) • Build capability to enhance capacity through programmes including IHI, QSIR and other development programmes (DS, March 2024)	29 March 2024	Quality Strategy update to CG&CSC AC OMG EMT Trust Board	9	BAF Ref, SO 3	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1432	Organisational risk within risk appetite	Risk of lack of succession planning and talent management may lead to gaps in key roles and fail to promote diversity	**CPO**	PRC	• Workforce Plans to include succession planning and talent management. • Leadership and management framework in place • coaching and mentoring available • Appraisal Policy reviewed. • Board succession plan paper part of WRC plan. • Comprehensive management and leadership programmes • Key element of Trust Workforce Strategy. • Shadow Board Programme and Reciprocal mentoring programme has been launched and in place. • Internal transfer process has been established and streamlined. • Appointed new Diversity, Inclusion and Belonging Lead (CPO) • Chief AHP now in post who will develop clear career pathways for AHPs	3 Moderate	2 Unlikely	6	8-12	• Develop our approach to diversity and leadership including our approach to talent management (review July 2023, CPO) • Supporting Fellowship Programme across the system as opportunities arise (CPO, Ongoing 2023) • OD plan being developed (CPO, June 2023) • Review of Succession plans following new Board appointments (CPO, June 2023 • Raising awareness via the staff network groups on opportunities and strategies (CPO, Ongoing) • Working with our places and systems to collaborate on integrated career pathways and opportunities (CPO & DNQ, – ongoing work) • Increase bank opportunities for all substantive staff through automatic enrolment on bank (CPO and COO, review May 2023) • Development of succession planning for second level post based on review by directors (CPO, June 2023) • Appointment of Interim Head of People Experience on 6 month post pending restructure of the People Directorate (CPO, review July 2023 2023)	31 July 2023	PRC EMT Trust Board	4	BAF Ref SO 3	May 2023
1114	Organisational risk within the risk appetite	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided	**DFR**	FIP	• Board, Committee and EMT oversight of progress made against cost saving schemes. • Active engagement in West Yorkshire and South Yorkshire ICSs. • Active engagement on place-based plans. • Enhanced management of CIP programme. • Integrated change management processes. • Non-Executive Director led Finance, Investment & Performance Committee.	3 Moderate	2 Unlikely	6	1-6	• Development of a longer-term financial sustainability plan and reinstatement of efficiency delivery and monitoring. (DFR, Review end of April/ May 2023) • Implement patient level costing for use by Directorates (DFR, July 2023) • Monthly financial reports to assess impact of inflationary pressures in particular working with estates and procurement to regularly update on actual increases to contract renewals or contractual inflationary uplifts (DFR, Monthly)	31 July 2023	EMT (monthly) FIP (monthly) Trust Board (quarterly)	4	Risk appetite: Financial risk target 1 – 6 BAF Ref, SO 3	May 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

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					• Stability of the financial regime for 2022/ 2023 • Continued Mental Health Investment Standard funding. • System-wide funding provided on a fair shares basis. • Use of national and internal benchmarking information to support productivity improvements. • Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services. (DS and DPD) • Operational and financial plan in place for 2022/2023 • 2023/24 financial plan presented to and approved by the Board in March 2023										

COVID-19 RISKS

Risk level <15 – risks outside the risk appetite

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1522	**Risk level <15 risk outside the risk appetite**	Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19.	**DNQ**	CG & CSC	• Policies and procedures revised to take account of Covid-19. • Publication of Covid-19 guidance on the intranet. • Regular communication to all staff. • Application of social distancing guidance. Updated as required. • Provision of appropriate personal protective equipment in line with national guidance. • Bronze, silver and gold command incident processes available to be reinstated as and when required. • Self-isolation guidance. • Process for testing all staff established in line with the national model • Covid-19 pathway including cohort protocol developed and implemented as required. • Enhanced IPC team offer to services as part of Covid-19 response. • Agreed pathway with acute providers to access clinically appropriate support for Covid-19. • Additional training and support plan for staff to respond to needs of suspected and positive Covid-19 patients. • Development of step-up and step-down guidance in partnership with acute trust colleagues. • SBAR templates are produced to share learning from outbreak	4 Major	3 Possible	12	1-6	• Work ongoing around promotion of vaccinations to both staff and service users (DNQ, May 2023) • Moving Forward Group are reviewing assurance level of being able to confidently identify where the vulnerable staff and service users are (DNQ, end of April/ May 2023) • Continuing monitoring of any Covid-19 cases and outbreaks (DNQ, review end of April/ May 2023)	31 May 2023	CG&CSC EMT (monthly) Moving Forward Group OMG ICIG Trust Board	4	BAF ref: SO 2 Note: Core members of the moving forward group are currently reviewing the control measures (DNQ, May 2023)	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					management investigations. • Timely delivery of flu vaccination programme with learning taken into Covid-19 vaccine preparations. • Daily absence reports to executive directors and senior managers continue. • Routine reviews of IPC BAF reported to NHS England and NHS Improvement via CGCS committee. • The Trust commissioned an independent review by NHSE/I regional IPC team of the Trust COVID ICP practice. • Ongoing review of IPC practice in line with regional and national guidance, and local feedback. • Moving Forward Group has been established to oversee our IPC response, membership includes IPC, operational, health and safety, staff side colleagues, reporting to OMG and EMT, Ongoing review (DNQ) • Vitamin D supplements position statement in place for all inpatient service users. • Covid-19 information leaflets provided to patients and carers. • High risk groups, either due to underlying health conditions or certain protected characteristics (notably people from a BAME background, and people with a learning disability), identified by clinical teams and treatment plans reviewed.									

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					• Service user Covid-19 vaccination programme is delivered in line with national guidance. Including using equality data and a robust EIA to determine cohorts and targeted communication, information, and involvement approaches. • Action plan related to the Physical Health Optimisation Strategy is regularly reviewed by the Physical Health Lead and with updates (CMO) • Continuation of easy read versions of new information has been developed by Trust Comms team include producing information in alternative formats (DS) • Recording and learning from covid outbreaks is now part of business as usual (DNQ)										
1545	**Risk level <15 risk outside the risk appetite**	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic or as a result of the public inquiry.	**CMO**	AC	• Initial sample audits in relation to District Nursing activities and Section 17 leave within Forensic services have been undertaken by the Inquiry Lead in conjunction with Service Directors and Lead Matrons (based on areas most likely to be looked at). No concerns in relation to Trust paperwork and compliance with NHS and Ministry of Justice were found. • These audits will be further developed in line with covid inquiry requests, • Covid Moving Forward Group established which reports into OMG, monitoring numbers of covid cases in patients and staff, IPC	4 Major	3 Possible	12	1-6	• Regular reinforcement of key messages to staff (DS, In progress and will continue, ongoing) • Covid task and finish group to continue to prepare for the inquiry in line with national guidance (DDCG, May 2023) • Confirmed by national inquiry team that NHS will be part of module 3 (procedural Hearing to be held mid-February 2023, risk score will be reviewed following this (DDCG, Review May 2023) • Current IPC guidance relating to public health legislation reviewed by IPC and moving forward group (CMO, ongoing review) • Impact of Covid19 outbreak on section 17 leave decision is on the outbreak meeting agenda to discuss and receive MDT view (May 2023, CMO)	31 May 2023 The completion date has been extended due to modular approach to inquiry (NHS Trusts module 3 to commence 2023 (continue to review on a monthly basis)	AC Moving Forward Group Covid Inquiry Task and Finish Group OMG EMT Trust board	6	The Moving forwards group review any current regional and national guidance and ensure Trust arrangements are developed in line with that.	May 2023

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					requirements and assessing information from the centre. • Covid Inquiry lead in place, linked into national inquiry, learning events and covid inquiry task and finish group established. • Review of estates requirements in relation to living with Covid and working in a hybrid way is included in the updated Estates Strategy • Process to receive and implement national guidance. • Command structure for decision-making was in place during the pandemic and is now being monitored via the Operational Management Group as part of business as usual • Trust policies and procedures. • Use of internal professional expertise. • Use of risk assessments. • Committee structure. • NHS Constitution embedded in Trust strategies, policies, and procedures. • Systematic review of, and adherence to national guidance. • Checklist approach for Equality, Engagement and Communication including EIA process. • Moving forward group review any current regional and national guidance and outbreaks to ensure Trust arrangements are in place including ongoing review of visitor arrangements in line with outbreaks and national guidance.									

ORGANISATIONAL LEVEL RISK REPORT

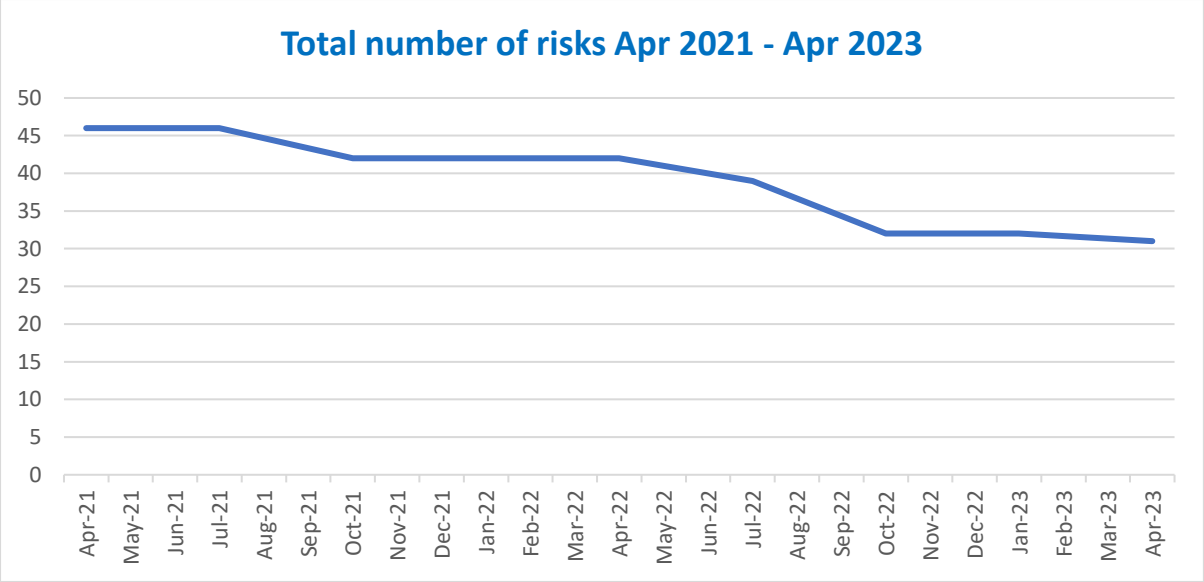
South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Type of Risk	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
					• Every positive result of Covid-19 is reported to IPC. • IPC monitor and initiate outbreak meetings when threshold is met (includes all disciplines) • Outbreak meeting agenda specifically reviews the impact on service users leave arrangements. • Where possible, escorted ground leave approved with limitations. (subject to individualised risk assessment). • Service users are informed of situation and reasons for any restrictions required to manage the spread of infection. • IPC attendance at national group • IPC attendance at regional mental health IPC group • Restrictions on leave during outbreak consistent with practice in other MH trusts. • Duty of Candour is applied at each outbreak meeting. • IPC have an isolation decision tool that is used during the outbreak meeting. •									

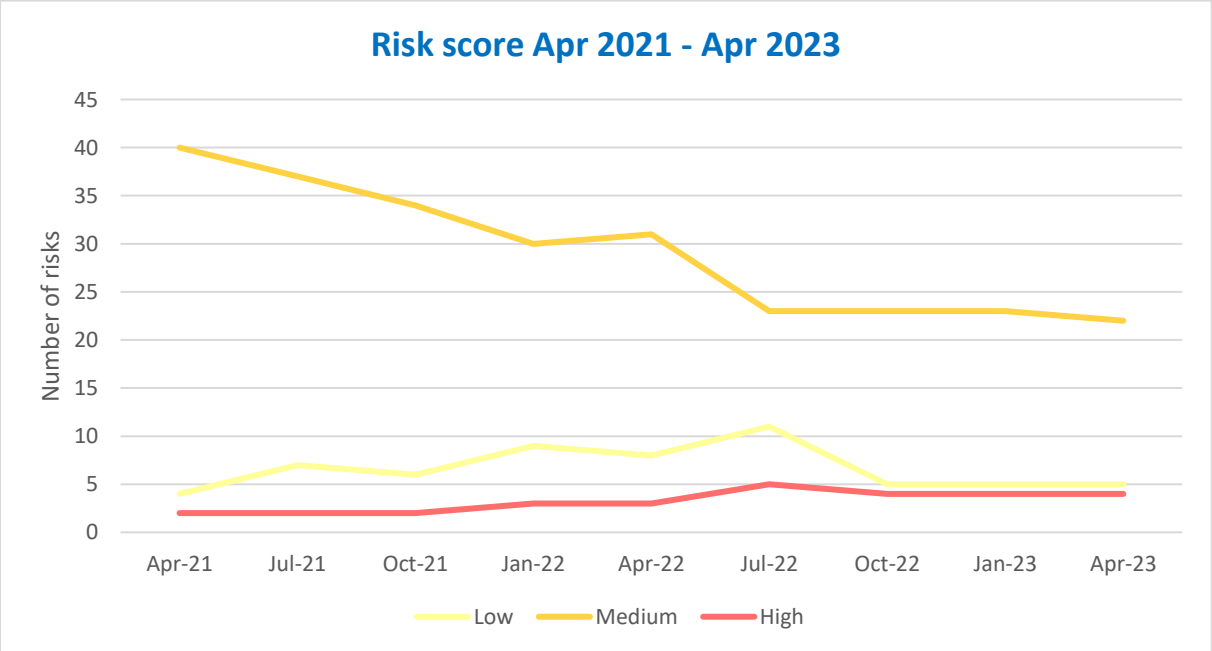
Trust Board
25 April 2023
Organisational Risk Register (ORR)
Quarter 4 Analysis, April 2021 – April 2023

Appendix 1

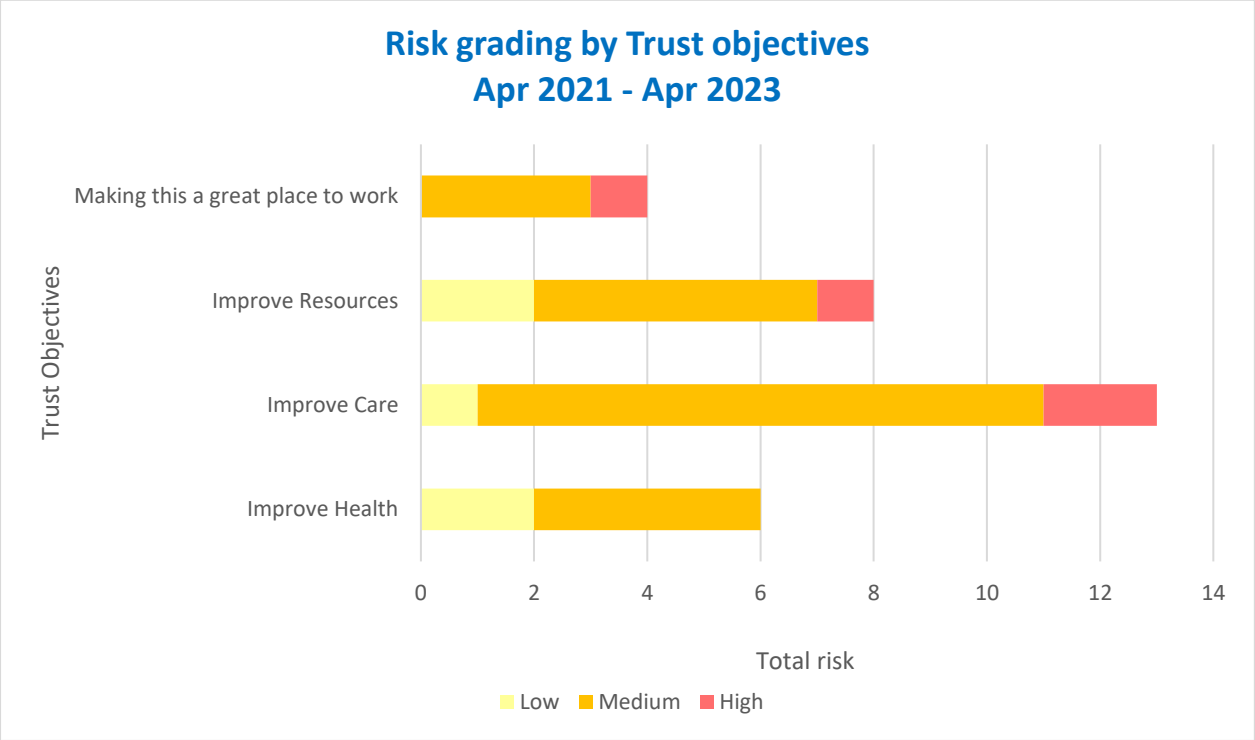
Total number of risks from April 2021 to April 2023



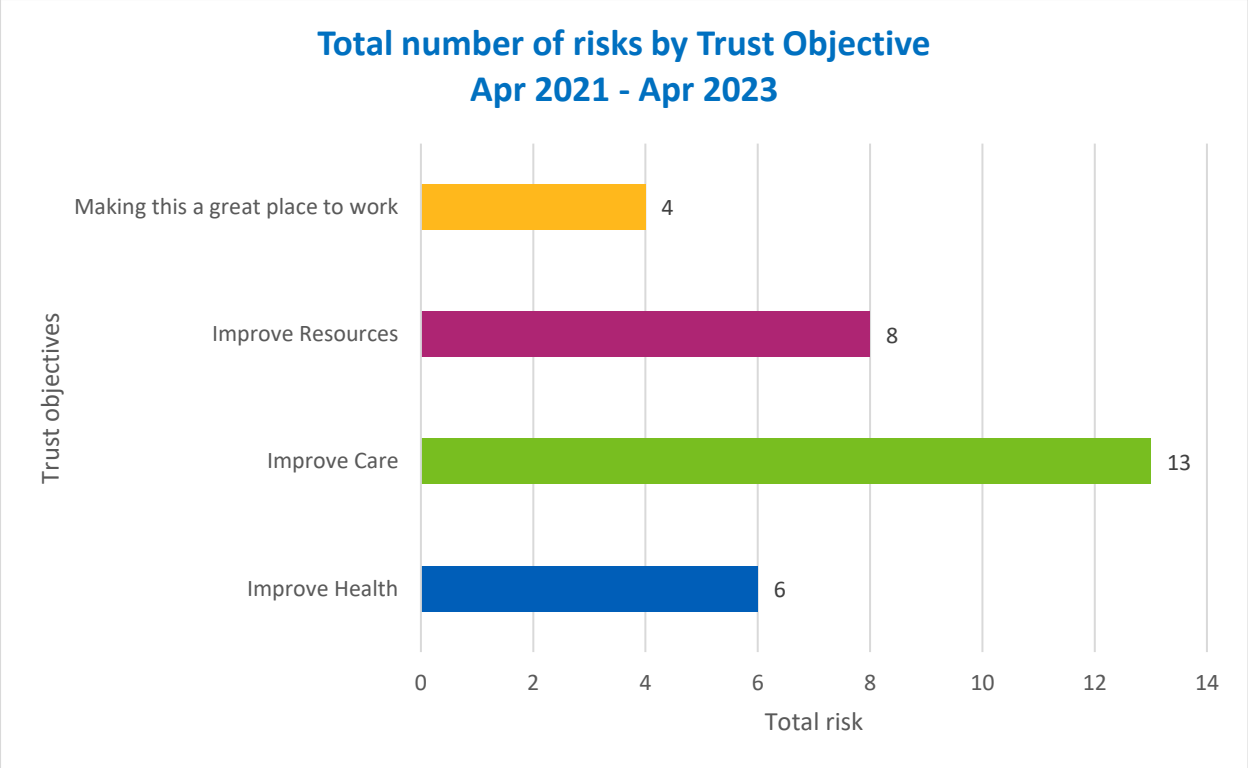
Total risk score from April 2021 – April 2023



A breakdown of Trust objectives April 2021 to April 2023



Total number of risks by Trust objectives, April 2021 – April 2023



South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 9.4

Private/Public paper:	**Public**		
Title:	**Data Security & Protection Toolkit update**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	Julie Williams – Deputy Director of Corporate Governance		
Mission/values:	All Trust objectives.		
Purpose:	To provide information to support the progress towards the submission of the Data Security and Protection Toolkit (DSPT)		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 2.4 - Risk of deliberate and malicious harm to the Trust including cyber-crime, arson and violence resulting in a loss of confidence in and access to the services the Trust provides		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The data security protection toolkit provides evidence to assure the Board and the wider system that the Trust is compliant with the ten data security standards recommended by the National Data Guardian.		
Any background papers / previously considered by:	An annual report is made to the Trust Board Internal audit provides regular updates to the Audit Committee Regular updates are received by the Executive Management Team, Operational Management Group, Digital TAG and Improving Clinical Information & Information Governance Group (ICIG)		
Executive summary:	The current Data Security & Protection Toolkit (DSPT) was released on 22 December 2023 and there are no significant changes to previous years. An interim submission was made prior to the deadline of 28 February 2023 and is on track for a final submission deadline of 30 June 2023. The DSPT allows organisations to self-assess their performance against the ten data security standards recommended by the National Data Guardian. To		

	ensure this self-assessment is considered and evidenced the final assessment submission is subject to review by internal audit. Internal audit has been given access to the DSPT evidence folders in order for them to commence their fieldwork week commencing 17 April 2023, to assist the Trust with action planning to achieve full compliance, as well as ensuring the self-assessment is based on robust and evidenced grounds. 92 of 113 evidence items are currently complete and work is underway to complete the remainder; however, it should be noted that as at 17 April 2023 Trust compliance with data security awareness training is at 86.1% against a mandatory target of 95%. (This data may differ from the data presented in the integrated performance report, which is finalised ahead of publication on Friday 21 April 2023). Compliance is being monitored weekly by the operational management group and individual managers are being sent lists of outstanding staff to follow up. The Trust has made good progress in its completion of the DSPT and has evidence of full compliance with some mandatory standards plus a number of non-mandatory standards. The full DSPT will be submitted to Trust Board on 27 June 2023 for approval prior to the submission deadline of 30 June 2023.
Recommendation:	**Trust Board is asked to NOTE the update for the Data Protection Security Toolkit.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 9.5

Private/Public paper:	**Public**		
Title:	**Draft Annual Governance Statement**		
Paper presented by:	Adrian Snarr – Director of Finance, Performance and Estates		
Paper prepared by:	Julie Williams – Deputy Director of Corporate Governance		
Mission/values:	Respectful, honest, open and transparent. Relevant today and ready for tomorrow.		
Purpose:	To enable the Trust Board to review and comment on the draft annual governance statement.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The annual governance statement is a requirement of the accounting officer on an annual basis to be approved in line with annual reporting requirements. This allows Trust Board to ensure the organisations effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnership and Integrated Care Board.		
Any background papers / previously considered by:	Considered and approved by the Executive Management Team (EMT), Audit Committee and Trust Board annually.		
Executive summary:	• As part of the annual accounting and reporting requirements the accounting officer (Chief Executive) is required to provide an annual governance statement (AGS), which needs to be approved in line with other annual reporting requirements. • The outline of the requirements of the AGS is provided in annual guidance by the regulator (NHS England). This version will be thoroughly checked against the Annual Report Manual (ARM) 22/23 and subject to audit by the Trust external auditor (Deloitte) • Certain elements of the wording are prescriptive and in other sections there is clear guidance on what to include. • At this stage it is a draft statement with some content only available on completion of the year-end.		

	• This report enables Board members to have an early oversight of the AGS and provide any feedback. • It should be noted that the requirements of the AGS have been carefully reviewed by the Deputy Director of Corporate Governance and Company Secretary to ensure the Trust's AGS complies with these requirements. • An earlier draft was reviewed by the Audit Committee on the 11 April 2023. • Areas highlighted in grey are standard wording • Areas highlighted in yellow still require update once final year-end figures and other information is complete. Please note this document will not be finalised until the Audit Committee meeting on 26 June 2023. A further draft will be presented to Trust Board in May 2023.
Recommendation:	**The Board is asked to REVIEW the draft annual governance statement and COMMENT accordingly.**

DRAFT

Annual Governance Statement 2022/23

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively.

I also acknowledge my responsibilities as set out in the *NHS Trust Accounting Officer Memorandum.*

This Annual Governance Statement reflects the challenging context within which I deliver my responsibilities and demonstrates the complexity and diversity of the services the Trust provides and commissions across a broad geographical area. The Statement also reflects the impact of the cost of living crisis, NHS industrial action, workforce pressures and the after effects of the covid-19 pandemic upon the Trust and the communities it serves.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation 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 system of internal control has been in place in South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Our 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 Trust's strategy and objectives, and for ensuring corrective action is in place where necessary. The Trust Board's attitude to risk is based on appropriate tolerance to risk. The Board acknowledges that the services provided by the Trust cannot be without risk and ensures that, as far as is possible, risk is minimised and managed within a risk tolerance. This is set out in the Trust's Risk Management Governance Framework and supporting procedure which have been reviewed in year. The Trust's Risk Appetite Statement has been reviewed by our internal

auditors (360 Assurance) in year to ensure it reflects the Trusts new responsibilities as a commissioner and lead provider.

The Board is supported and governed by an involved and proactive Members' Council, a key part of the Trust's governance arrangements. Since becoming a Foundation Trust in 2009, the Members' Council has become mature and well established in its role of holding Non-Executive Directors to account for the performance of the Trust Board. The agendas for Members' Council meetings, produced in partnership with the Members' Council Co-ordination Group, focus on its statutory duties, areas of risk for the Trust, and on the Trust's future strategy. Training and development programmes ensure governors have the skills and experience required to fulfil their duties.
I have now served as the Trust Chief Executive since February 2022 and have recruited substantively to all executive team vacancies to support me to meet my duties.
These changes are reflected below:

Executive	Role	Date left	Reason for leaving
Lindsay Jensen	Interim Director of Human Resources & OD	23/04/2022	Period of acting up completed
James Sabin	Interim Director of Finance & Resources	31/07/2022	Secondment
Executive	Role	Date Commenced	
Adrian Snarr	Director of Finance, Estates and Resources	11/08/2022	
Greg Moores	Chief People Officer	24/04/2022	

There is a balance of directors with internally and externally focused roles. Director portfolios are regularly reviewed to ensure appropriate balance and capacity is in place to meet the needs of the Trust. This has been visible in the last year with the effectiveness of the Director of Provider Development and Director of Strategy and Change roles ensuring appropriate links into enhanced partnership arrangements.

Now that all director posts have been filled on a substantive basis, I have been able to review portfolios and align with experience and capacity to best meet Trust needs. Adrian Snarr has been given responsibility for corporate governance whilst business development and planning has moved across to Sean Rayner. This helps the Trust to be relevant for today and ready for tomorrow.

The Members' Council, Trust Board and Executive team are operating in an environment of external change and wider system pressure where risk is constant and at a high level. This has been driven by the cost-of-living crisis, workforce pressures including national NHS industrial action and the continued impact of the Covid-19 pandemic on capacity and demand.

The Trust operates within a strategic framework that includes a vision, mission, and values, supported by four strategic objectives and a number of priority programmes. This approach is agreed and set by the Board and provides an effective underpinning of the Chief Executive's objectives and Executive team objectives, are determined in line with director accountabilities. I review these objectives on an on-going basis with the full executive team and with individual directors, with progress, issues and risks reflected in the Board Assurance Framework and corporate/organisational risk register.

This approach reflects the Trust's framework that devolves responsibility and accountability throughout the organisation by having robust delivery arrangements. Capacity for delivery is assured through business planning processes and control is executed through an appropriate scheme of delegation and standing financial instructions which have been reviewed and updated in year to reflect Trust and system changes.

We identify and manage risk at these levels, as well as at Trust level, and this is reflected in the roles and responsibilities of the Board, of Executives and of staff within the Trust. This is evident from the Board Assurance Framework and Trust risk registers.

The Trust continued to operate a comprehensive risk management arrangement during 2022/23 with regular reviews of risk at Executive Management team (EMT) meetings, and the Trust Board, alongside the Committees of the Board. This recognises the dynamic nature of the environment in which we operate and the need to constantly focus, assess and manage risk.

Risk management training for the Trust Board is undertaken biennially, latterly in December 2021. The training needs of staff are assessed through a formal learning needs analysis which was completed in 2022/23. All staff receive training appropriate to their authority and duties.

The role of individual staff in managing risk is supported by a framework of policies and procedures that promote learning from experience and sharing of good practice. The Risk Management Governance Framework has been reviewed, updated and approved by Trust Board in April 2022.

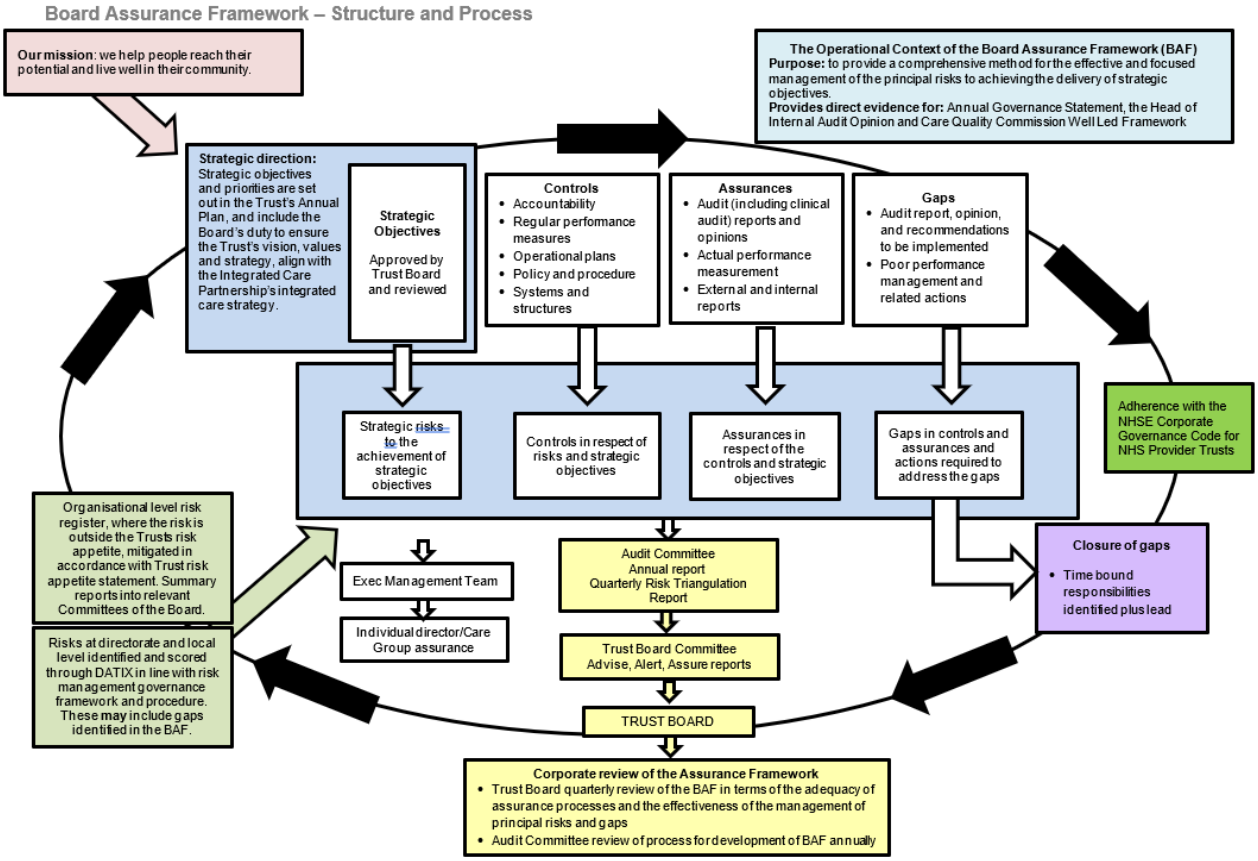
Guidance to support staff in the recording, reporting and management of risks procedure has also been reviewed and refreshed and was presented to the Audit Committee in July 2022.

Alongside this framework, the Trust has effective internal audit arrangements, with an annual work plan that helps to manage strategic and business risk within the Trust. This is approved by the Audit Committee following engagement with Executive Directors.

The risk and control framework

The risk and control framework flows from the principles of good governance. It uses effective board and committee structures, supported by the Trust's Constitution (including standing orders) and scheme of delegation. The Risk Management

Framework describes in detail how risk is applied within this framework which is depicted below:



The Audit Committee assures the Board and Members' Council of the effectiveness of the governance structures through a cycle of audit, self-assessment and annual review. The latest annual review was received by the Board in April 2023.

The Audit Committee assessment was supported by the Trust internal auditors who conducted a survey of Trust Board members for the fourth consecutive year in relation to risk management, which again supports this assessment.

The cycle of Trust Board meetings continues to ensure that the Trust Board devotes sufficient time to setting and reviewing strategy and monitoring key risks. Within each quarterly cycle, there is one monthly meeting with a forward-looking focus centred on business risk and future performance, one meeting focusing on performance and monitoring, and one strategic development session. The Trust Board meetings relating to business risk and future performance, and performance and monitoring are held in public, and the Chair encourages governors to attend each meeting.

Following the Covid-19 pandemic, the Trust Board meetings have been held face to face with members of the public able to join virtually. Minutes, papers, and details of how governors and members of the public can join Board meetings held in public are available on the Trust website. Regular reviews were made of the Board agenda during the year to ensure Board members were fully sighted on key issues.

The Board has developed stronger partnerships across the geography in which we operate. Formal partnership Boards and committees have reports and minutes received by the Trust Board and there is appropriate consideration made in our risk register.

The Committee in Common with West Yorkshire partners reports in line with other committees of the board.

The Trust's Risk Management Governance Framework sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk. The Trust's Risk Appetite Statement was defined in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix aligned to the Trust's own risk assessment matrix. The Statement was reviewed and approved by Trust Board in March 2023.

The Risk Appetite Statement sets out the Board's strategic approach to risk-taking by defining its specific boundaries and risk tolerance thresholds under five categories (strategic, clinical, financial, business and compliance risks), and supports delivery of the Trust's Risk Management Governance Framework and procedures.

All organisational level risks are aligned to and monitored by an appropriate Committee. During 2022/23, further work has continued to review risk registers, to consider where organisational risks scoring level 15 and below fall outside of their risk appetite. This ensures risks are managed within their tolerance where appropriate or escalated for further debate and action.

Risk reports are used at the relevant committees of the board, setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level.

The Board Assurance Framework (BAF) describes the strategic risks that will continue to be managed by the Trust. The BAF is aligned to the four strategic objectives of the Trust. This ensures alignment between the business of the Trust and the risks we manage across the organisation and the system. The BAF is used to help shape the agenda of the Board and its sub-committees. In 2022/23, the Trust Board conducted the annual review of strategic risks. In quarter four, a comprehensive review of all strategic risks took place and an updated BAF was reported to the Trust Board in April 2023.

As Chief Executive and the Accounting Officer, my accountabilities are secured through delegated executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, ensuring there is a high standard of public accountability, probity, and performance management. In 2022/23, personal objectives were set for each director and reflected in the Board Assurance Framework through the strategic objectives assigned to each Director. My objectives were discussed and agreed with the Chair and shared across the Trust, alongside a high-level summary of how Directors' objectives fit within this framework.

In support of the BAF, the Trust also has a corporate/organisational risk register in place which outlines the key risks for the organisation and actions identified to mitigate these risks. This is reviewed on a quarterly basis by the EMT and Trust Board, providing leadership for the risk management process. Risk registers are also developed at service delivery level within Care Groups (CG's) and within the corporate directorates. These are reviewed regularly at the Operational Management Group (OMG).

Insert risk tables after Q4 ORR report approved by Board.

There is a need for us to continuously balance the current government approach to Covid-19 prevalence operating guidelines with the need to keep our service users and all of us safe, this includes the Trust maintaining suitable infection, prevention and control (IPC) standards and oversight in order to prevent and manage outbreaks to maintain the safety of our service users and staff.

Our approach to enhanced local risk assessments ensures the Trust proactively bases all decisions on the right information and insight. To ensure that sufficient overview and scrutiny is in place the Trust has kept in place its "moving forward" group to ensure it has a robust and dynamic Covid-19 management system in place. This group reports jointly into the OMG and EMT.

In July 2022 the creation of Integrated Care Systems (ICS) across West Yorkshire and South Yorkshire provided a further mechanism for managing elements of risk across organisations. Both Integrated Care Boards (ICBs) recognise that the principles of good governance must be underpinned by an effective risk management system designed to ensure the proactive identification, assessment and mitigation of risks to ensure that the ICB achieves its strategic priorities and in doing so maintains the safety of its staff, patients, and members of the public.

The Trust Risk management governance framework and reporting provides the ICBs with assurance that the Trust has an effective risk management system to contribute to the delivery of the ICB's strategic priorities and delivery plans.

We are closely engaged in the leadership and delivery of these plans. The Director of Provider Development and Director of Strategy and Change roles means we have senior capacity working on the programmes that relate to the Trust, in West Yorkshire and South Yorkshire Integrated Care Systems.

Priority programmes

The Trust continues to lay the foundations for its ambitious vision to provide outstanding physical, mental, and social care in a modern health and care system. This is backed by priority programmes and associated structures. The priority programmes help to address the strategic risk of having insufficient capacity and help to prioritise our efforts. Our priority programmes are described in detail in the main body of the annual report (see page ??).

Working in partnership

In May 2022, the Trust established a Collaborative Committee, as a sub-committee to our Trust Board. The purpose of the committee is to ensure delineation between provision and commissioning responsibilities as coordinating provider (finance, contracting, planning and quality assurance) for the West Yorkshire Adult Secure Provider Collaborative, oversight of commissioning responsibilities as lead provider for the South Yorkshire and Bassetlaw (SYB) Adult Secure Provider Collaborative and other specialised mental health provider collaboratives as appropriate.

The Trust works in partnership with health economies predominantly in Barnsley, Calderdale, Kirklees, Wakefield, and the Integrated Care Systems of South Yorkshire and West Yorkshire.
The Trust achieved 'go live' for the South Yorkshire and Bassetlaw Adult Secure Provider Collaborative on 1 May 2022, as lead provider.
Provider collaboratives are a partnership of mental health, learning disability and autism service providers led by an NHS lead provider working to provide co-ordinated and improved specialised services across a specified geography. They work in partnership to improve services and ensure that services are provided as close as possible to patients' homes, using commissioning budgets innovatively to improve patients' experience and outcomes across whole care pathways. Commissioning arrangements for the collaborative are established through the SYB Mental Health Provider Collaborative Commissioning Hub. Oversight of the Trust's commissioning responsibilities for the collaborative is via the Collaborative Committee (described below). The Trust are members of the South Yorkshire and Bassetlaw Partnership Board which oversees the SYB specialised provider collaboratives (Adult Secure, CAMHS and Adult Eating Disorders).

In the **West Yorkshire Health and Care Partnership** we have been involved in a range of work under the auspices of the WY Mental Health, Learning Disabilities & Autism Programme Board, including work streams on neurodiversity, complex mental health rehabilitation, psychiatric intensive care unit beds and children and young people's mental health. The Trust is the coordinating (lead) provider for the West Yorkshire Adult Secure Lead Provider Collaborative, working with NHS and independent sector providers in West Yorkshire.

The Trust are a partner in the West Yorkshire Adult Eating Disorder Provider Collaborative, and Children and Young People's Mental Health Provider Collaborative – both coordinated by Leeds and York Partnership NHS Foundation Trust.

Over the past year, the Trust has continued to work with partners to plan for Phase 2 of the Specialised Provider Collaborative Programme.

The Trust are an active partner in work to improve learning disabilities assessment and treatment provision across West Yorkshire. The reconfiguration of Assessment and Treatment Units (ATUs) has progressed during 2021/22, and the provision of a Regional Centre of Excellence across two sites (Bradford and the Horizon Centre at Fieldhead Hospital, Wakefield) was implemented in 2022.

The Trust is an active participant in two Integrated Care Systems (ICS) and we have continued to work with partners. In both ICSs we have participated in the development of the transformation of community mental health services. A detailed

description of our work across our integrated care systems is described in the main body of the report (see page ??)

The Trust continues its commitment towards 'Delivering a Net Zero Health Service' under the Greener NHS programme. The Foundation Trust has undertaken risk assessments and has a green management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensure that its obligations under the Climate Change Act and the Adaptation of reporting requirements are complied with. The Trust Board approved the Trust's Green Plan in March 2021, progress against the plan was monitored by the Board in 2022/23. The Green Plan was integrated into the social responsibility and sustainability strategy and approved by Trust Board in July 2022.

Review of economy, efficiency, and effectiveness of the use of resources

The governance framework of the Trust is determined by the Trust Board. It is described in the Trust's annual report and includes information on the terms of reference, membership and attendance at Trust Board and its Committees, including the Nominations Committee, which is a sub-committee of the Members' Council. The Trust complies with Monitor's (now NHS England/NHS Improvement) Code of Governance and further information is included in the Trust's annual report. Please see section on governance arrangements (page ??).

Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, Finance, Investment and Performance Committee, through Executive Management Team (EMT) meetings, the Operational Management Group (OMG), finance and performance reviews, Care Group management teams and at various operational team meetings.

The EMT has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust's resources. This is subject to oversight by the governance mechanisms described in the previous paragraph.

Our Licence

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust continues to assess its compliance with CQC registration requirements on a regular basis through our quality improvement and assurance team. To support our assessment, we have developed a quality assurance and improvement 'self-governing' assessment model. This philosophy builds on our emphasis on self-governance and evaluation. As a series of methods and tools, this approach helps map the relationships between quality improvement and quality assurance and will provide a continual source of evidence for teams to inform how well they are performing against appropriate and helpful metrics for quality.

There has not been a full CQC inspection completed during 2022/23, however, the CQC rated our Trust as Good in 2019, recognising the improvements we have made since the previous inspection in 2018 and the strength and quality of the services we provide. We delivered on the actions from the last report, which led to four of the five overall domains now being rated as Good.

Overall, we are rated Good for being responsive, caring, well led and effective, and Requires Improvement for being safe. This means that overall we have been rated Good as a Trust.

12 of our 14 core services are rated Good. Over **87%** of our individual domains have been rated as Good or Outstanding. In summary:

- The significant majority of our services are rated as Good or Outstanding.
- Our community based mental health services for working age adults have improved and are now rated Good.
- Acute wards for adults of working age and psychiatric care units have improved.
- We have improved and are now rated as Good for being Responsive.
- 93% of our services were rated as Caring and Responsive.
- Staff were kind and caring towards service users, with positive relationships that demonstrated we knew them well.
- The values of the organisation were understood and respected by both leaders and those working in core services.
- Our strategy, vision and values were all identified as being patient centred.

Continuous improvement work on the areas for improvement identified by the CQC, has taken place during 2022/33 including:

- Record keeping – a Trust wide improvement group has been established to review all aspects of clinical record keeping and refresh the clinical record keeping audit
- Safe medicines – Electronic Prescribing and Medicines Administration (EPMA) has been rolled out, ensuring the safe prescription and administration of medications, pharmacists to clinically review and reconcile medications and pharmacy technicians to input drug histories and order medications.
- Reducing violence against staff – The Reducing Restrictive Interventions (RRPI) Team continue to work with care groups ensuring staff are trained and competent in de-escalation and RRPI techniques

However, In November 2022, the CQC carried out a focussed inspection of the Trust's Older People's service.

The CQC report was published on the 15th March 2023, with the following summary:

CQC deputy director of operations in the North, said:
"When we inspected the wards for older people with mental health problems, we saw a happy workforce that worked well together with kind and considerate staff who worked hard to ensure people's needs were met.
"However, we found some issues that required the trust to take action to ensure people were safe. It was reassuring that leaders responded positively to the points we raised and already had plans in place to make changes and improvements in the areas we highlighted.
"For example, leaders provided information which showed they were aware of issues with poor staff training compliance and were able to show us detailed plans to improve and manage risks in the meantime.

“In addition, the numbers of falls on the wards had been highlighted as an area for improvement and the trust were able to provide detailed action plans in relation to improving this area. Leaders were also taking steps to improve the environment to ensure it remained safe and fit for purpose.
“It was lovely to hear that staff were so positive about the culture they experienced working for the trust, with many reporting they felt listened to and fully supported by managers.
“We will continue to monitor the trust, including through future inspections, to ensure the necessary improvements are made so people are safe and can continue to receive a good standard of care.”

Inspectors found the following during this inspection:

- Patients and carers that we spoke to said they were happy with the level of care that they received and observed.
- Staff cared for patients and showed that they had a good understanding of their needs.
- The trust had not ensured that all staff had the correct level of training to safely care for patients. Training compliance rates for managing violence and aggression, basic life support and immediate life support were low.
- Physical health observations were not always documented effectively, it was not always clear why they had not been carried out.
- Not all staff had been offered an appraisal of their work.
- The delivery and quality of care offered to patients was inconsistent across the sites visited.

Actions have been incorporated into existing, ward quality improvement plans, monitored through Care Group Governance Groups.

Routine CQC Mental health Act visits have continued in 2022/23. There were nine in total across the following sites:

- Chippendale
- Ryburn
- Horizon
- Nostell
- Crofton
- Ashdale
- Beechdale
- Elmdale
- Melton Suite

The outcome of these visits and any actions required are reported into and monitored by the Mental Health Act Committee.

During 2022/23 The Trust assessed itself against the NHS Constitution, in line with good practice. The report was presented to the Trust Board in January 2023. This set out how the Trust meets the rights and pledges of the NHS Constitution and new Code of Governance for NHS Provider Trusts (October 2022) which comes into effect on 1 April 2023. At the time of writing, I believe that our performance metrics

and risk register contain no material or substantial risk of significant breaches of the constitution.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of interests in the NHS(23)) guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity, and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Values based culture

The Trust works hard to provide the highest standards of healthcare to people. The promotion of a culture of openness is a pre-requisite to improving business resilience, patient safety and the quality of healthcare systems. Good governance and a risk aware culture are emphasised in the values of the Trust and reinforced through values-based recruitment, appraisal, and induction.

Learning from incidents and the impact on risk management is embedded in the way we work. The Trust uses an e-based reporting system, Datix, at directorate and service line level to capture incidents and risks, which can be input at source. Data can be interrogated through ward, team, and locality processes. This encourages local ownership and accountability for incident and risk management. Data is interrogated regularly to ensure that any risks are identified and escalated at the appropriate level. Staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes, ensuring risks are reduced.

The Trust works closely with safety teams in NHS England/Improvement and uses Root Cause Analysis (RCA) as a tool to undertake structured investigation to ensure learning from serious incidents. Our aim is to identify the contributory factors and potential root cause of serious incidents, to identify the learning and improvement actions necessary to minimise the opportunity of recurrence and to ensure that the Trust takes every opportunity to learn and develop from an incident and mitigate future risk.

The provision of mental health, learning disability and community services carries a significant inherent potential risk. Unfortunately, serious incidents do occur which require robust and well governed organisational controls. In 2022/23, there were 14,352 incidents reported (a 12% increase on 2021/22), of which 97% resulted in low or no harm to patients, service users and staff or were external to the Trust's care, recognising that the Trust has a risk based and good reporting culture.

During 2022/23, there were 16 serious incidents across the Trust compared to 22 in 2021/22. There were no 'Never Events' (as defined by the Department of Health) relating to serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

There were 374 notifiable safety incidents during the year where Duty of Candour applied. There were six Duty of Candour breaches representing 1.6% of all applicable incidents. These incidents all involved community patients who self-harmed resulting in moderate or severe harm. Details of the six breaches are below:

A community patient self-harmed at home. Staff contacted emergency services and the patient was taken to the acute hospital in an ambulance and was treated in ICU. The team were unable to undertake duty of candour because the patient was uncontactable in ICU. The team subsequently spoken to the patient's mother who contacted them, and an apology was provided to her.

A community patient self-harmed. The patient received treatment in the acute hospital as a result of the self-harm. The Duty of Candour apology was carried out during home visit at a later date.

A community patient self-harmed at home. The patient was transferred to the acute hospital and was treated in Intensive Care Unit (ICU). The Community Team contacted family at the time of the incident to offer support which was declined. The patient was in ICU therefore staff were unable to apologise within the time frame. Associate Quality & Governance Lead visited the Service User following transfer to a Mental Health ward and Duty of Candour completed in person.

A community patient self-harmed. The patient was transferred to the acute hospital for medical intervention to the wounds as a result of self-harming. Due to the patient's injuries and subsequent hospital admission out of area it was difficult to make contact within the specified time frame for duty of candour despite many attempts by a member of the team. Duty of candour was completed as soon as possible following discharge. Staff did speak to the family and unfortunately missed the opportunity to complete the duty of candour.

A community patient self-harmed. The patient was taken to accident and emergency and admitted to Intensive Care Unit. Duty of Candour was delayed as patient was in Intensive Care and whilst the Care Coordinator had been in contact with patient and family it was not felt to be an appropriate time due to mental state. Apology given when patient was more stable.

A community patient self-harmed. The patient was transferred to the acute hospital and was treated in Intensive Care Unit. The clinical judgement was to deliver the

apology at the next appointment with the therapist. However, the patient did not attend the appointment, a letter was therefore sent offering a further appointment with duty of candour being completed within the letter.

The Clinical Governance and Clinical Safety Committee has a leading role to play. It scrutinises and monitors quarterly serious incident reports and bi-annual reports on how and where lessons have been learnt and practice improved and/or changed. The Committee also monitors implementation of recommendations arising from external reviews and reports. In the last year, this has included the Trust's action plan in response to the CQC. The Committee routinely monitors infection prevention and control, reducing restrictive practice interventions, safeguarding, patient safety, health and safety, quality impact assessments and issues identified at the drug and therapeutics committee. During the year, the Committee continued its review of the implementation of the Trust's priority programmes from a clinical perspective and receives a regular 'exception' report as well as more detailed presentations as appropriate. The Committee continued to review its allocated risks. The Committee oversees all quality and safety action plans until completed and closed and it is satisfied that risks have been moderated.

The Clinical Risk Panel, chaired by the Chief Nurse and Director of Quality and Professions,)membership includes Chief medical and Chief Operations officers) provides an organisational overview of the incident review, action planning and learning processes to improve patient safety. It also provides assurance on the performance management of the review process, associated learning, and subsequent impact within the organisation. The panel takes place weekly and reports directly into the EMT at every meeting.

The key elements of the Trust's quality governance arrangements are as follows:

- The Trust's approach to quality reinforces its commitment to quality care that is well led, safe, caring, responsive, efficient, and effective. The Quality Strategy outlines the responsibilities held by individuals, directorates, the EMT and Trust Board. The Trust Board approved an updated Quality Strategy on 28 March 2023.
- The Trust's Quality Strategy sets out our commitment to providing high quality care for all while achieving our organisational mission to help people to reach their potential and live well in their communities. It sets out what we mean by quality and provides a framework for how we assure and improve quality across the organisation. It also describes our integrated change framework that supports innovation and improvement at all levels. The Quality Strategy has three main aims: 1) To deliver the quality priorities, both our current priorities and future priorities, and be flexible in what our priorities are to make sure that they are always fit for purpose and reflective of need; 2) embed quality improvement across our organisation to support our journey to becoming a Trust that delivers outstanding care; 3) monitor and identify success, through measuring, reflecting and ensuring we have robust systems in place to understand where there have been improvements in quality, and where we could do better.
- This is supported by the Patient Safety Strategy to improve the safety culture throughout the organisation whilst supporting people on their recovery journey. It

aims to reduce the frequency and severity of harm resulting from patient safety incidents, to enhance the safety, effectiveness and positive experience of the services we provide, and to reduce the costs, both personal and financial, associated with patient safety incidents. The strategy was presented reviewed approved in December 2019 and covers the period up to and including 31 March 2021. A new Patient Safety Incident Response Framework (PSIRF) was released in Spring 2022– this will replace the current Serious Incident Framework and will change our approach to investigating patient safety incidents and have a stronger focus on learning. Following receipt of this document we are reviewing our patient safety strategy, and this will be presented to Trust Board in early Q3 2023/24.

- Annual quality priorities are agreed through the Board and published in the Quality Account.
- The Clinical Governance and Clinical Safety Committee is the lead Committee for quality governance.
- The Safeguarding Strategic Sub-Group provides assurance to our partners that we are compliant with national standards and adopt a quality improvement approach to developing our service offer
- Monthly compliance reporting against quality indicators sits within the Integrated Performance Report. Clinical Governance and Clinical Safety Committee receives a quarterly report on complaints, concerns, comments and complements through a patient experience report, the outcome of which is presented in Trust Board throught the alert / advise / assure document as necessary. In addition, Trust Board receives an annual Patient Experience Report.
- CQC regulation leads monitor performance against CQC regulations and the Trust undertakes self-assessments.
- External validation, accreditation, assessment, and quality schemes support self-assessment for example: accreditation of electroconvulsive therapy (ECT), Psychiatric Intensive Care Units (PICU) and memory services; CQC Mental Health Act visits; and national surveys (staff and service user).
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as serious incidents, infection prevention and control, information governance, reducing restrictive practice group, drugs and therapeutics and policy development. During the pandemic, these continued to meet and/or were strengthened by the development of groups within the command structure. For example, the Infection Prevention & Control (IPC) Bronze Command. The Trust retains the Moving Forward Group, to retain our oversight of COVID-19 activity.
- Quality impact assessments are carried out on all Trust cost improvement plans with Chief Medical Officer and Chief Nurse / Director of Quality and Professions approval required before a scheme can proceed. Quality Impact Assessments (QIAs) can also be invoked in year where concerns trigger the requirement to do so. Given the temporary financial arrangements in place, with the suspension of cost improvement programmes during 2022/23 this process was not required during the year
- Measures are implemented and maintained to ensure individual practice, teams and services are reviewed and improvements identified and delivered. This includes the Trust's prioritised clinical audit and practice evaluation programme.
- The annual validation of the Trust's Corporate Governance Statements as required under NHS Foundation Trust conditions. The Board certified that it was

satisfied with the risks and mitigating actions against each area of the required areas within the statement (as described on pages ????).

- Freedom to Speak Up (FTSU) Guardians ensure that where staff feel unable to raise concerns through the usual channels, there is a mechanism for doing so. The Trust has a full-time Guardian who is supported by civility and respect champions across the Trust. In year three further volunteer guardians have been recruited and will be completing the training. A Freedom to Speak Up Steering Group has been established to further strengthen the Trusts arrangements. Over the year 53 concerns were raised through this mechanism, 11 of which followed the freedom to speak up process and the remaining 42 were signposted to the appropriate avenue for support. Reporting was shared with the Office of the National Guardian.

The Trust continues to build on its engagement framework to enhance and increase understanding of the Trust's services, to demonstrate the quality of services and to show the actions taken in response to the feedback. These are described in detail in the main body of the annual report (Page ??)

Equality, involvement, and inclusion

The Trust believes that an integrated approach to equality, involvement, and communication (bolstered by our membership) will ensure we deliver on our inclusion agenda.

The Trust approved an equality, involvement, communication and membership strategy in 2020 which has supporting annual action plans to ensure an integrated approach. This is insight driven and will ensure:

- Every person living in the communities we serve will know our services are appropriate and reflect the population we serve
- That our workforce reflects communities, ensuring our services are culturally appropriate and fit for purpose
- Service users, carers and families receive timely and accessible information and communication, ensuring a person-centred approach to care
- That our services are co-created and designed with our staff, those with a lived experience and our communities

The Equality, Involvement and Inclusion Committee oversees the implementation of the equality, involvement, communication and membership strategy to improve access, experience, and outcomes for people from all backgrounds and communities. This includes people who use, work and volunteer for our Trust services and those who work in partnership with the Trust with the strategic aim of improving health, care, resources and making our Trust a great place to work.

The key approaches to support this work are set out below:

- The equality, involvement, communication and membership strategy is supported by annual equality and involvement action plans. These plans set out our Trustwide approach to delivering strategic objectives and describe the Trust actions for the forthcoming year. The plans align with existing internal resources,

data, and insight frameworks to ensure a systematic and integrated Trust wide approach.

- The effective use of insight and data underpins what we do. This includes robust equality monitoring. Data is used to identify who uses and works in services, highlighting areas of inequality that can be addressed through insight work and action planning.
- Equality Impact Assessments (EIA) are in place for all services, strategies, and policies. This ensures that equality, diversity, and human rights impacts are considered, recorded and action taken for every service. Action to mitigate impacts are taken through service level actions plans which are used to implement service improvements.
- A Trustwide Equality Impact Assessment and approach was developed in direct response to the pandemic. This approach includes a Trustwide EIA that has regularly been updated and reviewed and signed off by Equality, Inclusion and Involvement Committee and Trust Board and the development of a resource and research bank which is an internal resource of all literature published during this time. These tools have ensured that our public sector equality duty to advance equality of opportunity and consider impacts has been a core focus in response to the pandemic.
- The Trust have a clearly articulated approach to formal consultation, this includes a training pack, plan on a page and governance through EMT and Equality, Inclusion and Involvement (EII)Committee who sign off the appropriate approach.
- The Trustwide change framework includes the process for involving people at each stage and a 'checklist' approach and dedicated inbox for involvement ensures that a systematic and considered approach to engagement, co-production and consultation is considered at the start of any new project or programme of work
- All networks attend the Board at least once a year to share and any issues or concerns for action by the Trust board
- The Board and governors believe they should be reflective of communities and represent the workforce and population it serves. Over the last year a good level of diversity has been retained across the Board with a good balance of gender, age, and ethnicity. Governors use a targeted approach to support recruitment from local communities and those with lived experience.

Further examples are provided in the main body of the annual report (see page ??)

The Trust has improved in all four WRES indicators published in the NHS Staff Survey and has plans identified to continue this improvement.

The Trust submitted its 2021 gender pay gap audit as required by law, in March 2022.

The Trust has adopted the National EDS2 Framework and focussed on improving the following areas, working closely with service users, public and commissioners:

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

The Trust Board approved a Workforce Strategy on the 28 September 2021, which includes objectives, linked to the EDS2 Framework and the NHS Workforce Race Equality Standards (WRES), to support a representative workforce. The Trust has a joint EDS2 and WRES action plan.

Building on listening events and feedback from staff during 2020/21 this resulted in a new organisational priority. “Making SWYPFT a great place to work” supports the provision of a healthy, resilient, and safe workforce. This covers five key areas:

- Feeling safe
- Being part of a supportive team
- Positive health and wellbeing
- Developing my potential
- My voice counts

As part of making the Trust a Great Place to Work, a senior leadership forum was created involving senior managers, clinicians and corporate services to develop local actions plans in response to the key themes above in line with “Developing Workforce Standards” 2018.

In 2022/23, the Equality, Inclusion and Involvement Committee received reports on the following:

- Equality and diversity annual report prior to Trust Board.
- Learning from NHS staff survey and well-being at work survey
- Progress on development of peer support workers
- Equality, inclusion and engagement audit.
- The Committee received delivery updates on the carers agenda
- Received Care Group reports on equality and involvement
- Received Equality and Involvement exception and highlight reports
- Received the Insight report
- The Committee monitored the Trust’s progress against the equality standards including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES); and the Trusts progress against the Equality Delivery System 2 (EDS2).
- Received feedback from staff equality networks.
- Reviewed inclusive leadership and development programme updates

In the last year we have continued to increase our investment in health and wellbeing support following the Covid-19 pandemic. A BAME health and wellbeing taskforce has been established and a health and wellbeing and an organisational development practitioner for the BAME workforce has been appointed. We have delivered through our hospital hubs a successful Covid-19 vaccination programme for our staff and social care partners. In doing so, we have worked hard to s address different levels of vaccine take up, with significant progress made and work continuing into 2022/23

The Trust is a member of the NHS Benchmarking Network and participates in a number of benchmarking exercises. This information is used alongside reference cost and other benchmarking metrics, such as the Model Hospital, to review specific areas of service in an attempt to target future efficiency savings and reduce waste. Work has continued with Care Group's to implement service line reporting, including the use of bespoke performance dashboards. During the year enhanced reporting for the Covid-19 pandemic continued, this included live updating of staff absence, testing and vaccinations.

The Trust has a well-developed annual planning process which considers the resources required to deliver the organisation's service plans in support of the Trust's strategic objectives, local commissioning intentions and local health and wellbeing plans. Increasingly we are ensuring that Integrated Care Systems (ICS) inform our work. These annual plans detail the workforce and financial resources required to deliver service objectives and include the identification of cost savings.

Annual accounting information to be added on completion.

Information governance

Information governance compliance is assured through a number of control measures to ensure that risks to data security are identified, managed and controlled. The Trust has put an information risk management process in place led by the Trust Senior Information Risk Owner (SIRO). Information asset owners cover the Trust's main systems and record stores, along with information held at team level. An annual information risk assessment is undertaken. All Trust laptops and memory sticks are encrypted, and person identifiable information is required to be only held on secure Trust servers. Add in Trust compliance with information governance training as at DSPT submission (June 23)

Information governance has had continued focus through 2022/23 through proactive monitoring of incidents, providing awareness raising sessions at all levels in the organisation, including senior level through Extended Executive Management Team, and offering advice and increasing availability of training for staff. Information governance had a continuous and high profile in the Brief, cascaded monthly to all staff.

Incidents and risks are reviewed by the Improving Clinical Information Group which informs policy changes and reminders to staff.

The Trust is required to report any information governance incidents where the severity is minor (2) or above and the likelihood is likely (3) externally to the Information Commissioner's Office (ICO). Two incidents were reported during 2022/23. One incident involved the theft of a Trust vehicle containing personal data about patients of the Trust and of another NHS organisation that the Trust provides post services for. The vehicle has never been recovered and the police have closed their investigation. No adverse effects have been reported as a result of the incident. The second incident involved a trainee on placement disclosing

sensitive information about Trust patients to their peers. The ICO have closed the case but the Trust investigation is ongoing.

In addition to the SIRO, the Trust has the following:

- Caldicott Guardian: acts as patient data champion and conscience of the Trust
- Chief Clinical Information Officer: provides expert clinical advice to business intelligence, information governance and systems development
- Data Protection Officer: monitors compliance and advises on data protection obligations

All those in specialist roles are substantive members of the Improving Clinical Information Group, the aim of which is to ensure good clinical information quality and IG by undertaking and overseeing work on behalf of EMT and Trust Board, providing both strategic leadership and an open forum to discuss the quality of clinical information, IG and any barriers to improvement.

Good information governance will continue to be a feature of the Trust in 2023/24.

The Data Security and Protection Toolkit update following final audit.

Data Quality and Governance

We have a strong system of quality reporting:

- Quality metrics are reviewed monthly by Trust Board and the EMT, alongside the performance reviews undertaken by Care Groups as part of their governance structures.
- The Integrated Performance Report covers substantial quality and performance information and is reported to the Board and EMT. This is supplemented by detailed reports on specific elements of quality, such as incidents, complaints, and patient experience.
- The Clinical Governance and Clinical Safety Committee oversee the development of the Quality Report and associated detailed reports.
- Corporate leadership of data quality through the Director of Finance, Estates and Resources, supported by the Chief Nurse and Director of Quality and Professions.
- Data quality objectives that are linked to business objectives, supported by the Trust's Data Quality Policy, and evidenced through the Trust's Information Assurance Framework.
- The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, mandatory training for information governance and training for the Trust's clinical information systems.
- The Chief Nurse and Director of Quality and Professions (Caldicott Guardian) and Director of Finance, Estates and Resources (SIRO) co-chair the Trustwide Improving Clinical Information and Information Governance (ICIG) meeting. The group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation.

- The effectiveness of the Trust's arrangements is scrutinised by the Audit and Clinical Governance and Clinical Safety Committees.

Role of information policies and plans in ensuring quality of care provided

- Good clinical record keeping is part of good clinical practice and provision of quality care to the people who use our services.
- There is comprehensive guidance for staff on data quality, collection, recording, analysis, and reporting which meets the requirements of national standards, translating corporate commitment into consistent practice, through the Data Quality Policy and associated information management and technology policies.
- There are performance and information procedures for all internal and external reporting. Mechanisms are in place to ensure compliance through the ICIG with reports to the Audit and Clinical Governance and Clinical Safety Committees on data quality.

Systems and processes

- There are systems and processes in place for the collection, recording, analysis and reporting of data which are accurate, valid, reliable, timely, relevant, and complete through system documentation, guides, policies, and training.
- Corporate security and recovery arrangements are in place with regular tests of business-critical systems. These systems and processes are replicated Trust-wide.

People and skills

- Behaviours that reflect the Trust values and the necessary skills are essential elements of good data quality, recording and reporting and compliance with policy.
- Roles and responsibilities in relation to data quality are clearly defined and documented.
- There is a clear training plan for information governance and the Trust's clinical information systems (SystmOne and a small number of additional systems) with the provision of targeted training and support to ensure responsible staff have the necessary capacity and skills.

Data use and reporting

- Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through the Executive Management Team meeting and Trust Board, with key performance indicators set at both service and Board level. This includes identification of any issues in relation to data collection, quality and reporting of data with focussed action to address such issues. Work has continued in 2022/23 and now includes a Trust wide waiting list project to ensure waiting lists are fully captured, reviewed and managed. In addition dedicated "making data count" resources have been put in place to support data completeness, accuracy and analysis to inform decision making.

The Trust is committed to a continual improvement in the quality of its data in order to support improvement of the service it offers to users of its services and to meet its business needs. Regular reviews of the quality of the Trust's clinical data are undertaken by the ICIG and, where data quality standards are identified as a risk factor, these are reported to the Trust's Senior Information Risk Owner (SIRO) for further investigation.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Clinical Governance and Clinical Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework (BAF) provides evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principal objectives have been reviewed. The BAF is approved by Trust Board on an annual basis and reviewed and updated on a quarterly basis throughout the year. There were no significant gaps identified in the BAF.

Directors' appraisals are conducted by me in my role as the Chief Executive with objectives reviewed regularly and monthly meetings on business delivery and progress. This has provided a good discipline and focus for Director performance. My appraisal is undertaken by the Chair. Non-Executive Director appraisals are undertaken by the Chair of the Trust. The Non-Executives' performance is collectively reviewed by the Members' Council. The appraisal of the Chair is led by the Senior Independent Director and reports to the Members' Council on the outcome.

The Trust has a values-based appraisal system for staff and also uses values-based recruitment and selection. During 2022/23, we continued to embed and streamline our electronic appraisal platform, helping to facilitate meaningful conversations. 2660 staff had an appraisal at 31 March 2023. This is 72% of the 3691 staff eligible for appraisal as at 31 March 2023.

All Committees of Trust Board are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. The Committees have met regularly throughout the year and their minutes and annual reports are received by the Board.

In May 2022, the Trust established a Collaborative Committee, as a sub-committee to our Trust Board, as described in the "working in partnership" section of this annual governance statement at page ??

The Audit Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and has done so as part of its annual work programme. This was reported through its Annual Report to the Board. The Audit Committee was able to provide assurance that, in terms of the effectiveness and integration of risk committees, risk was effectively managed and mitigated. Assurance was provided that committees met the requirements of their terms of reference, that committee work programmes were aligned to the risks and objectives of the organisation, in the scope of their remit, and that committees could demonstrate added value to the organisation. Areas of development identified in the last Audit Committee annual report have been acted upon.

The role of internal audit at the Trust is to provide an independent and objective opinion to the Trust, its managers, and Trust Board on the system of control. It provides a Head of Internal Audit opinion each year. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The internal audit function within the Trust for 2022/23 was provided by 360Assurance.

The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the EMT. It is based on an audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the EMT focusing on risk and improvement areas. Internal audit provides the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses.

In respect of the internal audit plan for 2022/23, eight internal audit reviews have been conducted and presented to the Audit Committee. Of these, there were five significant assurance opinions, one report was issued with a substantial rating (NHS Digital rating for Data Security and Protection Toolkit), and one report had a limited assurance opinion; this was the exit interview process audit. One audit, review of HFMA Improving NHS financial sustainability checklist, was a non-opinion piece of work so no assurance opinion was assigned.

The Head of Internal Audit's overall opinion for 2022/23 provided **significant assurance**' that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Action plans are developed for all internal audit reports in response to the recommendations and the Audit Committee invites the lead Director for each 'limited' or 'no assurance' report to attend to provide assurance on actions taken to

implement recommendations. For all 'limited' and 'no assurance' reports, a follow up audit is undertaken within twelve months. Completion of recommended actions is tracked by the Audit Committee and over the course of the year 90% of actions were completed within the original time frame specified, and 98% of all recommendations have been completed.

Conclusion

I have reviewed the relevant evidence and assurances in respect of internal control. The Trust, its Board and members of the leadership and management structure are alert to their accountabilities in respect of internal control. Throughout the year, the Trust has had processes in place to identify and manage risk.

The review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. I can confirm that my review has concluded no significant control issues have been identified. A small number of internal control issues outlined in this statement are not considered significant. I can confirm that those control issues have been or are being addressed.

Over the past year, the Members' Council, Trust Board and Executive team have operated in an environment of external change and wider system pressure where risk has been constant and at a high level. This has been driven by the cost-of-living crisis, workforce pressures including national NHS industrial action, and the continued impact of the Covid-19 pandemic on capacity and demand. During this time the system of internal control has remained robust and enabled change and risk to be managed effectively.

Mark Brooks
Chief Executive Date: xx June 2023

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 9.6

Private/Public paper:	**Public**		
Title:	**Role of the Executive sponsor of Learning Disability services and the clinical and strategic approach to improvement of Learning Disability services**		
Paper presented by:	**Prof. Subha Thiyagesh, Chief Medical Officer**		
Paper prepared by:	Prof. Subha Thiyagesh, Chief Medical Officer and Executive sponsor for Learning Disabilities Dr. Tom Jackson, Fareena Rasaq, Dr. Sarah Talar - Learning Disability Clinical Trio		
Mission/values:	• 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		
Purpose:	To describe the role of the executive sponsor in relation to learning disability services and sharing the clinical and strategic approach to improvement in learning disability services.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 1.4 - Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The paper, along with the attached strategic approach paper, outlines the principles of the approach of the learning disability services in response and in keeping with the targets and priorities set by national and Integrated Care Systems (ICS, both West and South Yorkshire). The approach actively seeks and builds on partnership working with our stakeholders across both the ICS. We are part of the West Yorkshire Assessment and Treatment Unit provider collaborative and actively work together across the ICS to provide a high quality inpatient assessment service.		

Any background papers / previously considered by:	A detailed paper was taken to Executive Management Team (EMT) for discussion and feedback on 23 March 2023. The attached paper was taken to Clinical Governance & Clinical Safety Committee (CGCSC) on 11 April 2023.
Executive summary:	The Trust fully recognises the need to address health inequalities for people with a learning disability. To provide even greater focus on this a decision was made by EMT colleagues to nominate an executive sponsor for the Trust's Learning Disability (LD) services. The sponsor's approach to the role is as follows: • To raise the profile and visibility of the LD service and the needs of people with a learning disability internally and externally • To raise the profile via networking, social media and meetings with internal and external stakeholders with the aim of improving lives and addressing inequalities • To support the LD clinical trio to develop a clear service vision and strategic approach to delivery of high-quality services and have clarity of impact from the role and from the service • To help the clinical trio develop clear improvement priorities and support in their achievement • To enable quality improvement activities, share learning and aiding the clinical trio through removing any potential barriers to delivery of priorities • To provide further focus on addressing health and care inequalities • To facilitate and influence in place and wider system meetings to raise the profile of improving lives and outcomes for people with a learning disability • To help the service focus on achievement of high impact key performance indicators such as annual physical health checks, implementation of greenlight toolkit, working collaboratively with our partner organisations to reduce out of area placements and long term stays • To help the service consider further areas of improvement such as: number of activities in inpatient wards, review of environmental audit including sensory needs, and engagement approach with our service users, families and carers The sponsor has met regularly, members of the clinical trio and director of service to facilitate some of the above. The meetings have provided opportunity for the clinical and operational colleagues to have clear headspace and safe space to consider strategic priorities. Early feedback suggests that this approach has been considered helpful by the team. As an example of using our influence effectively, in our alliance with Barnsley Healthcare Federation a year one target is for an improvement in the completion of annual physical health checks for people with a learning disability. A quality

	improvement approach has been taken and based on the latest information available at the end of February, Barnsley was the highest performing place across our integrated care systems in terms of annual health checks completed. The attached paper details some of the work that has progressed and outlines the strategic approach to improvement activities. The clinical trio have outlined the strategic context for the Trust's learning disability services. The paper describes how improvement activity within the Trust's learning disability services will be organised and coordinated in a more methodical manner. It also details the areas identified and prioritised for improvement within the Trust's community and inpatient LD services in 2023/24; highlighting particularly where the Executive sponsor and the wider trust, can play a helpful role in achieving some of the prioritised objectives.
Recommendation:	**Trust Board is asked to NOTE the overview of the Executive sponsor role and the clinical and strategic approach of the service to improvement priorities over the next year and COMMENT.**

Introduction

As part of our commitment to high quality, effective and safe care, the Trust's Learning Disability Services undertake a range of improvement activities, both systematic/continuous and targeted, each year. These improvement activities are grounded in our vision for the provision of the core activities of our learning disability services (Service Vision & Strategy available on request), and as described in our contracts with each of our place commissioners and relevant strategic, policy & practice-guidance and service specifications/descriptions from national and regional bodies[1][2][3].

A. POLICY & STRATEGIC CONTEXT:

National Strategy: The NHS Long-Term Plan (2019)

The headline aims of the Long-Term Plan for the NHS are that over the next 10-years the NHS will:

- Ensure people have a good start & end of life.
- Focus on health inequalities and major health conditions.
- Promote system-wide working and integrate concepts of health, care and wellbeing.
    - Focus on staff wellbeing and workforce challenges.
    - Ensure services are 'digitally-enabled'.
    - Ensure services provide value for money.

As one of 7 *'clinical priorities'*, the Long-Term Plan states that *"people with learning disabilities and/or autism should lead longer, happier and healthier lives in their communities"* and builds on other recent key policies relating to people with learning disabilities – most notably the 'Transforming Care Programme', 'STOMP' and the 'National Mortality Review (LeDeR)' – making 5 further commitments specific to the provision of services to people with learning disabilities:

- To reduce morbidity, premature deaths and the number of preventable deaths of people with LD.
- To improve the understanding of learning disabilities within the whole NHS.
- To reduce waiting times for specialist learning disability services.
- To establish more care in the community; less care in hospitals and ensure all health and care services are inclusive of people with learning disabilities.
- To improve the quality of inpatient care for people with LD across the NHS and the independent sector.

The Long-Term Plan also pledged to ensure patients, service-users, families & carers are much more involved as key service-delivery/service-improvement partners and committed the NHS to employing more people with learning disabilities within its own services.

[1] Long Term Plan (2019)
[2] NHSE Service Models (2018)
[3] Professional Learning Disability Senate Guidance (2017)

Regional Strategy: West Yorkshire Health & Care Partnership (WYHCP) / South Yorkshire & Bassetlaw Integrated Care System (SYBICS)

In 2019, the West Yorkshire Health & Care Partnership (ICB) published a 5-year strategy for improving the lives of people with mental health, learning disabilities and/or autism. With a focus on community living and a reduced reliance on inpatient care, the strategy committed that local services would provide equitable treatment and care of people with learning disabilities and reduce the number of times when disabled people are treated differently by health and care services, with the aim of reducing the gap in life expectancy of people with learning disabilities (as well as those with MH and autism) by 10% by 2024. The strategy in West Yorkshire further committed to:

- Develop the local provider market (including affordable housing and workforce)
- Eliminate the use of out of area placements
- Reduce unnecessary attendance at A&E departments
- Increase the number of people who can live in the community / Reduce inappropriate admissions (and length of stay)
- Ensure that people with learning disabilities receive hospital care of the highest standards.

In South Yorkshire, the ICS coordinates and oversees the provision of services to people with learning disabilities through its 'Mental Health & Learning Disabilities (MHLD) Workstream' and a regional Transforming Care Partnership (TCP) Board.

The TCP Board focusses on improved quality of life, improved quality of care and reducing reliance on inpatient settings for people with a learning disability.

Rather than having specific strategic objectives for people with learning disabilities, the MHLD workstream has identified over-arching goals for people with mental health and/or learning disabilities and/or neurodiversity, with the aim of providing holistic services, delivering the right support and care, in the right setting, by the right people, with increased prevention services and the return of patients to a hospital that is closer to their home and to the least restrictive environments appropriate to the patient's health.

Trust Strategy: South West Yorkshire Partnership NHS Foundation Trust

Trust Priorities	Quality Priorities
Improve Health	Equality, Inclusion & Equity
Improve Care	Safe & Responsive Care
Great Place to work	Health Wellbeing & Experience of Staff
Improve use of Resources	

B. IMPROVEMENT ACTIVITY

Coordinating Improvement Activity

Improvement activities undertaken by the Trust's learning disability services have historically been coordinated through the monthly LD Governance Meeting. It is proposed that moving forward there will instead be 2 dedicated forums where improvement activity will be planned, coordinated, and reviewed:

1. *Community LD Improvement Group*: Focussed on improving the quality & safety of community services.
2. *LD Inpatient Improvement Group*: Focussed on improving the quality and safety of our ATU

Organisation of Improvement Activity

Improvement activity within the LD service will be organised within 3 categories:

1. *Routine Improvement*: Ongoing and systematic audits and action plans (corporate quality & governance)
2. *Strategic Improvement*: Activity aimed at evolving provision in line with agreed service delivery objectives
3. *Targeted Improvement*: Actions taken in response to specific risks or concerns identified

The LD service has detailed plans (available on request) which describe the comprehensive improvement activity being undertaken and /or proposed for the Trust's community and inpatient learning disability services, which have been organised within these 3 categories: Routine, Strategic, Targeted.

Next steps: Improvement Priorities 2023/24

The following 3 areas have been identified as key priorities for improvement within the Trust's provision of services to people with learning disabilities over the next 12 months. These are areas which would benefit from corporate support to deliver the desired outcomes – for example support from QIAT(Quality Improvement & Assurance Team), input from the Nursing Quality & Professions directorate and leadership from the executive sponsor of learning disability services (Dr Subha Thiyagesh, Chief Medical Officer):

1. Green-Light Implementation within adult Mental Health Services
- People with learning disabilities should access mainstream MH services by default.
- Would benefit from a clear statement of intent and expectations from Trust

MEASUREMENT: Bi-Annual Audit of community and inpatient MH Services (suggest including LD practitioners as part of the Green Light audit)

2. Improving Interfaces between Trust Services (Mental Health, Learning Disability, Older People, Children & Young Person)
- Encouraging collective endeavour ownership & responsibility from the Trust as a whole, to meet service-user needs rather than the current 'silo' working approach by discrete services which can (and does) exclude people who do not meet individual services' inclusion criteria from accessing help.
- Improving handovers of care between services and promoting joint working rather than hard transfers of care.

MEASUREMENT: Audit/Report of handovers of care between Trust services (e.g. CYP to MH/LD). Suggest considering Ease, Timeliness, Quality of information shared of transfers, Number and quality of Joint Working between different specialisms (MH, LD, ASD/ADHD) with case studies.

3. Quality & Safety within the inpatient Assessment & Treatment unit (ATU) service
- Targeted support (QIAT & NQP Directorate) to enable recovery of ATU practice, performance and governance: overseen by the Inpatient Improvement Group.

MEASUREMENT: Compliance with the standards being developed by NHS England as part of the 'Mental health, learning disabilities and autism inpatient Quality Transformation Programme' (2023).

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 9.7 – Assurance from Trust Board Committees

Collaborative Committee

Date	4 April 2023
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)

Key items to raise at Trust Board	**Alert:**
	• Quality issues continue across a number of providers but these remedial actions are in progress
	• Contracts have still not been finalised for 22/23 and this is having a knock effect for 23/24; the Committee has set a deadline of December for the resolution of all contracts.
	
	Advise:
	• The Committee carried out the review of its effectiveness as well as confirming changes to the Terms of Reference/Annual Workplan in preparation for presentation to Audit Committee
	• Committee members are to review options for further visits to services including those provided by the independent sector.
	
	Assure:
	• The Committee continues to receive reporting across the following areas from both collaboratives:
	  ○ Finance
	  ○ Contracting
	  ○ Quality
	  ○ Risk
	• Reporting for the Phase II FCAMHS Collaborative to be developed for future meetings
	• A new summary performance report for oversight of the West Yorkshire PC has been developed and was presented to the Committee
	• There is continuing activity to harmonise the reporting across the two larger collaboratives but there will always remain differences due to the nature of the individual supporting systems.

Approved Minutes of previous meeting/s for receiving	7 February 2023 to be presented in private due to be being commercial in confidence.

Audit Committee

Date	11 April 2023
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Assure:** • The Committee received and reviewed the annual effectiveness reports from all Committees (including the Audit Committee itself)

	which showed strong delivery against the objectives and Terms of Reference for all Committees
	• Positive assurance received from regular reporting of
	  o ORR Risks assigned to the Audit Committee
	  o The triangulation of those risks against the performance reporting and other governance arrangements (see comments above)
	  o Internal Audit and Counter Fraud activity by 360 Assurance including the interim annual report of the Head of Internal Audit Opinion as Significant Assurance
	  o Two individual Internal Audit Reports were received both with significant assurance
	  • Key Financial Systems – pay expenditure
	  • Sustainability
	  o Procurement & Treasury activity
	• The Internal Audit Plan for 23/24 was approved
	• As part of an update on the year-end/annual accounts process, an early version of the Annual Governance Statement was presented for review and comment offline
	• The Committee also received another positive update on activity to develop the Trust's IT systems including System One.
	• As part of papers presented on H&S/EPPR, positive assurance was received re progress against two actions assigned to Audit Committee by the Board (EPRR Standards – areas of non-compliance/Ligature Audit)
	• A private session was held with External and Internal Audit; positive confirmation was received regarding the effectiveness of the Committee
	• NOTE – the Lead Governor was also in attendance at the committee and subsequently provided positive feedback
	
	<u>Advise:</u>
	• A paper covering a review of the BAF process for 23/24 was received
	• The Committees Terms of Reference and Annual Workplan for 23/24 were approved
	• The Committee approved an update to the Prevention of Violence and Aggression Policy
	
	<u>Alert:</u>
	• Whilst the regular report into the triangulation of risks between the BAF, ORR and the IPR gave strong assurance, there are a growing number of operational risks that are not reported regularly on the monthly IPR. The action for the Audit Committee is to confirm that these risks are being covered/discussed at other Committees and to consider whether they should be picked up through the IPR as part of the ongoing review of performance reporting
	• The Committee reviewed the feedback from its annual effectiveness survey; an action was noted to review the specific training provided for new NEDs joining the Audit Committee; NB this may have implications for NED/Director induction training more generally
	• NOTE - An action has been taken to review the design of the effectiveness surveys for all committees for next year

Approved Minutes of previous meeting/s for receiving	10 January 2023

Clinical Governance & Clinical Safety Committee

Date	11 April 2023
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**Alert:** • The committee agreed to the increase in risk score for 1568 and 1368. Risk 1568 is the availability of a seclusion room due to damage and has increased from a score of 12 (amber) to 16 (red). Risk 1368 relates to capacity and specifically access to CAMHS beds with an increase in score from 12 (amber) to 16 (red). • The committee agreed the new risk in relation to team culture and the need to continue to have oversight of this at committee and at board. • The committee discussed the use of mechanical restraint in Elmdale ward in Halifax and requested assurance through evidence on the use of this and the process for approval. • The safer staffing report was not received by the committee and had been deferred due to a delay. This report is being reviewed by committee members outside of the formal meeting and will be submitted and discussed at board on 25th April. The board are asked to note that the committee has stressed the importance that this is not deferred again in the future and do not expect a recurrence. • The committee were advised that learning has taken place around the report into Tees, Esk and Wye Valley. The committee asked that the board receives a comprehensive report on the learning. **Advise:** • The committee heard directly from the Barnsley Speech and Language Team and were very impressed and proud to hear of their award winning innovations around digital provision to support those accessing the service. • There are a number of risks that overlap across committees e.g. 1651 and 1641. The discussion led to a recommendation that the Chair (who was present at the meeting) bring a discussion on risk to the wider board. • The annual community mental health service user survey was deferred to May's meeting. • It was noted by the committee that there is the need to review and restart the Clinical Ethical Advisory Group sub-group. **Assure:** • The committee received the regulatory and oversight report and noted the key themes around specific wards with leadership issues and the ongoing programme of revisits to gain assurance around improvement e.g. Johnson, Horizon. • The committee received the Patient Safety Strategy update. • The committee received and discussed the waiting list management report. This provided assurance around ethnicity reporting and that there was no disproportionate experience for those waiting.

	However, the report contains significant performance metrics and the committee recommends that this is reported through FIP and CGCS retains a focus around the impact on quality of care. • The committee received the report on the Clinical and Strategic approach to the improvement of LD services. • The committee received and discussed the Complex Case Review report in the private session. • The committee received and discussed the Care Group Quality and Safety report (Trio report) acknowledging the ongoing pressures around staffing, the mitigations and impact of industrial action and the review of inpatient establishment.
Approved Minutes of previous meeting/s for receiving	14 March 2023

Finance, Investment & Performance Committee

Date	17 April 2023
Presented by	David Webster, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert** • West Yorkshire ICB's financial position in 23/24 plan has attracted national attention. Expect further challenge on all relevant Trust's financial plans (including our own), Adrian to provide an update at Private Board **Advise** • Financial Sustainability continues to be reviewed on the risk register, and while there is no immediate increase in the risk, there is general tightening • 22/23 financial position landed in line with plan with a deficit month in March mainly driven by a commercial provision and providing for greater costs than income for pay award (as national income figures are estimated on lower percentage of staff costs than in mental health sector) • Mental Health Investment Standard (MHIS) new roles are not currently included in the 23/24 headcount growth plan. • Capital landed at £7.1m vs revised plan of £7.5m, given significant changes to plan with pause of major project, the team did a great job ensuring some other items were brought forward. The gap vs the revised plan was driven by availability of materials and the backloading of activity. • Discussed and reviewed the commercials relating to an AI tool that has been developed in collaboration with the University of Huddersfield. The committee had a few questions outside of the commercials that were asked to be reviewed by the relevant parties to provide the appropriate assurance on these elements. **Assure**

	• Benchmarking plan is being worked on, including with a business analyst to ensure the information is visible and specifically from an assurance perspective, in a way that allows variances to be addressed and acted upon appropriately. • Where there have been challenges delivering on recurring MHIS funds, the commissioners have committed to these funds, and will work collaboratively with us to determine whether we can deliver these or the funds allocated elsewhere, however the funds and agreed areas remain in our control unless mutually agreed.
Approved Minutes of previous meeting/s for receiving	14 March 2023

Note: assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

Minutes of the Audit Committee held on 10 January 2023
(Virtual meeting, via Microsoft Teams)

Present:	Mike Ford (MF)	Non-Executive Director (Chair of the Committee)
	Mandy Rayner (MR)	Non-Executive Director (Deputy Chair
	David Webster (DW)	Non-Executive Director
In attendance:	Rob Adamson (RA)	Deputy Director of Finance
	Claire Croft (CC)	Principal anti-crime specialist, 360 Assurance
	Leanne Hawkes (LH)	Deputy Director, 360 Assurance
	Caroline Jamieson (CJa)	Senior Manager, Deloitte
	Lianne Richards (LR)	Client Manager, 360 Assurance
	Adrian Snarr (AS)	Director of Finance and Resources
	Julie Williams (JW)	Deputy Director of Corporate Governance
	Nicola Wright (NW)	Partner, Deloitte
	Jane Wilson (JWi)	Note taker

Apologies Paul Foster, Tony Cooper

AC/23/01 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, Mike Ford (MF), welcomed everyone to the meeting and wished everyone a Happy New Year. He confirmed that Tony Cooper (TC) and Paul Foster (PF) will join the meeting later to present their items.

AC/23/02 Declaration of interests (agenda item 2)

There were no further declarations over and above those made in the annual return to Trust Board in March 2022 or subsequently.

AC/23/03 Minutes from the meeting held on 11 October (agenda item 3)

It was RESOLVED to APPROVE the minutes from the Audit Committee meeting held on 11 October 2022

AC/22/04 Matters arising and action log from the meeting held on the 11 January 2023 (item 4)

The following matters were discussed from the action log:

AC/22/72

It was agreed this action be updated to reflect the new timescale of April.

AC/22/43

Adrian Snarr stated his understanding was that this was a time limited advance rather than an ongoing process and it may be that this is now complete. He confirmed that mileage rates are on the agenda for EMT this week. MF suggested this action be updated to AS and that he updates the committee once discussions have taken place at EMT.

AC/22/47

MF confirmed that following the meeting earlier in the week there is an action outstanding for NP to send copy of more detailed control risks. This action to be updated to NP.

ACTION: Jane Wilson

It was RESOLVED to NOTE the updated in relation to the action log

AC/23/05 Consideration of items from the Organisational Risk Register allocated to the Audit Committee (agenda item 5)

JW provided the update to the committee, stating that following a meeting early last week to determine if we had the right risks at this committee which now includes responsibility for EPRR and Estates and Facilities, it was agreed that the members were happy with this but have requested further detail on some of those risks that sit underneath the organisational risk register.

Risk 852 - MR asked JW if we have a Data Protection Officer. JW replied yes and that this is Rachael Smith who directly reports into herself.
Mandy Rayner (MR) commented that in her previous role the DPO had reported directly into herself as CEO, and although she is aware many Trusts do not operate this way it might be something we want to check.
JW commented that RS does still have direct access to Mark Brooks as CEO, and that she has regular catch ups with him.
AS commented that up until recently Julie Williams team was split between himself and MB as CEO and that this has been aligned more now to himself, he remarked there are still one or two things that still have direct access to the CEO, this being one of them.

Risk 1080 - MF asked AS if he believed the actions that Paul Foster (PF) had listed in his report and also this risk paper is going to get us to risk level 10, as since his time on the committee we have always been at risk level 15.
AS replied that part of the challenge with risk assessing Cyber is that it is so dynamic that there are a lot of controls in place now, and if it is not very live and up to date the Cyber risk changes. He remarked that we have a reluctance to over assure on Cyber and although we think we are in a good place compared to others, it does not mean we are still not subject to significant risks on cyber, because the cyber criminals are fleet of foot in finding new ways to access systems. AS stated that he would pick this up with PF, because he felt if we benchmarked on Cyber we should benchmark better than other organisations, but he suspected everyone was in the same ballpark in terms of risk scores.

ACTION: Adrian Snarr

AS confirmed that following a conversation with PF last week around funding, because we are performing well compared to the NHS Standards we do not attract external funding to support us with Cyber, whereas if we slowed down and moved back into the pack we would probably attract National funding, AS remarked that to do this would not be the right approach.

MR commented that the committee would discuss this further when we get to the Cyber report which she felt was concise. She remarked that there are very few Trusts who get to full compliance on Cyber essential plus. Also, the other assurances around the ISO27001 that Daisy have as part of their security offer is really good, she agreed that to reduce the number actually takes our eye off the ball and she felt the committee receive plenty of assurance from this paper that there is lots of work going on to keep the Trust safe which is good.

MF commented that he felt the only one thing missing is that the committee are not able to thank PF in person for the excellent work. MR confirmed that AS would pass on their thanks, she remarked that alternatively the committee could drop him an email.

JW commented that following a conversation with PF around whether they thought the organisations risk appetite was too low for this risk given the external challenges, and the innovation that Cyber criminals have, she remarked we have asked the question of ourselves in that do we think we have got this slightly wrong. MF replied that it is fine to still do this but what the committee are actually saying is whatever we do to that number we are still going to want to invest in the same way we are doing now, so that we are constantly on guard and using whatever the latest technologies are available to ensure we stay as safe as possible.

It was RESOLVED to NOTE the current Trust-wide corporate / organisational level risks, relevant to this Committee, and NOTE comments made in relation to the risk content, risk levels and risk appetite.

AC/23/06 Triangulation of risk, performance, and governance (agenda item 6)

JW presented the update stating that following feedback from the committee at the previous meeting reporting periods have been realigned for each of the reports that are used to produce this report. She explained we are now using Month 7, which reports to the Trust Board in November but is based on October's data, so this will hopefully help with the committees understanding of how the information is triangulated.

MF commented that this is a really important piece of work and taking the report as read each meeting does not do justice to it, he felt it was important that we carry out this triangulation to ensure there are no gaps between the way the risks are being raised and reported through the IPR and then reflected in the Board Assurance Framework (BAF).

MF asked LH, 360 Assurance if this was something they see other organisations doing. LH replied it is not, and that this is an element of the organisation doing something extra, she stated she could not point the Trust to another example of an organisation currently doing this.

MF commented that this piece of work is one we should not be complacent about just because we do not get anything coming out of it each time around.

JW agreed with MF stating this is a key piece of work and ensures we are picking up the risks particularly around our performance.

It was RESOLVED to RECEIVE the report as part of the evidence of assurance on the operation of risk processes within the Trust.

AC/23/07 Risk Management Procedure (agenda item 7)

JW stated this procedure was presented to the committee back in October 2022 and they had asked for some amendments to be made. She explained that although a procedure would not normally come to the Audit Committee it was agreed that this would be brought back for completeness as the risk management framework had been brought here. JW stated that one of the additions that was consulted on with staff and that had been well received was risk management on a page, which helps staff on the ground understand risk management; this also forms the basis for training which is being rolled out in April. JW remarked that she had hoped this would be rolled out in this financial year but due to the pressures on the wards they did not want to be asking staff to be released for this training.

MF commented that he liked the risk management on a page approach, and he felt it was something we should be aiming for in all policies and procedures across the Trust. He

remarked that he had not gone through the whole procedure line by line and given this was not a tracked changes version of the document he asked JW if there were any significant changes since the last update. JW replied there were no significant changes.

MR also liked the plan on a page stating it was a really good summary. She commented in relation to categories, we are using business instead of commercial, but that on page 7 of the document and in the Appendix it still relates to commercial. JW apologised stating she had missed this one and would update the document accordingly.

MF asked if anything would have to change following the board session yesterday re risk appetite facilitated by 360. JW replied yes it will.

MF asked JW what was the next stage for this procedure now. JW replied that it will get rolled out across the organisation and then hopefully launched through team brief which is a good way to cascade information across the organisation. She confirmed the training will be rolled out from Quarter 1 April – June 2023.

ACTION: Julie Williams

AC/23/08 Board Assurance Framework (agenda item 8)

JW confirmed that following year end work being undertaken with 360 Assurance this item has been moved to April, she stated it makes sense to discuss this once all the reviews have been completed.

It was RESOLVED to NOTE that this item be moved to the April Committee meeting to enable all the reviews to be completed.

AC/23/09 SFI and scheme delegation update (agenda item 9)

RA presented the update stating the Standing Financial Instructions and scheme of delegation were last brought to the Committee back in January 2022. He explained that finance have continued to review them against other Trust examples, the national template, also AS has reviewed these thoroughly to ensure they are in line with his experience. He confirmed they have also been through EMT.

AS commented that there were no specific comments from EMT on the SFI's. In relation to scheme of delegation the only feedback was that had we gone far enough in terms of delegated limits, he said this could be debated but he felt that the approach taken was the right balance.

RA commented that he had kept a tracked changes log and that most of these had been name changes. He remarked that tables have now been included within the SFIs to try and make it more explicit about who can make each decision within their delegated limits. He explained the values have increased since the previous version and this reflects the move to purchase orders and the fact that we will be getting annual values rather than individual invoices to approve.

MF commented that looking at the tables he felt it was quite hard to make a decision as to whether it is right or wrong. AS replied that they had looked at other organisations and it is fair to say our limit thresholds are quite low in terms of what we would send through to the Board as opposed to what we would sign off through Executive or through the Budget Holder route. He stated that RA had also worked with Tony Cooper (TC) in Procurement to ascertain if we put these limits in place what would it actually mean.

AS explained another thing they have tried to get the balance right on which is a bit tricky is running the provider collaboratives, which means that we have some high value invoices and therefore the way the scheme of delegation was set up meant that nearly everything

contracts wise went to Mark Brooks, CEO for sign off. He explained they have tried to build some appropriate tiers in, which means that operationally we have appropriate control at the right level in the organisation. The budget holder is still accountable, but we were escalating all the formal sign offs to a high level in the organisation. He remarked the budget holder is still accountable, but we were escalating all the formal sign offs to a high level in the organisation, and although it is difficult to gauge, by looking at what others are doing we think we are in the right place. He explained that we have also looked at overlaying the provider collaborative and we think we have got that appropriate, so some things will still escalate, and we will also make sure we only take things through to the Board when we think it is absolutely necessary and part of that strategic oversight of the Board need to have on the key decisions that we are taking.

MF remarked that he had noticed there was no separate column for provider collaboratives. AS stated yes this is the case as it is quite difficult to split control limits.

MR commented that having looked at this she felt the distribution was well balanced and it allows decisions to be made, but there is also a mount of assurance at the level to which it can be approved.

AS confirmed all of this assumes it is within planned expenditure and is part of the plan that was sent to Board at the end of March.

DW raised a question in relation to some of the smaller delegated levels, he asked AS if there were any controls in place that would stop general managers for example raising four quarterly purchases orders at £15k just to circumvent approval which could in turn lead to fraud.

AS replied that this would be a separate breach of the SFI's as splitting orders is not part of the procurement process. He confirmed there are checks and balances in place to ensure budget managers do not split orders, and our move to purchase orders will further reinforce this.

Claire Croft (CC), 360 Assurance, remarked that there was an amendment required on page 11 of the document, she stated item 4.24 refers to a completed SRT, and it should read Counter Fraud Functional Standard return (CFFSR). RA confirmed he would update the document accordingly.

ACTION: Rob Adamson

MF asked Deloitte & 360 Assurance if they had a view on the levels of approval and do they think they look sensible.

CC replied that in terms of what she had seen previously when reviewing documents for other providers she had not seen anything out of kilter.

Nicola Wright (NW) Deloitte, stated that they would not compare to other organisations. MF replied that he appreciated they would not do a direct comparison table by table but would they have an overall sense of appropriateness. NW replied that if they were widely out of kilter Deloitte would clearly have something to say.

MF remarked that he understood the reason this item had been deferred a number of times was to take account of any impact of moving to the Integrated Care System (ICS), and yet when he looked at the track change table he did not see any addition of ICS in there. MF asked if this was because changes had been made to the system, we have reviewed its impact on our SFI's and decided that there is no impact from the establishment of the ICS on our SFI's. RA replied that this was his view.

MF asked what the review process was for this. RA replied that this is usually reviewed bi-annually through committees. MF remarked that we should keep a watching brief on whether anything might come out from the ICSs that might mean we have to go back and have a look at it. RA replied the document is live and continues to be reviewed regular.

It was resolved to RECOMMEND the draft SFI and Scheme of Delegation to Trust Board for APPROVAL

AC/23/10 Terms of Reference (agenda item 10)

JW provided the update, stating that following the Aqua Review to support our preparation for Well Led, they fed back that our Audit Committee Terms of Reference did not reference the fact that a Non-Executive Member of the committee should have recent and relevant experience, so the TOR have been amended to reflect this. JW confirmed that since we submitted this paper feedback has been received from 360 Assurance. Lianne Richards (LR) confirmed that 360 Assurance do a comparison against the HFMA Audit Committee handbook that contains a standard Terms of Reference for an Audit Committee and they do a comparison to ensure all the points are covered.

JW stated that subject to the requested changes being made she would like to request the Audit Committee recommend the Terms of Reference to Trust Board for approval.

MF asked JW to forward him the draft document offline, he remarked that if MR and DW were happy for him to sign this off on behalf of the committee he would do so.

ACTION: Julie Williams

It was resolved to RECOMMEND the Draft Terms of Reference to Trust Board for APPROVAL subject to the requested amendments being made

AC/23/11 Annual Account Progress Update (agenda item 11)

RA presented the update, stating the Trust's annual accounts are prepared in line with International Accounting Standards and as informed by both the Department of Health and Social Care Group Accounting Manual (DoH GAM) and the NHS Foundation Trust Annual Reporting Manual (NHS FT ARM).
RA stated there are, however, occasions where critical accounting judgements or estimates made due to uncertainty are required and this paper identifies a number of these which we are aware of ahead of the financial year end.
For 2022/23 the following areas have been identified as areas which require judgements or estimates.

- IFRS 16 and leases
- Annual estates revaluation
- Loss / bad debt matrix (IFRS 9)
- Capital - paused Bretton Centre scheme. Treatment of costs incurred to date
- Capital / revenue - additional sale proceeds for CNDH.

RA provided an update to the committee on each of the above to ensure they were happy with the work being carried out and the reasoning behind it.

IFRS 16 and leases

MF commented that he would not expect people to have detailed questions on it, but from his point of view these numbers looked in line with what his knowledge of this is.

CJ stated there was one specific question that Susan Baines had asked around the implementation around IFRS16 that Deloitte would need to look at as part of the planning process. She remarked the process that RA has outlined is very much in line with our understanding from last year and also incorporates some of the points that have been highlighted as part of the year end audit around the lease dates and making sure they all line up.

IFRS 9 loss/bad debt matrix

MF stated he could not find this paper in his pack.
He asked if Deloitte had received the PDF version and is there anything that raised a concern.
Caroline Jamieson (CJ), Deloitte replied that the only thing that stood out for her was the increase in the other debts, and that historically our bad debt position had been immaterial, so it had never been scrutinised in any great level of detail. She confirmed that Deloitte would have to look at what the position is come year end.

MF asked RA if we had exposed ourselves to bad debts as a result of taking on the Provider Collaborative roles. RA replied this was not the case.

MF, DW & MR agreed to look at the PDF version of the document outside the meeting and agreed to respond if there were any particular issues. MF remarked that he would assume the committee is noting the contents of this section.

Annual estates revaluation

MF commented on the Bretton Centre scheme and the decision to pause which had resulted in us having impaired expenditure to date. He asked RA if this was a full impairment. RA replied we have impaired all the costs as having spoken to the experts it looks like it will re-start as part of a different scheme.
MF commented the challenge would be that we have used the word pause, as the implication is the same project is going to start again which potentially then counters against the notion of full impairment.
MF remarked it would be useful if Deloitte could give us a view on this early so that we can then have further discussions and reach an agreed view rather than it being one that comes out late on.
CJ commented that she was going to link this in with the update to follow. She confirmed that RA and Susan Baines, Head of financial accounting had discussed everything that had been included in this paper with herself and it would flow through as part of the planning work.

DW stated that unless he was mistaken when the Board approved this being paused some 2 or 3 months ago the discussion was around not all of it being impaired and that some of it could be reused.
AS remarked that we did get into a discussion around impairment, and that the official decision from the Board was to pause. RA and his team have discussed what does a pause mean in terms of accounting for impairment, and broadly speaking in non-technical terms the view is that the costing is so far adrift of the scope of the scheme that we can afford, that even when we lift the pausing it will have to be a fairly materially different scheme that we put in place, hence why we thought it was a full impairment. AS confirmed that this is something that RA is going to test through with Deloitte and colleagues to make sure we are applying the right treatment. He explained because it was so far apart and not marginal where we need to tweak the scheme and start again, we are going to have to fundamentally reshape the scheme.

MF asked NW & CF if Deloitte have a view on this or did they still need to go away and look at the evidence and material.

CF replied that Deloitte have had a high-level discussion with RA around the principles but this was prior to the Board decision being made to fully pause this, so they will have to look at all the various supporting information and the principal around defining actually what is a pause and what does the scheme fundamentally look like now.
MF asked if we had a view of the scale of that impairment. RA replied that it was £787k. MF remarked it was good that there are early ongoing discussions on these topics.
He asked if he was right in thinking there was an issue around the re-evaluation process.
RA stated there was one linked to the leases and making sure the asset register was fully reconciled but there was not an issue with the revaluation itself.
In relation to the verification process MF asked of the 164 assets that have been disposed, are we saying that these are assets that we have on our register, we went to look for and they were not there, and if so, could there be a fraud aspect here.
RA replied they all have a nil value and finance did a sample of trying to find them and could not.
MF stated it might be worth having a look at what those assets were and if there is a potential fraud risk around them.
AS replied finance would look at this as an action.

ACTION: Adrian Snarr/Rob Adamson

Annual Account Timetable

RA stated that usually in January the committee are provided with the full timetable of key dates for year end. He confirmed the draft accounts are due to be submitted on Thursday 27th April, with final accounts due to be submitted on Friday 30th June. He remarked we do not currently know the in between dates and how we are going to conduct the audit and get to the end point. He stated the June date seems quite fixed, and financé are working to that extended deadline.

MF commented that a meeting invite had been sent out for 9th June and he asked if the committee are quorate on that date.
RA stated there had been no discussions with Deloittes about this date as yet.
AS commented that this was only a provisional date, and that we do still need to agree this with Deloitte colleagues.
Nicola Wright (NW), Deloitte, commented that the 9thJune did feel a little early, but she would be happy to have a chat about logistics etc. She stated what we do not want is an Audit Committee meeting where we bring a paper that is half finished, so this was a concern.
JW agreed with NW and suggested looking at a later date, she agreed to look at this offline.

JW asked NW if she knew when the FT Arm was going to be published.
NW replied that she had not currently heard anything and that she would email a colleague to try and find out.
RA confirmed the FT Arm is not out yet so National guidance is still pending.

ACTION: Julie Williams

The Audit Committee NOTED the update on material estimates and discussed each specific issue / recommendation to ensure this was in line with accounting standards and the Trust approach.

AC/23/12 Review of draft Accounting Policies (agenda item 12)

RA provided the update stating that traditionally a draft version of the policies is always brought the January meeting with a view to taking the final version to the June meeting.

He stated the paper outlines the changes which are highlighted in red and generally relate to removing some dates and sections that are not applicable anymore.

MF commented that there seems to be 2 sections on IFRS16, he asked RA if we have followed the standard templates.
RA replied yes we have followed the standard templates, but we also work on these to try and make them more understandable, and the national template and IFRS16 is a perfect example of one that is not easy to follow.

It was RESOLVED to NOTE the current draft Accounting Policies to be used within the 2022 / 23 Annual Accounts pending further review.

AC/23/13 FT ARM Update (agenda item 13)

NW confirmed Deloitte are still awaiting guidance, which is usually out pre-Christmas, she stated they are not expecting big changes. RA commented that he was awaiting the discount rates and that this is a quick exercise once we receive them.
JW commented in terms of the general annual report, she said they are starting planning now based on what is in the current code of governance, as the new code of governance does not come into effect until 1st April 2023. She confirmed it will be based on Deloitte's feedback last year and then amended when the FT Arm comes out.

AC/23/14 External Audit Plan (agenda item 14)

Caroline Jamieson (CJ) provided the update confirming the audit plan would be brought to the April Audit Committee following completion of Deloitte's planning procedures.
CJ stated in terms of the Charity, the plan is to sign these next week and she will liaise with Susan Baines, Head of financial accounting, to ensure she has all the final documents.
CF confirmed that planning work is also going to have to incorporate some new auditing standards which are called ISA315, this will look at risk assessment procedures in a slightly different way and introduces a new level of risk materiality nothing too significant. CJ stated that Deloitte are leaving planning until later to ensure they have as much data from the Trust as possible to see how our transactions come through the year, as their planning processes are very much geared around Trust specific data.
CF stated the only other thing she wanted to flag was around revaluation and now that Deloitte know what the indices are going to be between 31st December and 31st March, when they see what the revaluation schedule has done they will give an early insight to the Trust to check that those movements are not going to be material, and it may provide an indication that no additional work is required.

MF remarked that could he assume that deferred income which was one of the things that caused the most debate last year in terms of accounting judgements, that this time around we have a firm view of what the treatment should be.
RA replied that he should have confirmed that we are not going for the judgement and that there is a paper around the collaborative accounting which is still to follow which is not quite finished yet. He confirmed once finalised this would be shared internally and with Deloitte to try and get an early opinion.
MF commented that he thought we had accounted for our role as lead provider last year and did we have any transactions last year.
RA replied yes and it linked specifically to the deferred income element.

It was RESOLVED to NOTE the External Audit Update

AC/23/12 Cyber Security update (agenda item 15)

AS presented the update stating he would take the paper as read as there is quite a lot of reassurance messages in there around the ongoing work.
He remarked he would just like to call out three things.

Firstly AS explained there is an update around Windows 11, and we should take a lot of positive assurance, given most of the NHS were trying to catch up when Windows 7 expired and was out of support for many years, the fact we are already considering Windows 10 going out of support in 2025 shows we are on the front foot with this.

Secondly AS explained and probably the most significant work that is live now is the penetration testing that is happening throughout January, and the team are on with this and doing the design and scoping work along with the actual testing this month.

Thirdly AS explained, one of the biggest risks around Cyber is people still responding to Phishing emails, so within the paper we are looking to use the Microsoft module that can simulate phishing exercises. This will send out phishing type emails, but it is under the Microsoft guise, and we just see how many people click on it, and if a significant number of people do click on it, we will start to send out more comms, more support to people to advise people they should not be doing this.

AS remarked that there is a fairly comprehensive pack of information in the paper of everything we are doing and as MF stated at the outset we tend not to shout about this too loudly outside of the Trust as we do not want to make ourselves a target and a challenge for hackers into our systems.

MR remarked that she thought the paper was really good and had been written well. She commented that assurance for her was around the awareness piece, and it was not so much what we are doing as we have some results from a survey coming through soon. She stated if you think about the pressure the staff are under, they are just not going to see some of the numerous videos and posters and this is where she would like her assurance to grow a little bit more, and not because we are not putting effort in but for her it's more about the impact of the effort and is it really making a difference around awareness, as that is where we can get caught out.
AS fully agreed with this.

DW commented that the bit for him was around other ways people could hack in, and although phishing and penetration exercises are being carried out, he asked have we considered individuals trying to access people's computers, as MR has stated people are remarkably busy and this could open the door to people.
AS replied that a good number of the Trust logins already have multifactor authentification and we are increasing these to most clinical facing services.
MF asked if the NEDs would be subject to multifactor authentication. MR replied as a NED she already has this and also for her computer. MF wondered if it was a question of age of PC etc and he felt in reality it should be single sign on. AS replied that single sign on is a separate challenge within the NHS.
MR remarked she felt the Trust was quite strong around the device piece and within the paper it talks about the encryption of PCs and not just laptops and not all Trusts do this, as it is hard work and takes a lot of resources. For her she felt it was more around the phishing exercises.
MR commented that whilst Chief Information Officer (CIO) at Calderdale and Huddersfield Trust (CHFT) she had carried out an exercise and this might be one worth picking up with AS offline. She explained it was a large brief which took around 25 minutes on whaling, and it had a pointed dotted line to phishing and she said this was a fun thing to do. She commented that maybe there is some kind of briefing we can bring if we are not getting people to look at these things because they are too busy.

MF remarked that he would pick up with IT separately as it feels his IT equipment is slightly out of date with some of these things which he felt was slightly alarming when you consider the papers he is receiving as a NED.

MF stated the thing that has always intrigued him is sending SWYPFT information to private email addresses. AS replied that you have to be able to send an email to a non-NHS email, so using your personal email is quite tricky but within our policies.
MF commented that we do not categorise our papers into confidential etc, and there isn't a data classification process. AS replied that his understanding is that it is reliant on the individual, and so there is a human element to this.
MF commented that in his previous employment they had carried out a phishing exercise and what they found was a number of very senior people responded to the email in a very short period of time. He explained what transpired was they had given their PAs their login details, so they were accessing everything their boss received, and this compromised the organisation through that delegation of authority. MF asked AS is this something we have rules around. AS replied that you do not have to give your PA your password, you just give them access rights through the mail system. AS confirmed he would check this, but he would be incredibly surprised if we did not have a way of identifying this, as sharing passwords is not allowed.
MF remarked this is a particularly good update and we feel the Trust is applying the right level of skill and expertise into this.

IT was RESOLVED to NOTE the paper and COMMENTS made by Committee on the Cyber Security Update

AC/23/16 Procurement report including waivers (agenda item 16)

AS presented the update stating he would take the paper as red but he would like to call out a few things:-

- Our level of comply and spend remains high and we are having a push on use of purchase orders which drives people through a comply procurement route
- We do still have a fairly consistent level of single tender waivers, some of these relate to time pressures, most of them relate to the estates team and trying to get jobs through in a timely manner. Tony Cooper, Head of Procurement (TC) is working with estates colleagues to ensure we have a better pipeline of minor work schemes coming through so that we can market test when appropriate
- All of our tenders now have a 10% scoring for sustainability and we are starting to focus much more on how people bid and what sustainability they put into the bids, also the social aspects of when they put their bids in, and we go back to review those suppliers to make sure the social values they have said they have in place they do actually have in place. TC and his team are working on this with end users across the organisation so there is a strong link into the trust wide sustainability strategy we have in place and that is increasing the focus within the Procurement team.
- We still have this potential for a conflict between best price and a desire to use local suppliers, so again there are some helpful tables within the report that shows the level of spend that goes through local supply. We are trying to make sure we get best price value for money and wherever possible use a local supplier, and that also feeds back into sustainability and social value which is what we are trying to do.

MF commented that there is a useful table on Page 10 of the report around expenditure by region which is local expenditure and it would be useful to see what proportion of total expenditure this is.

ACTION: Tony Cooper

MF commented on the single tender waivers stating the numbers look quite low for quarters 1 to 3, and if he remembered rightly there was a big rush to get things done for Q4 which resulted in a much higher level of waivers in Q4 which caused the committee and he suspected external audit also concern. He remarked if Estates are the biggest culprits, is there any way of getting some communication out now through Nick Phillips (NP), Head of Estates & Facilities, to try and get that business in place before year end in a timely way.
AS replied that we do see this every year and we do see some in revenue, but one of the challenges is the minor capital schemes and the way the capital regime works now, you either use it or lose it, so we have quite a lot back ended in Q4. He stated RA is sitting very tight to the financial forecast on capital and there are some ambitious plans going through Q4 and they are nearly all estates. We are working very closely with NP to make sure we support him to get them delivered on time but also through an appropriate procurement route.
MF stated he did not mind Q4 but he was slightly against week 52 and if we could avoid that it would be helpful. AS fully agreed with MF.

It was RESOLVED to NOTE the progress made and comment on the information provided within the Procurement Report

AC/23/17 EPPR Update (agenda item 17)

AS presented the update stating it centres around the energy resilience conversations that have been taking place, and actually it is more specifically around electricity. He explained that through the EPPR (Emergency Prevention, Preparedness and Response) networks, there was a level of concern being flagged, because what we had initially been planning for was planned outages on a 3 hour basis as determined by the National Grid, and there is a clearly defined process and a code reference number for what areas are impacted so you can plan with a level of certainly by geography. AS explained we were then asked to consider upping that planning to between 24 & 48 hr unplanned outages. He remarked we are now back to planned outages and we have a number of sites with onsite generators, so if mains supply goes off, the big generators kick in, so we have no problems with the big sites such as Fieldhead and Kendray.
AS explained, we have a number of sites that do have inpatient services on them but do not have back up power supply. He explained we made a decision early to buy in temporary generators and we have had to do some minor works to ensure the sites can accommodate these and we have now carried out testing etc.
A number of sites will have no back up supply and if it is a non-patient site and it is a community touch base our contingency plans for remote working will kick in and these are well tested through Covid.
AS confirmed, we feel like we have a comprehensive plan in place should we have planned power outages and we continue to keep testing to ensure those supplies can continue uninterrupted.
MF stated this was a good paper. He thought it would be useful addition if this paper included an appendix with a table of all the main locations and what the arrangements are for each of them so that it gives the committee a visual sense of the Trusts estate.

ACTION: Nick Phillips

It was RESOLVED to NOTE the EPPR update

AC/23/19 Treasury Management update (agenda item 19)

RA presented the update, confirming that all funds remain within the Government Banking Service (GBS) unless invested with the National Loan Fund. Unless external investment rates exceed 3.5% plus GBS rate this will continue to be the case.
We currently have no funds invested.

The Bank of England announced that the bank rate had increased to 3% with effect from 3 November 2022 with corresponding increases to the GBS base rate and national loan fund. This does not significantly change the Trust approach to treasury management.
This increased again to 3.5% with effect from 15th December 2022
It does however increase the requirement to ensure that the cash position is maximised in order to secure the highest possible return and support the overall Trust financial position.

MF commented that he thought it was 3.5% plus GBS. RA stated we are getting to the stage where we will have to start to think about this.
.
MF stated that during his tenure we have not had to think about this at all, so when we do get to this position how does the role of this committee or FIP change in terms of investment strategy, and does it become something we have more of a role in. RA replied yes and in line with the strategy we may have to bring papers around investment decisions. He remarked there is a strategy, but it is quite a risk adverse one.

AS stated that he thinks it is this committee that makes all the decisions on investment strategy as every organisation has an Audit Committee and not every organisation has a FIP. He explained because of the regime we operate in now it will be interesting to see what happens in the medium term as there is an awful lot of money in foundation trust bank accounts, and whilst that is all in GBS, Treasury is not too concerned about it. He explained if everyone starts taking it out of Treasury bank accounts for money in effect that we cannot spend anymore because we cannot get the capital money to spend it, it does make you wonder if there will be policy changes at Treasury level.

DW commented that because the Bank of England are expecting another 1% increase, he wondered whether it would be worth starting to do some soft investigation of what the other options are, as based on that 1% you would expect all our costs to go above 3.5%.
AS & RA agreed this was a good suggestion.

ACTION: Rob Adamson

It was RESOLVED to NOTE the update on the Treasury Management Update report.

AC/23/20 Losses and Special Payments (agenda item 20)

RA provided the update, he stated the Trust accounts include a breakdown of specific exceptional payments under the heading of losses and special payments and as exceptional items these are shared with Audit Committee for oversight.

He explained there are 15 claims in the period totalling £998 and that the majority relates to broken glasses and lost property, and although smaller in value these will be subject to review through the pending internal audit on service user property.

He stated other claims in month include reimbursement of a taxi fare relating to a cancelled session/complaint.

MF asked if the internal audit had been undertaken during his tenure. MR thought it had taken place around 2 years ago.

MF asked when the audit planning process is. Leanne Richards (LR) 360 Assurance confirmed there was a meeting scheduled with AS to start the process and then there would be a meeting arranged with MF as Audit chair to discuss prior to Audit Committee.
MF stated his observation at this point would be based on the relatively low values of these issues that come through on this paper every quarter he wondered why devoting a whole audit to it that quickly after it had been carried out previously feels proportionate and can we pick this up as part of the planning cycle.
LR confirmed she would take this forward
RA commented that the audit is not really focussed on the value of things but more around ensuring the interest of the service users are protected.

It was RESOLVED to NOTE the update on the losses and special payment update report.

AC/23/21 Internal Audit progress update (agenda item 21)

Lianne Richards (LR) provided the update. She stated since the last meeting 360 Assurance have issued the following reports:

- Review of HFMA improving NHS financial sustainability checklist: this was a non-opinion piece of work, two medium risks were raised.

  LH remarked that the Trust had self-assessed quite critically compared to other organisations.

  AS commented that the reason why NHS England wanted to mandate this review is in effect a reset as we come out of Covid, so there is an awful lot of good practice in there that arguably we would have had in place pre Covid and has lapsed or slipped, so this is a reset moment. He commented that as LH had stated we have assessed ourselves quite harshly but appropriately and it certainly gives us a few areas we want to focus on, all of which are in the action plan but many of these will be tied into the planning round, particularly those areas around efficiency programmes.

  MF stated he was comfortable with the way this is being reported. The only thing he was slightly uncomfortable about was that this is a mandated piece of work for which we do not get an opinion and therefore cannot contribute to our overall internal audit opinion.
  AS commented that part of that is probably because the NHS England do not have the power to mandate an opinion report .
  LH explained that NHSE did not give any stipulation around whether we should put an opinion on or not so 360 Assurance came to a consistent view across all NHS providers not to do so because quite a lot of the information is subjective and wide ranging. She confirmed they also only looked at 12 elements of this. LH stated they will still take it into consideration when forming their year-end opinion.

- Exit interview process (staff retention): this was issued with limited assurance, three medium risks were raised. Our limited opinion was based on weaknesses in the process for issuing online exit surveys, an absence of an action plan to address identified staff retention issues and a low level of awareness of the requirement for line managers to promptly conduct and document retention discussions.

  Greg Moores (GM) joined the meeting, he stated he had requested this report as he was not assured the Trust were where they needed to be. He explained the importance around the report and as discussed at Board workforce is a huge priority for us. GM remarked that he was really pleased with the quality and findings of the report, stating that he fully supported the recommendations.

GM stated that work has already commenced on implementing some of the findings and recommendations that need to be taken forward. He explained that he would like to make the committee aware that when the report was carried out there had been a real issue with exit questionnaires being sent out for a couple of months as the process had completely fallen down. He confirmed these changes had been made and our response rate for Q3 up to the end of December was 37%, which benchmarks really well. He commented this may not appear to be particularly good but from his experience of HR and benchmarking exit questionnaires, this is a good response rate and shows the changes we have put in place have already started to have an effect.
GM stated in terms of the second action around having an annual review of the themes coming out of the exit questionnaires, he confirmed that he completely supported this. He stated that previously a quarterly paper had gone to OMG, but he felt we now needed something more comprehensive that will go to the People & Remuneration Committee (PRC) and we are committed to do this from the end of January, and this will go to PRC in March.
Thirdly, GM remarked there has been some restructuring within the directorate and there is now a new post, which is Head of People Resources and will be responsible for recruitment and retention, and supported by two Band 8a's. One of their key priorities is making sure that the ownership of retention is led by the managers, and it is not just seen as an HR issue. The target date to complete this, which includes training but is also wider than this is the end of March, and he confirmed we are comfortably on track with this.
GM asked MF if he felt this update provided too much detail.
MF replied that he was happy with the update, and it showed that GM was on top of this piece of work before the Internal Audit report was produced. He stated for him the early conversations are fascinating, as from his point of view if we can find a way of preventing people from leaving through this process or get an early identification as to why they want to leave this will be useful information and used well.
GM stated that one of the questions that LH and the team asked which was really helpful through this work was "has anyone asked you to stay," and he remarked that worryingly the response to this was nowhere near where the Trust wanted to be.
MR commented that she was aware of the problem but not the report and it only confirms the work that herself and GM have been discussing over the last few weeks, and the initiatives that are taking place around the recruitment and retention actions. She said it is especially useful and creates more depth of detail when creating the right response.
MF informed GM that an earlier conversation had taken place as part of the overall Internal Audit update where the committee were made aware of another future People based audit being carried out, this would be around e rostering.
MF remarked that the Board recognise that Workforce is one of the biggest risks the organisation faces and he confirmed LR will be coming to talk to EMT members about their priorities for next year. He stated there is a balance of risk across the organisation and it is also essential we prioritise the internal audit resource across all areas of risk.
MF stated that as this is a limited assurance report this will be reported at Board as part of the Triple A to alert them, and GM would provide an update based on today's conversations on the progress to date.
MF asked the committee if GM needed to attend a future meeting to provide an update going forward.
JW replied that this would be reported in terms of actions completed via this committee and only come back via exception if there were any issues with this.
MF thanked GM for attending the meeting and providing the update.

- FIRM risk assessments: this was focused on governance arrangements and was issued with significant assurance. This audit completes delivery of the 2021/22 Internal Audit Plan.

- System/partnership working: place governance: this was issued with significant assurance.

Work has been completed for stage 2 of the Head of Internal Audit Opinion work programme One advisory action has been raised as part of stage 2.

LR confirmed that terms of reference had been agreed for Sustainability and Care group risk management.

The draft report for the 2022/23 pay expenditure audit has also been issued, the final report will be issued once 360 Assurance have received the Trust's final management responses. As reported in our last progress report and in agreement with the Trust, we have cancelled the review of learning from incidents in 2022/23. The Trust had requested a 'people' focused audit in its place. We met with the Director of Finance and Resources, Chief People Officer and Deputy Director of Corporate Governance and it was agreed we would undertake an audit of rostering in late quarter 4.

The Trusts follow up rate is:-

- first follow up rate - 93%
- overall follow up rate - 95%

There are two actions overdue for completion (originally due 31 August and 30 September 2022 and extended to 31 October 2022). These are in relation to the 2021/22 review of agency and overtime. The Trust has requested a further extension to complete the actions (to 31 March 2023) to allow for full implementation to be evidenced.

MF commented on the contract performance and the fact we are only at 59% of the actual days versus the plan, he asked LR when does this run to. LR replied that this runs until the end of the financial year but there will be some overruns into month 13.

MF remarked it felt quite a low number as it really should be nearer 75%, he asked if 360 Assurance were happy that they were going to get to the end of the year with a suitable plan delivered to enable them to issue the audit opinion.

LR stated the performance management waiting list has been pushed to further along in the year and so this will be a month 13, which will run into early next financial year. Also, the e-rostering one which has been discussed with AS will be picked up to mid/late Q4.

Leanne Hawkes (LH) commented that from an ideal perspective you would be looking at 75% by the end of December, however it is quite unusual to be at that point, so it depends on how your plans are phased as to what point you are at. She stated given the phasing of the plan and the fact a couple of pieces have been knocked into Q4 we are fairly comfortable with 60% by the end of December. We are also comfortable where we are with delivery and that we can still give an Opinion on time.

When it comes to the 31st March we will agree how many days we still have to deliver and agree this with AS and be transparent about what we will be delivering post that position, and we will accrue for that time and carry it forward.

MF remarked that on the follow up 360 Assurance are saying 95% is a positive sign, and if he remembered rightly in previous year's, it had been 100%. LR replied that is quite unusual and this is still positive. MF wondered if it was an early indication of the pressure people are under across the Trust. AS remarked the two overdue actions have his name against them, although there is some debate as to whether it should be himself or GM who owns them, he confirmed they were working on them jointly.

MF commented that there was a request to do a people-based audit and we are doing something on e-rostering, he stated one of the reports in this paper is on exit interviews, so it looked like we are doing a people audit and he asked if we have the right balance. AS remarked that GM is relatively new in post and the previous post holder was in post for a significant period of time, and we are using the opportunity to look at some of our systems

and processes within the people and workforce teams, a lot of which are quite manual. He confirmed that a lot of conversations at Board are around workforce and GM is restructuring the team and looking at lots of different systems and processes, so this was intended to be supportive to GM and the team to get some focussed attention on what he is trying to redesign to ensure we pick up the right control elements at the right time.

MR commented that there are going to be lots of elements as GM works through the next 12 to 18 months where we need to focus on some of the areas.

MF remarked it is therefore appropriate that on the basis the internal audit plan will always be risk based that that area is subject to internal audit review, and we have an opportunity at the April meeting to look at the plan and see where the balance of activity is.

It was RESOLVED to NOTE the Internal Audit progress update

AC/23/22 Counter fraud progress update (agenda item 22)

Claire Croft (CC) provided the update stating that since the last meeting she had been able to meet with the remainder of the risk owners to discuss counter measures for the Trusts fraud risk assessment. She confirmed she has produced a residual risk score for each identified risk and the assessment has been handed over to the Trust to record and manage the risks in line with the Trusts owned risk management and procedure. CC confirmed that once this has been concluded by the Trust the RAG rating for component 3 of the standard will move to green. She stated it is currently at amber and has moved from red to amber since the last meeting to show the progress that has been made from that date. CC stated she was confident after speaking with Andy Lister (AL) Head of Corporate governance Manager, that this work will be completed before 360 Assurance have to submit the Counter Fraud functional standard return which should be the end of May 2023.

CC stated there are two new fraud risks which have been added to the fraud risk assessment as a result of discussions with risk owners and further information regarding these risks is included within page 7 of the report.

CC informed the committee that she had conducted a couple of site visits during international fraud awareness week to both Fieldhead and Kendray and this provided herself with the opportunity to meet staff and refresh some old posters around site. She confirmed there is a QR code on some of the posters now so staff can simply report fraud by clicking on the QR code which is good.

CC stated she had agreed a proactive piece of work with AS and is liaising with the Trust bank and agency lead to gather the data required to undertake this work, which involves comparing substantive shift data to bank and agency data for the same period to identify any potential double overlap claiming of shifts.

CC confirmed she had received one new fraud referral during the reporting period which is being dealt with.

MF asked what the new referral referred to. CC replied that it concerned recruitment having some suspicions around some documents that were provided by a prospective employee by an applicant. CC had contacted the Home Office to confirm the validity of the documentation and there were no issues with it. She stated it was good that the Trust are being vigilant and asking the questions to enable 360 Assurance to undertake the checks.

MF asked CC if the Trust are on track for all aspects of the framework to be green by the time we get to submission.
CC replied that we are, and in terms of the Component 2 which is the strategy, and Component 4 which is the policy and response plan, they are currently amber, and although

she has done the policy and it contains the appropriate reference to the strategy, the Trust needs to ratify the policy and this is due to be take place before the time the submission is due.
MF commented that looking at the contract performance on page 4, the plan days proactive worked 50, actual days 31, which is the same sort of numbers as internal audit. He asked if the proactive work concludes the work on the standards. CC replied that it does and that there has been a significant amount of work needed to get the Trust to the position they are now. CC remarked it is important to note that those actual days are to the end of November and that some of the work around risk had been undertaken in December so the figure will have raised by now.
MF remarked is he right in thinking that as 360 Assurance counter fraud services with us matures it will move more from the process side of things, i.e., the statements and standards to actually look for fraud.
CC replied yes and that currently they have been focussing on completing the risk assessment as the Trust did not have one to work from, and now the risks have been identified they will move to undertaking pieces of work to try to mitigate the risks that have been identified. CC explained that proactive work encompasses a number of things, it encompasses such things as the annual report and audit committee etc. She stated there used to be 4 different sections prior to the new standard coming in, and these have all been lumped into proactive work under that heading, apart from investigations.
AS commented that he did not think an organisation of this size has zero fraud it is a case of we have just not found it.
JW commented that we may want to look at our trust policies to see where there is the potential for fraud for 360 Assurance to be able to focus their 23/24 work. It was agreed that CC, JW & AL would meet to discuss this piece of work further.

ACTION: Julie Williams

CC stated she has produced a list of mitigating actions for each risk owner where she identified that further work could be done and there are a number of things that have been identified during conversations that could be picked up and examples of these are given on the risk assessment.

It was RESOLVED to NOTE the Counter Fraud update.

AC/23/23 Policy updates (agenda item 23)

AS informed the committee were no policy updates

AC/23/24 Agreement of committee meeting dates for following year (agenda item 24)

MF confirmed that other than the 9th June which is currently being held for accounts sign off and which could potentially change following today's discussion, meetings dates for the remainder of the year have all been agreed and are in the diary.

AC/23/25 Any other business – National costing update (agenda item 25)

MF stated there had been a paper uploaded to Diligent relating to national costings.
AS remarked it was his fault and this should have been removed from the agenda.
RA commented that is should have actually come to the October audit committee.
AS commented that is why he put it back on the agenda at the last minute as it was well overdue, and this was an assurance report.
MF asked if it this was subject to Audit in anyway
RA confirmed that the costing process is spot checked and there was a national one carried out 3 years ago where the Trust received good assurance.

MF remarked that this needed adding to the work programme for April, with a view to a paper in July asking the committee to delegate authority to AS, alternatively a paper asking the committee to approve.

ACTION: Rob Adamson

AC/23/26 Review committee timetable/work (agenda item 26)

DW commented that given he had not been a member of the Audit Committee long enough to experience a full cycle, in relation to the review of effectiveness of the other committees he asked if someone could give him some guidance on this before the next meeting. MF suggested that both AS and JW take DW through this.

ACTION: Adrian Snarr/Julie Williams

CC commented that there was some duplication on the work plan, she confirmed that the Counter Fraud progress update along with the Annual Plan were the only items required.

AC/23/27 Items to redact from public facing minutes due to being commercial in confidence (agenda item 27)

MF commented that he did not think there were any items to redact from the public facing minutes.
AS remarked it depends how the Cyber update is worded
MF agreed this was a good point

AC/23/28 Meeting evaluation & confirmation of:

a) Meeting effectiveness
b) Significant issues to report to the Board of Directors

Assure

- Update on ORR review
- Assurance on Triangulation
- Updates on IA & Counter Fraud
- Procurement update
- Cyber progress update
- EPPR update

Advise

- Risk management procedure approval
- Scheme of delegation recommendation to Board
- Early progress on annual report and accounts, currently working on last year's annual report guidance until FT arm is received, any necessary changes will then be made

Alert

- Treasury management, potential for future deliberation
- Limited assurance audit report on exit interviews

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 14 March 2023 via MS Teams

Present:	Nat McMillan (NM)	Non-Executive Director (Chair of the Committee)
	Darryl Thompson (DT)	Chief Nurse / Director of Quality and Professions (Lead Director)
	Marie Burnham (MB)	Chair of the Trust
	Dr Subha Thiyagesh (ST)	Chief Medical Officer
	Kate Quail (KQ)	Non-Executive Director
In attendance:	Carmain Gibson-Holmes (CGH)	Deputy Director of Nursing, Quality and Professions
	Yvonne French (YF)	Assistant Director of Legal Services
	Sarah Harrison (SH)	PA to Chief Nurse (author)
	Sionadh Curtis (SC)	CQC Inspector – observing
	Carol Harris (CH)	Chief Operating Officer
Apologies:	Julie Williams (JW)	Assistant Director of Corporate Governance & Risk

CG/23/50 Welcome, introductions and apologies (agenda item 1)

The Chair, Nat McMillan (NM) welcomed everyone to the meeting, invited introductions and noted the apologies, as above. Sionadh Curtis an Inspector from the CQC was observing the meeting.

It was noted that due notice had been given to those entitled to receive it and that, with quoracy, the meeting could proceed.

CG/23/51 Declaration of interest (agenda item 2)

The Committee noted that there were no further declarations over and above those made in the annual return to Trust Board in March 2022 or subsequently.

CG/23/52 Minutes of previous meeting held on 10 January 2023 & 7 February 2023 (agenda item 3)

The notes were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the meeting held on 10 January & 7 February 2023.

CG/23/53 Matters Arising (agenda item 4)

NM reminded the Committee that the Complex Case Report and the Serious Incidents update would now be taken in the private part of the meeting.

The action log was reviewed and updated as follows:

Darryl Thompson (DT) informed that a date had been arranged to attend the NED meeting to discuss Safe Care.

CG/22/187 Care Group Quality & Safety Report.
Some dates have been provided to NM and DT to visit Johnson Ward in April and will report back to the Committee after the visit.

CG/22/111 RRPI Annual Report.
Health, Wellbeing and Experience of Staff was now a standing agenda item in the Clinical Governance Group meetings. NM was still unsure that this answered the original query around whether there was a correlation between the decreased in physical violence and the increase in restraints and asked for clarity from an assurance point of view. DT advised that he would arrange for a review of the incidents to ascertain any patterns.
Action: DT

Kate Quail (KQ) queried how service users were asked about their experience of being restrained and where the information was held. Carmain Gibson-Holmes (CGH) informed that service users would be debriefed following any episode of restraint, this is documented within their clinical records and would form part of their care plan. Specialist advisors would also support teams and service users.

NM noted that the RRPI annual report is due in July and asked for this be captured in the report.
Action: CGH DT

Trust Board Actions
Items raised at Trust Board:

- Nil.

CG/23/54 Review of Committee Related Risks, including a focus on COVID-19 related risks – update following Board discussion (agenda item 5)

No further update since last discussed at Trust Board**.**

CG/23/55 Staff / Team Story – (agenda item 6)

No staff / team story for the March Committee.

CG/23/56 Chief Nurse / Director of Quality and Professions update report (agenda item 7)

The paper was taken as read and DT highlighted that the key points:

DT noted:

- The Trust had been noted an outlier in the region in relation to COVID-19 rates for staff and service users. The regional teams have been assured by the processes in

place and that the Moving Forward group was still in place in the Trust to oversee our COVID-19 response.

- No quality impact assessments (QIAs) at the moment, however the QIA process will be re-established for the next financial year.
- Use of Force Act policy will be taken to EMT at the end of the month.
- Continued focus on complaints and the current backlog, whilst also maintaining a focus on the quality of our response.

NM was pleased that the QIA process is to be re-established.

NM had a query of where the Use ofForce act would be reported in terms of compliance and progress. DT advised that it would be through this Committee and also EMT.

The Committee RECEIVED the update.

CG/23/57 Quality and Regulatory Oversight Paper (agenda item 8)

The report was taken as read and CGH gave a brief update.

Key points to note:

Quality monitoring visits (QMV's)

February 2023

- North Kirklees Enhanced Team 2 – visit completed
- Calderdale Early Intervention Team – visit completed

March 2023

- Waterton Ward, Forensics (re-visit)
- North Kirklees Enhanced Team 1 (rearranged from January 2023)

April 2023

- Horizon Centre, Learning Disabilities (re-visit)
- Elmdale Ward, Halifax May 2023
- Waterton Ward, Forensics
- Ryburn Ward, Forensics

- Requests for visits have been received from clinical and operational teams with dates to be set. Any themes from the QMVs undertaken will continue to be shared and will be contained in the QMV annual report. Presentations within care groups continue. Nineteen have been undertaken so far and one is planned for Trust Board. A report following the focused inspection of Older People's in-patient services which took place in November 2022 has been completed by the CQC, the draft has been shared with the Trust and has been checked for factual accuracy.

Marie Burnham (MB) noted the good relationship with other trusts and the feedback, however highlighted the need to enhance partnership working further to alleviate and improve patient flow and access.

NM would like the continuity of visits to continue where possible with revisits to see the results of the feedback and the 12-month plan was welcomed.

NM echoed MB's point of working with Mid-Yorkshire Trust as system partners and queried whether there was any learning that our Trust could share with Mid Yorkshire, particularly around ligatures and whether there was anything the Trust could do to support them around estates work beyond the organisational boundaries.

Carol Harris (CH) advised that this was done routinely and they have asked us for specific help in relation to the above which will be conducted by the Liaison Teams. Calderdale Royal Hospital have also asked for help in relation to ligature points for their new build.

DT informed the group that he had met with the Chief Nurse (Talib Yaseen) at Mid-Yorkshire Trust and some of his senior team, where they discussed ligature risk in Accident and Emergency and also the ways that in spite of protection action, people can still ligate.

NM raised that we need to use the learning learning from this report to inform and develop our Organisational Development programme and to triangulate the themes.

NM suggested that she raise this at the People and Renumeration Committee.
Action: NM

DT informed the group that this report was also shared with EMT and DT will also raise with Greg Moores, Chief People Officer.
Action: DT

The Committee RECEIVED and NOTED the update.

CG/23/58 Patient Safety Strategy Update (agenda item 9)

This report was taken as read and CGH gave a brief update and noted that a full update will be given to the April Committee.

March 2023 will be a critical month as work moves from orientation, diagnostic and discovery into more practical phases.

The update was provided in the form of a table which covered the three elements below and all actions were detailed in the plan. Any uptake of training will be reported into the Clinical Governance Group.

1) Patient Safety education and training
2) Learning From Patient Safety Events (LFPSE)
3) Patient Safety Incident Response Framework (PSIRF)

MB noted this as a really helpful report, was looking forward to the more detailed report and queried how the training was actually undertaken. CGH advised that there were multiple layers of training and is factored through all of the Trust's training that is provided from induction, however this specific training had online modules (dependent on level of training required).

MB queried whether the gaps in training would be evidenced within operational meetings. CH advised that a report was received monthly through OMG that included training figures and Yvonne French (YF) also presents a report. Support for teams is given if they are struggling with any mandatory training. CH was satisfied in relation to training and that good performance management systems were in place to ensure standards.

Subha Thiyagesh (SThi) added that the weekly Clinical Risk Panel triangulates risks and would notify if any incident related to training, that from a medical perspective CPD funding can ensure adequate training, and a report on the employee's training received by managers, which can be used as part of appraisal.

The Committee were assured that there was more than one route to ensure that this was being managed.

KQ queried whether the indicators could be gathered together to triangulate a full picture of patient safety. CGH noted that a piece of targeted work was underway through the Quality Improvement and Assurance Team to determine more clearly how the Trust could identify areas of required additional support. This is currently undertaken through the QMV process . Further conversations have taken place at regional levels around peer review between neighbouring trusts.

KQ asked if there was a way to isolate a ward to check on areas of concern, and DT advised that incidents can be filtered by ward to provide that information on a dashboard.

DT advised that all incidents are discussed with the weekly Clinical Risk Panel and that the Customer Services Manger would also be in attendance and can feedback intelligence from such as complaints and compliments.

CH advised that OMG also received the clinical risk report and discussions have been had with CGH on how better to use this information / data. OMG also receive an operational management report and a Freedom to Speak up Guardian's report and the discussions are about the triangulation of that information.

Kate highlighted that when preparing for a QMV, participants are also provided with information on the places that they are visiting.

NM will take an update to the NED meeting after the full update in the April Committee to give an overview of the report.

Action: NM to take the NEDs meeting

The Committee RECEIVED and NOTED the update report.

CG/23/59 Patient Experience Report update (agenda item 10)

This paper was taken as read and CGH gave a brief overview.

- The team continue to explore opportunities to collate evidence of impact following Friends and Family Test Feedback and patient experience feedback.
- CHATpads require updating and wards have been asked to return them. Paper surveys have been provided to wards to complete until the CHATpads are returned.
- There is a proposal to pilot CHATpads in hubs for community staff, to take out on visits to support gathering patient experience feedback.
- Friends and Family Test ratings remain positive, averaging at 89%
- A new text message service for Friends and Family Test for Barnsley Community Services went live in February 2023

NM noted the helpful update, which had been requested previously at this increased frequency.

The Committee RECEIVED and NOTED the report.

CG/23/60 Waiting List Management Report (agenda item 11)

Went to the February Committee meeting.

CG/23/61 Care Group Quality & Safety Report (agenda item 12)

CH gave key highlights to the group from the report.

- Junior Doctors' strike - 34 doctors went on strike yesterday. Consultants, other Doctors and Senior Managers have worked to minimise the impact on services. Some clinics,however, have been cancelled which affected 13 patients in Wakefield and 10 Kirklees. The Trust is taking part in calls both regionally and with partners to offer support through the liaison teams. SThi noted the productive work with the British Medical Association (BMA) and local negotiating committee (LNC) representatives to enable the Trust to be in a good position. Kate Dewhirst has also provided cover in terms of electronic prescribing.

- There are no concerns in relation to patient safety and there are four meetings a day to keep abreast of the situation.

- Adult and older people's mental health inpatient services had moved into OPEL 4 (Operational Pressures Escalation Levels) at the time of this report. Although the Trust embedded the use of the OPEL levels during the pandemic, the Trust overall OPEL 4 status was not directly related to COVID-19 pressures but related to demand and capacity. Mutual aid was requested, however colleagues in other providers were in similar positions.

- OPEL 4 was stepped down on Tuesday 7th March. The pressures and demands continue. CH will be discussing the increase in demand at a meeting on the 3rd April to obtain a better understanding, and will bring an update back within this report.
  Action: CH

- In relation to recruitment, CH highlighted that the overall numbers in the Trust are looking positive, however inpatient services continue to see a decline in registered nurse and health care assistant substantive staff, which was a concern. CH noted that the Trust was part of the regional and national work in relation to the quality and safety on inpatients wards and Tim Mellard (Lead Matron) and Mary McSharry (Lead Matron) are working closely together on that.

- Feedback has been received from the CQC Mental Health Act visits to Elmdale Ward and Ashdale Ward. Some environmental issues were noted in the feedback, however of more concern was the note that staff had been reported as 'being short' with service users and not being available for access. The Trio have prioritised a further visit to both Ashdale and Elmdale.

- Trio talks. The Executive Trio has established these meetings, provided both out in services and also via Teams meetings, to give opportunity to meet and talk with colleagues. The first meeting will be a continuation of some work already undertaken with OMG attendees around culture.

- The Horizon Centre. Evidence of improvement was noted, however some more freedom to speak up concerns have been raised therefore the additional support and oversight will continue. An interim Ward Manager is in place to give leadership as the current manager is on sick leave.

- Johnson Ward. The quality monitoring team for the provider collaborative have asked for more evidence from the action plan and have expressed wider concerns around the care and treatment review (CTR) processes and culturally sensitive practice.

- Delayed transfers of care are still increasing so teams are working closing with each of the Places to look at solutions. The Trust is part of the multi-agency discharge planning meetings and also part of the 100 day discharge challenge for mental health.

- Positive progress has been made in terms of international fellows recruitment.

- DT noted the staff engagement work CGH has also been doing around 'Tea for Quality'.

- DT advised that the work that Tim Mellard was undertaking about culture, which was discussed in the regional group, had been noted Liz Durrant (Head of Quality Transformation (Mental Health)) who will be approaching Tim to be part of some national work.

- 'Perfect week'. This is a planned improvement focused piece of work with a goal of bringing mental health in-patients back from out of area.

MB liked the report and found it helpful, however noted that there was a correlation between the information that comes here and what goes to the Peoples Committee such as culture.

MB also queried what would happen to the findings from the Trio Talks.

There was discussion around the concerns with regards to mental health, inpatients and the need to consider the overall OD strategy for the organisation. SWYPFT is a values-based organisation and Committee considered the potential of a video of staff who work in inpatient, care to promote inpatients as a career. The Committee were also keen to link this conversation with the People and Remuneration Committee.

Building on this conversation, and the conversation about culture, the Committee suggested a drill down for assurance on areas where culture is potentially an issue.

NM noted the follow up QMVs that are being done e.g. Johnson / Horizon, and was pleased to hear that these were in place.

It was noted that it was a helpful report, especially now it is a report from the Executive Trio. NM raised a query in relation to clinical pressure in areas of demand and how to obtain assurance that harm isn't occurring. NM would like a deep dive into some of the areas that have been discussed, to give Committee that extra level of assurance. CH advised that some community areas may also want to be considered.
Action: DT / TRIO to consider best ways to undertake this.

The Committee RECEIVED and NOTED the update

CG/23/62 Committee Annual Report (agenda item 13)

NM noted that the report was self-explanatory and shows adherence to governance expectations. The report will be taken to the next Audit Committee in April.

NM questioned some of the findings in the committee members' survey around the risk element, In particular Question 10, 'sufficient knowledge to identify key risks'. One person had answered "no" and NM would have liked more information on that to understand what it meant. NM asked whether the individual would like to make contact outside of the meeting to give NM further insight.

KQ noted that there was also a "no" in relation to question 4 regarding the workplan and queried whether this was a mistake as the workplan was attached to all papers at every meeting. NM noted that the work programme was used dynamically and noted it was always included within the papers for each committee.

NM raised the changes that had been made to the Committee with the increased frequency but with a reduced time and asked what Committee members thought about this.

MB stated that a year ago she had concerns about this Committee, however in the last 12 months there had been a significant shift and was now one of the best committees in the Trust. MB described it as an improving committee with a high level of assurance.

KQ echoed the above and noted that the increased frequency enabled more time to drill down and get the assurances that were needed.

CH agreed with everything above but noted how quickly the Committee comes round and the amount of papers to get ready / prepare. NM noted this and was mindful and was aware of the hard work behind the scenes, would keep this in mind and highlighted that not everything had to come to every meeting. As more assurance was gained more highlight reporting would only be needed and NM and DT would continue to review the workplan in light of this

DT stated that he felt safe to raise issues in Committee, and felt that the focus of the conversations were about the right things.

DT noted the significant pressure in planning for the next meetings and therefore the need to be explicit about what was required.

The Committee approved the annual report, terms of reference, survey and work programme.

The Committee RECEIVED and NOTED the update.

CG/23/63 IPC BAF (agenda item 14)

CGH gave a verbal update to the Committee.

A regional and national group have been tasked with updating the current infection prevention and control board assurance framework (IPC BAF), which was mainly respiratory focused, due to the impact of COVID-19 in recent years. The Trust has been represented in this work.

The new proposals had been out to consultation and the closing date for feedback was 9 March 2023. The working group are hoping this framework will be finalised by the end of March to implement from April 2023.

Our Assistant Director of Nursing, Quality and Professions has consulted with the IPC NHSE regional meeting around the expectations for Trusts whilst awaiting the updated national guidance. The advice from this group was to wait for the new IPC BAF, to ensure it covered all IPC requirements.

The Trust have systems in place to keep us in line with the current IPC BAF requirements and continue to be involved in the NHSE regional meetings in the interim.

The new IPC BAF expected June 2023

The Committee noted the update.

CG/23/64 Final Internal Audit Report – FIRM Risk Assessments (agenda item 15)

This paper was taken as read and DT highlighted the following

The audit opinion was significant assurance. The risk management activities and controls were viewed as being suitably designed, and were operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed during the period under review.

Some specific weaknesses were identified by the audit in the areas examined, and these recommendations are all being actioned

The report had been to Audit Committee and was being shared for information.

KQ queried whether the auditors had looked at how far FIRM had been rolled out, and whether other risk assessments were being used. Also, if significant assurance was being received why does the Trust receive actions from the CQC Mental Health Act Visits around risk assessments? DT advised that part of the assurance was that when the actions are received from the CQC Mental Health Act visits the actions are not a surprise, the Trust is aware and there are processes to show the oversight.

NM noted that Audit Committee will hold to account to ensure that actions are completed within the stipulated timeframe.

The Committee RECEIVED and NOTED the update.

CG/23/65 Sexual Safety Report (agenda item 16)

This paper was taken as read and CGH highlighted the following.

Since the last report there have been three reported amber incidents which had been appropriately managed by services, two community incidents and one incident which involved the disclosure of a potential historical sexual assault.

The most commonly reported incident was inappropriate sexual behaviour by a service user whilst in receipt of care in an inpatient setting. Within the time frame of this report there had

been no incidents relating to inappropriate sexual behaviour from a staff member to a service user.

In 2022/23 five freedom of information requests relating to sexual safety were received and all have been processed within the guidance. Three had been received in quarter four due to a lot of interest both regionally and nationally.

It was noted that the Trust's sexual safety guidance and sexual relationship guidance are being combined to ensure consistency in the approach.

NM highlighted the good thread of a reporting culture and interesting to see the change ideas that have been sustained.

The Committee were happy with the report and would like to keep receiving this as an update.

The Committee RECEIVED and NOTED the update.

CG/23/66 Quality Strategy (agenda item 17)

NM noted that the slides had been seen at Trust Board and were at this meeting to formally receive.

NM noted that the discussions that take place within the Committee are seen threaded throughout the Strategy. MB also stated that this was an excellent strategy.

The Committee RECEIVED the Quality Strategy.

CG/23/67 Reports from Formal Sub-Committees (agenda item 18)

Drug & Therapeutic (agenda item 18.1)
No further update.

Infection, Prevention & Control (agenda item 18.2)
No further update.

Joint Safeguarding (agenda item 18.3)
No further update.

Reducing Restrictive Physical Interventions (agenda item 18.4)
The updated was received and noted.
CGH highlighted that performance around mandatory training was still a challenge however processes were in place to manage this.

Improving Clinical Information Governance Group (agenda item 18.5)
No further update.

Clinical Governance Group (agenda item 18.6)
The updated was received and noted

Clinical Ethics Advisory Group (agenda item 18.7)
No further update.

QUIT (agenda item 18.8)
No further update.

Safer Staffing (agenda item 18.9)
The updated was received and noted.

Physical Health (agenda item 18.10)
No further update.

CG/23/68 Issues and items to be brought to the attention of Trust Board and other Committees (agenda item 19)

NM suggested the following could be included for the triple A report to Board:

Alert:
The IImpact of Junior Doctors' industrial action and assurance to date that it is being managed safely..
Issues and concerns highlighted through the Trio report around pockets where the culture needs to improve and is not aligned with expectations. A need to triangulate this and use as learning to inform the overall Organisational Development work and impact.
We continue to be made aware of the increase in acuity and demand and overall, operational pressures. The committee was made aware of the Improving Access meetings taking place in April to investigate the demand and acuity in more detail.
Perinatal Team Chief Nursing Officer for England (CNO) award and the Perinatal team received accreditation - Royal College of Psychiatrists Perinatal Quality Network standards.
Memory Service National Accreditation Programme (RCPsych) for Calderdale Memory Service.

Advise:
QIA process being re-established in anticipation of the cost improvement programme.
PSIRF and patient safety update
Connection and Learning from the QMV programme.
IPC BAF deferred as awaiting guidance and expected to be June 2023.

Assure:
Continued working with Partners across the system such as Mid Yorkshire and sharing practice around ligature risks and the environment
The committee discussed the RRPI sub-group and the improved compliance rate around training which is now 80.4%. Further assurance was requested in the annual report around the experience of the service users to be included when it reports in July 2023
Quality Monitoring visits and the programme of repeat visits – Johnson, Horizon, Elmdale & Ashdale.
Sexual Safety report and appropriate actions and investigations
The Quality Strategy is recommended for approval at next Trust Board.

CG/23/69 Risk Register review (agenda item 20)

Nil.

CG/23/70 Work Programme (agenda item 21)

Noted as above at item 13.

CG/23/71 Date of next meeting

The next meeting will be held on 11 April 2023.

AOB

DT made the Committee aware of the CNO Silver award that is to be received by the Perinatal team. Margaret Kitching, Regional Chief Nurse (North East & Yorkshire), NHS England, will be spending half a day next month with the team to present the award. MB would like to send an email to the ICB to inform them of the good news and would also like to send on her congratulations. NM will also send on her congratulations.

CH also informed the Committee that the same team received accreditation from the Royal College of Psychiatrists Perinatal Quality Network standards.

SThi also gave good news and noted that the Calderdale Memory Service gained accreditation from the Memory Service National Accreditation Programme (RCPsych).

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Glossary

ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View

HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IBCF	Improved Better Care Fund
ICD10	International Statistical Classification of Diseases and Related Health Problems
ICO	Information Commissioner's Office
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
JAPS	Joint academic psychiatric seminar
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement

NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YHAHSN	Yorkshire and Humber Academic Health Science
YTD	Year to Date

South West Yorkshire Partnership NHS Foundation Trust

Finance, Investment & Performance (FIP) Committee
Monday 20 March 2023
Virtual meeting, via Microsoft Teams

Present	**Apologies**
Rob Adamson (RA) Mike Ford (MF) (agenda item 8) Carol Harris (CH) Erfana Mahmood (EF) (agenda item 8) Natalie McMillan (NM) Nick Phillips (NP) Kate Quail (KQ) Adrian Snarr (AS) David Webster (DW) (Chair) Izzy Worswick (IW) (agenda item 8)	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Meeting behaviours	David Webster (DW) (Chair) opened the meeting and advised members that the meeting would be recorded for audit and record purposes.	DW	
2	Welcome and apologies	DW welcomed everyone to the meeting There were no apologies received.	DW	
3	Declarations of interest	There were no declarations of interest.	DW	
4	Notes/minutes of previous meeting	The notes/minutes from the FIP meeting held on 23 January were presented. The FIPC reviewed and APPROVED the minutes of 23 January 2023	DW	
5	Matters arising and Action Log	**Actions to remain open** Actions 144 & 147 **Actions to close**	AS	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		Actions 145, 146 & 148 **Agency Report** RA stated this is a regular report that goes to the Organisation Management Group (OMG) and one which is also being picked up by the Agency Scrutiny and Management group in terms of pushing the actions forward. The focus is currently on medical, admin and clerical staff in terms of understanding what we have and why we have them and the exit strategy around each of these. RA felt it was good that the committee were able to see what other information was available other than the one slide that forms part of regular finance update. DW asked RA if the Trust was okay from an IR35 perspective with agency staff that have been here a long time. RA replied that all agency staff are assessed for IR35 and there is a rolling programme that looks at these, DW remarked that there had been reference to a couple of permanent job offers, and that they could not be matched from a salary perspective, he asked if there was any flexibility around this. RA replied that medics are bound by the same national terms and conditions as admin and clerical, with national pay scales being prescriptive. He remarked there is also far more flexibility with temporary contracts. CH remarked that they work very hard with consultants to see if there is anything that can be done creatively within the realms of the consultant contract, she said it is usually a case of they prefer agency, even if the salary can be matched. KQ commented from a NEDs point of view, as an organisation we really do need to have a handle on this and we need to drive forward from an assurance point of view, she asked who from the executive team, and which committee is involved in driving this forward. KQ felt that when Trust are benchmarked we would be a real outlier. RA responded we are not an outlier, but that being said there will be lots of pressure to reduce the usage of agency staff. AS commented that Greg Moores chairs the agency working group which includes finance and operations, so going forward there will be more balance between clinical quality, clinical safety and finance, which means when we discuss the plan you will see we have set a trajectory that says we will hit the agency cost cap target. Therefore, it forms part of our overall financial position and we will have to track against it and will be performance managed against it both internally and externally. AS remarked that it is not creating as much noise in the planning round as we thought it might, probably because there are so many other challenges at the minute. He stated agency is quite an easy headline figure to measure and over the last couple of years everybody has pretty much failed it, so this does provide a little context of where everybody is at. KS asked AS in terms of committees is he saying that because there is going to be more clinical governance and clinical safety that they will work alongside the People Remuneration Committee (PRC). AS replied this is a good question and it will definitely go through PRC as it is going to be a key workforce metric, he said we will probably have to link into the Clinical Governance & Clinical		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		Safety Committee (CGCSC), and if we get it right it should not compromise the clinical quality and we can carry on doing what we are doing, but if we do not get it right it might pose some questions there. KQ thanked AS for a very helpful update. **ACTION: Julie to check how this group sits within the governance structure from assurance point of view** NM felt there is something for us to escalate through this committee to Board more formally about where that governance is, so we do not run the risk of each committee thinking they are doing something, also so we have a really explicit audit trail. NM felt it was also appropriate for the whole Board to have a conversation around where this should sit. She stated it is the PRC meeting tomorrow, so will ensure it is discussed there. She remarked that if this is going to be one of our key priorities is it possible that we could have some kind of trio report that covers the 3 committees, she felt it would be good to get a collective view on this at Board next week. CH commented that just as a reminder to the committee, the agency group reports go to OMG, which reports to the Executive Management team. She remarked that last year when we had the Covid money to spend, we put pressure on teams to think of creative ways to spend money in order to offset pressure for next year. CH stated she did not necessarily think they had offset the pressure but they have used agency as we have given them permission to use agency this year. She remarked we must not assume that the agency spend we have had this year is the pattern for going forward, we have had to change people's mindset in order to use agency and that was tricky at first as they did not want to use it as there had been a zero-tolerance approach to this in admin. CH explained we still have some work to do to review things which we said were going to be short term to ensure they are short term and are taken out, so we can see what it is we need to do without relying on agency going forward.		**JW**
6	Action delegated from Board (new standing item)	DW stated there were no new actions to report.	DW	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
7	Committee related risks	AS presented the review of committee related risks stating there were no real changes to the two significant risks, other than the timelines. Risk 1114 - AS advised there is nothing coming through in planning that would want him to immediately change this risk to a higher level. He stated finances are more pressured but not to the point where we become unsustainable in the near to medium term. Risk 1585 - AS advised this risk will probably require some more detailed review at a few touchpoints during the year. The overarching capital environment in the NHS is very challenging and there is not sufficient capital to go round to deliver operational schemes and strategic schemes at a West Yorkshire level. AS explained that there are a number of strategic schemes across the system we would want to pursue as a Trust and there will have to be prioritisation of these. One of the challenges we will increasingly find as an organisation is that we are in the middle of the pack, in that our estate is okay, there are some organisations where their estate is in a pretty poor state and therefore trying to get our schemes strategically prioritised will be increasingly challenging. AS stated he is comfortable that operationally we will continue to deliver what is required but strategically we are going to have to work quite hard. He stated the reason he is not changing anything at this point in time is that Nick Phillips is in the process of finalising the Estates Strategy that will go to Board that will set our ambitions. As part of that we will get Board feedback on the estates strategy and then we will reflect on the risks of delivery once this is complete. NM remarked is it correct that capital spend is through West Yorkshire or is there any implication for South Yorkshire. AS replied that how the financial regime works is that all capital funds flow from the West Yorkshire system, even if we spend them on our estate in South Yorkshire. NM commented that as Bradford and Airedales estate in places is derelict they are more likely to be at the top of the pile. AS replied yes, they are trying to tackle Airedale separately as this is literally falling down and Bradford District Care Trusts main MH site is not in great shape either compared to some of our estate. AS remarked that the way the capital formula works is that we are not disadvantaged because we have estate in South Yorkshire, it is calculated on our asset base, so although the funds flow via West Yorkshire we do receive some funds for our South Yorkshire estate. **The Finance, Investment and Performance Committee DISCUSSED the current Trust-wide corporate/organisational level risks, relevant to this Committee and were ASSURED that the current risk level is appropriate.**	AS	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
8	Operational Plan 2023/24	DW remarked that he had received a message from Mark Brooks, Chief Executive, copied to Marie Burnham, Chair of the Trust to say from his perspective this has been reviewed at EMT and challenged. Following this, adjustments were made and the plan was re-presented, so MB is quite happy to put forward with his support. AS commented that we will shortly be taking the committee through the SWYPFT plan that we will submit to the ICB and then this will be consolidated into the system plan. He remarked it now feels like we are back in to proper planning, more akin to a normal NHS financial planning round with all the complexities and challenges that this throws up. He confirmed this is the first time that we have done this level of detailed planning since before Covid. AS stated he would like to provide context around what is happening out in the system and he reminded everyone that at the end of this he will be asking this committee to recommend the plan for submission to the Integrated Care Board (ICB). He stated there is some risk or challenge that the ICB may place on our plan and if they do this or they ask for any amendments we will have to take this back through our governance process, be it FIP or Board. AS explained that across the West Yorkshire system there is a process in place called flash reporting, where every week everyone provides their high-level numbers, and as of last week there is a system gap of £143m across the West Yorkshire ICB. He stated if this correlates up to a national position we are looking at a £5bn planning gap, so we all need to be in acceptance of the fact that when our plans are submitted that is not the end of the story, as the NHS cannot live with a £5bn planning gap. AS confirmed that of all the provider organisations in West Yorkshire only two as of last week are proposing to submit a balanced plan, this is ourselves and Leeds and York Partnership, everyone else as a provider is in deficit. The CIPs range from the highest value of 6.6%, which is Mid Yorkshire, to the lowest of 3.1% which is Leeds Community. AS stated our plan is 3.5%, so we are at the lower end of efficiency, and are in a minority that is proposing to break even, AS commented that as members are in receipt of the full planning document Izzy Worswick will take them through the construct, what we have done in care groups, areas of the plan we might not be fully compliant with, and areas of the plan that still needs some further work because our Place leads have not yet confirmed their positions. He confirmed we will then go through the financial assumptions and pick up the other elements of the plan. Izzy Worswick, Business Development Manager, confirmed that planning guidance was published at the end of December, and that lots of work had been undertaken internally prior to this with each of our Places to start the planning process. She confirmed that		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		draft submissions were shared with Places and the ICB back in February and a draft ICB plan submitted in February, with a final plan due for submission by 30th March. IW stated to support us in this process work has taken place with care groups and corporate service areas, along with a number of workshops with each service area to ensure a consistent set of assumptions around our plans. She explained that because we contribute to 4 Places we have been part of the planning discussions in each Place with regular meetings along with 2 checkpoint meetings with NHSE. IW explained that we have looked at our compliance against the planning guidance, and our care group plans and overall plans meet all areas of the guidance, some of which are more system targets, and a full breakdown of this will be provided in a paper that goes to Board next week. The areas we do not currently meet the planning guidance but with plans to address them are around criteria around self-referral for services and this primarily affects Barnsley Community Services. Currently there have been no discussions at Place to decipher what the plans will be around this, so whilst we are aware it is something we need to aspire to and work towards at the moment it is not factored into plans. The other area is around IAPT access and the planning guidance clearly states the need to increase adults and older adults accessing IAPT. Our plans state that we will continue to achieve the access rates that we have in 2022/23 and that is felt to be realistic, and if there is more we can do to achieve this we will do, this is also due to the fact we have not had any further investment confirmed around Mental Health Investment Standard (MHIS) or System Development Funding (SDF) funding. AS stated we have to submit our plan by the end of this month, and in parallel we also submit a workforce plan. GM, Richard Butterfield, Head of Recruitment and Resourcing and his team have been developing their workforce plan as part of this process. He explained the way the national system works is that you make a separate submission for finance and workforce, this is then aggregated and triangulated at a system level, then at a national level. AS confirmed that all planning assumptions are being triangulated internally to ensure the workforce assumptions match the finance assumptions and a final check will be carried out before submission. AS explained that at very high level our financial plan is predicated on growing our workforce by 3%. The area that still requires some clarity is what all our Places intend to do around MHIS. AS explained that on finances we have looked at all the national planning guidance, along with the inflation assumptions that they have constructed the allocations on and applied them to our organisation, and then further assessed whether we need to apply variations to the planning assumptions or not. AS confirmed we have stuck with the national planning requirement around pay which is to plan for a 2% pay award. He remarked we now know it is likely to be higher than that although we cannot confirm until the unions formally accept the offer. AS stated that		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		the message has always been that anything above 2% would be funded by NHS England, so we can submit our plan with confidence that 2% is the right planning assumption. He remarked we do need to be mindful of the fact that there is still quite a bit of work to do now that the government has made a pay proposition, as to how this will be resourced and how this will flow through to the Trust so we can keep this as a live conversation with the Board as we go through the next month or two. AS confirmed in relation to non- pay, we have the national guard rails of what they expect non pay inflation to be, and we have tested this to all of our contracts and in a few areas we have decided to go higher and in others to go lower, but broadly speaking it comes to where the national expectations are. AS stated that our plan also needs to include the provider collaborative work that we lead on and so in effect we need to look at the inflationary pressures as a commissioner, and particularly in South Yorkshire but also in West Yorkshire we are reliant on bed placements in the independent sector and they will set out their stall as to what they think their inflationary pressures are and we are working all of this through. AS confirmed that some of the early indications with IS sector is that that we have set sufficient aside for inflation on those contracts. He explained when all of this plays through we definitely see a considerable tightening of our financial position because some of the national uplifts are not covering everything that we need to do and there are pressures in the system, and they build an efficiency factor into all of those uplifts. Also, we have to marry that into the fact we have a reduction in income because some of the funding we are using is non recurrent funding, the most significant of which was covid funding, so when we see cost pressures going up and income going down we see a convergence of our financial position moving from surplus to what we are proposing is a break-even position. AS stated the break-even position has some pressures within it which we need to flag to everyone and also to let you know what we intend to do about them. He stated pulling all of that together we will be proposing that we submit a balanced plan. He remarked members will recall that last year's plan was a £3.2m surplus, so we have moved from a surplus to a break-even position. He commented that going back to what we are seeing in the system, everybody has moved to the left, maybe in slightly different proportions but we think the financial position is tight for everybody. AS explained we have some unaddressed risk within our plan which is around CIPs, where we have had several years of not having the requirement to make cost efficiencies through covid. Some where we have a CIP target, we do not have a robust scheme in place to say we can deliver these from 1st April, as they need to go through equality impact assessment. We also need to do more work on who ownership of those schemes, along with more work on the phasing. He stated this married with the cost pressures list and the amount of non-recurrent spend that we are in control of.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		AS was still comfortable that we will hit balance but will have to concentrate on our ambitions for getting the CIP plan fully worked up. He remarked this is a conversation that was held at EMT last week and EMT were supportive of this and as DW stated earlier we are comfortable with break-even. AS stated it is important when we get into the system context we are only one of two showing break-even, and there is still a huge financial gap in the system. He explained we fully expect that the system will come back to us and ask us to do more, but at this point we will have to push back as we have risks within our own plan that we need to address before we can consider doing more. He stated this is quite challenging because as we know one of the reasons we have risks in our plans is because we want to grow our workforce by 3% and we all know from Board discussions how difficult it is to predict whether we will hit that 3% growth target or not. AS confirmed from a financial calculation point of view he was comfortable that we will break-even, but we might have some upside if we do not hit our 3% workforce growth and we may get into conversations with the system about what we can play back in. He remarked that sat here today he did not feel comfortable asking the Board to constrain an ambition about growing our workforce by 3% and again this is a conversation we have been having at EMT. AS confirmed the pressure points in the plan are agency spend, OOA, CIP development and the pay award, and he said we need to be mindful of the fact that we are running two complex and high value provider collaboratives who are going to submit a balanced plan, and as always there is volatility within those because of the way the services are commissioned within the independent sector which are spot purchased. In relation to the pay award KQ remarked that as she understood it there was not anything in the budget around the pay award, and as we had budgeted for a 2% increase, now that a 5% permanent award has been offered how will we factor this into our plan. AS replied notwithstanding the fact that MH trusts can have a differential because we have a higher proportion of pay expenditure compared to non pay , the reality is the government have done a deal with the unions and there are multiple ways it can be funded, which is either by the government treasury, by the Department of Health, by NHS England, or it can be just pushed out into the broader NHS. He confirmed that when the planning guidance came out, and in the absence of knowing what the pay award was that we had to plan for 2% and anything over and above will be dealt with at national level, and this is what the Trust has done. MF thanked everyone for all their hard work on this and he felt going with a balanced budget does makes sense, his expectation was that there would be push back on us as we are only one of two that are balanced and also the fact that our CIP number is relatively low.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		MF commented that AS had mentioned earlier about cash transfers and that we have £3m of interest assumed in the plan, so any cash we give away would have an impact on this target, and this is something to bear on mind. In relation to workforce, MF remarked that we are planning for a 3% level of increase, he asked what level of vacancies are built into the current plan and are vacancy rates staying high and is this an obvious way of bridging the gap. AS replied there has been a lot of debate about vacancies at EMT and the vacancy factor that is embedded within that budget position. He did not feel we could sustain a high level of vacancy within the organisation to balance the finances, hence the reason for the planned 3% growth. AS explained the challenge we have is that we have an establishment across the organisation down to budget holder level, then to team level, and for a number of years now we have been making some decisions on workforce that sit outside that establishment. AS stated that what we have agreed at EMT is that we need to reset the workforce plan so that it is matched to reality, so that when people are in post we have a budget for them, and the workforce plan matches the finance plan. He commented that for understandable reasons we have started to see some variance for decisions around the quality and safety that needed to be taken at pace, and this is the year to do that reset. He explained that a very lengthy conversation took place around what does this actually mean, and in reality it means himself, CH & GM getting their heads together and figuring out how they do a baseline reset of the workforce plan, and he felt that although finance stacks we may not want to recruit into this the same we did 3-5 years ago. AS commented that in all honesty he has struggled with the narrative in that he did not want to be seen as spooking people, and them thinking he is saying we are going to cut your budget, when in reality he is saying you do not currently have these people and you will not have freedom necessarily to recruit to a position that has been vacant for 3-5 years, as we need to do a workforce plan that says we have the got workforce aligned in the right areas. AS explained this definitely needs careful and sensitive handling so that we do not spook people unnecessarily but it is something we need to do as we enter this new financial phase of significant constraint. MF commented that even though our CIP figure is lower than others, it is still a significant number and he felt the approach on workforce was the right way forward, obviously without spooking people. AS remarked that normally within the NHS, people say something in the 3% area is the best you can expect an organisation to deliver in year on a CIP. He remarked that organisations that have 6.6% CIPs or something around this, does that mean they are going to come up with some extra ordinary delivery or are they just going to fail their target, he felt 3.4%/3.5% for us means we are at risk of failure. NM commented that she was not utterly convinced about what sits behind the workforce assumptions. AS replied we have tried to set a trajectory of workforce growth that we think is deliverable and we have landed on 3%, which is the average and it will vary in team areas, as some posts are harder to recruit to than others. He stated what we are trying to do is grow		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		our substantive workforce and therefore we should be able to reduce our reliance on agency but at the same time reduce the agency rate and it is a combination of both. NM asked is the workforce plan saying we are growing our workforce to reduce agency. AS replied, it should be described as our desire to grow our substantive workforce by 3%. NM commented this did help with her understanding. She stated at the People committee there needs to be more scrutiny around what this looks like and if it is achievable as this is going to be one of our biggest risks. AS remarked he was potentially over simplifying this by saying 3%, as at a team level it will vary and when we get into the delivery of it, it will vary. He explained that what makes it more complex is if the areas that that find it harder to recruit for example inpatient units, then we have to substitute it with bank or agency as they have minimum level they need to run at, so it is not quite as simplistic as saying we are driving for a 3% target. MF asked AS if he thought the pension changes in the budget would have any impact. AS replied it is difficult to say because there are so many variables in there, but from our consultancy workforce they were very vocal about the impact of pensions driving them to consider their retirement options, so the fact that a range of pension measures are being put forward should help, he said we have no formal mechanism of capturing this their career/retirement plans. AS remarked that GM had arranged a series of seminars with pension experts prior to changes, he felt it might be worth checking whether we should do a re-run to see if the mood has changed. In relation to cost improvements DW commented if we are able to recruit quicker it will mean we will have to do more cost improvements and do we have the ability to do this. Secondly if we are not able to recruit quick enough are we still going to continue with the cost improvement plans which will then deliver a surplus. AS replied the big requirement on cost improvements is ensuring we have ownership across the organisation, so once we start to change the culture around efficiencies back to how it was pre covid we should keep going with that, and if that means we do not deliver on the plan then so be it. In terms of the 3% growth in headcount which is focussed on clinical staff, we do not intend to hold that back, what we intend to hold back is new developments. He explained we have a £1m non recurrent investment pot which is managed by OMG which we will hold back until the CIP plan is robust, there is also some phasing upsides on the 3% growth. AS stated he intends to set up a group to look at CIPs which will probably be a subset of OMG which will focus on robust phasing and ownership and KPIs. He remarked we still have an obligation as a system partner, as everyone else is struggling so it will be incumbent on us to do whatever we can for the broader system. DW commented that this sounds like a cultural shift and will initially probably be a hard sell. AS replied it is probably just reminding people how it was 3 years ago as the NHS has never been in this position before and it is only through additional covid funding that financial constraints were eased throughout that period.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		KQ commented that historically on CIPs the target feels about right. For her it is more about the governance arrangements and the need to test hard on the deliverability of the plan which she felt should be through FIP and also Board. AS replied yes it will be FIP and Board and we need to get the quality impact correct as part of the CIPs, he said we would also face some peer challenge as part of this, we are going to drive some efficiencies through procurement and what we buy to see if there is any merit in doing this with partnership organisations in the system, in that can they collectively deliver more than the individual and this will form part of the FIP and Board conversations. AS reminded the committee that as part of the IPR the CIP tracker is largely green because of non-recurrent measures and what we need to think about splitting recurrent and non-recurrent so the committee is sighted on what is the underlying cost reduction on a recurrent and non-recurrent basis. **ACTION: AS confirmed that a paper will come to FIP** Unfortunately, at this point DW experienced another power failure. NM, as deputy chair asked the committee if they were in support of the recommendation to formally submit the plan. AS explained that it had been agreed with Marie Burnham, Chair of the Trust that there would be an open invitation to all Board members to join the meeting today. AS confirmed he still intended taking the paper to Board but this would be after it had been formally submitted as the submission date is the 23rd March, and the Board do not meet until the 26th March. MF confirmed he was happy to support and approve the plan, he stated he would still appreciate MB's views as she was invited to the meeting but was obviously not able to attend, and he would like to see it minuted that MB has reviewed and supported this. AS stated he would take an action away from todays meeting that FIP were supportive of the plan submission but they would also like to give MB the opportunity for further clarification, questions. DW re-joined the meeting at this point. NM welcomed DW back, stating that MF had made a valid point in his absence that whilst the FIP committee understand approval has been delegated to them, as MB as chair of the Trust is not present at today's meeting, also Mandy Rayner as vice chair is also not present we should give MB the opportunity for further comment. NM felt it was appropriate for DW as chair to email MB confirming this. DW confirmed he was happy to support the approval on this basis. NM remarked she would now leave it with DW pass on a huge thanks on behalf of the committee, as she appreciated this work takes a huge amount of effort.		**AS**

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		AS apologised, stating he had omitted to cover capital as part of the formal approval and he would like to do this. He stated he had alluded earlier to the fact that capital is very challenging and the organisations allocation is determined on a formula basis, we receive around £8.3m to determine what we would like to do as a Trust, which is largely split between estates and IT. He remarked that he is proposing we submit a balanced capital plan which will commit us to spending £8.3m, which in reality there is there is a little bit of work to do to get our expenditure up to this level, this is slightly odd in as much as there is some high value projects that we want to do strategically but they all have long lead in times. He commented that he is comfortable that we will deliver operational capital, but we want to continue the conversations with the system about some of our strategic schemes. AS stated that this will be debated more when the estates strategy is taken to Board. DW remarked that this was a very thorough paper and he wanted to thank everyone for their efforts, he commented that due to the fact there had not been a huge amount of questions it was testament to the fact the document has been put together really well. AS remarked that he would like to thank the NEDs for reviewing this at such short notice as the document was only circulated on Friday as they were working on it until very late.		
9	Financial performance	RA presented Month 11 key headlines:- • The Trust planned surplus for 2022/23 is £3.2m and the focus remains on managed delivery of this target. • February has been reported as an in-month deficit of £554k. Year to date is a surplus of £3.7m which is £672k ahead of plan. • Adjustments have been made each month as elements of the managed delivery have been agreed. • A normalised run rate has been developed, which is presented as part of the finance forecast paper reflecting the large number of one off/non recurrent adjustments actioned during 22/23. • Workforce is a major area of spend and we are looking to increase our workforce. In February there was quite a stepped increase in substantive and wholetime equivalent worked, 39 compared to the previous month, this trend continues and has been modelled into the planning. • Out of area expenditure remains the most volatile forecast risk. Alongside operational pressures, financially the risk is impacting both 2022/23 and is expected to have an increased run rate, and pressure, into 2023/24 • Some small reductions in bank and agency, this continues to fluctuate each month. • No real focus on non-pay this year, reporting will change next year to show adult procure collaborative separately. • Continued pressures in overall position, OOA placements remain a pressure and has seen an increase in the latter half of the year. Spend this year on out of area placements is the highest it has been in previous years and there is a lot of focus in the operational teams to mitigate this.	AS	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• Year to date capital spend is £4.3m which is £7.6m behind the plan profile. Following the pause in the Bretton Scheme, a revised forecast of £7.6m was calculated. This is still forecast to be achieved in 2022/23, although this does require significant expenditure in month 12. All schemes have been checked with leads and confirmations received that these will be delivered. • Cash position remains positive at £81.8m. Actions continue to maximise cash to take advantage of positive interest, although the focus does remain on paying all valid invoices in line with contractual terms and specific issues and bottlenecks in the system are being managed. DW commented that now the Bank of England interest rate has increased to 4% and is expected to rise to 4.25%, it had been agreed we would start looking at options at 3.5% and have we started to look. RA replied that as an organisation we have to ensure we have all the cash in our main bank accounts on 31st March, he advised that a member of the team will start to look at this from 1st April. RA remarked there is still work to do, and this will involve building relationships with banks, as this work has not taken place for 3-5 years. AS commented that without wanting to pre-empt this work, given what is going on in the broader world economy around banking, a switch away from safe government banking might not be the right thing to do at this time, he agreed an analysis should be undertaken and facts presented to the Audit Committee before a further decision is made on this. RA stated that our policies are quite risk adverse and that there are some national loan funds that might become available which are low risk and would be something to explore as first port of call. AS remarked that what we might see emerge through the next financial year is some national or treasury views on cash as the way cash is at the minute there is definitely the haves and the have nots, and we are in the haves and there are people in our system who are in the have nots. He explained CHFT for example will run out of cash within the next 6 months and there may be a push to start redistributing cash across systems, which we would be very reluctant to do given the interest we are earning, but he felt this would become a more prevalent conversation as we go through 23/24. KQ remarked that she was looking for some assurance that the various on the two lines on capital clinical improvement and safety is not going to cause us a problem, and if there are any risks are they being well managed. RA replied that he will take a look at this as there is quite a lot of detail below, he confirmed he would work out which schemes they are and report back with Nick Phillips. **Financial Forecast**		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• The forecast continues to be reported externally as £3.2m which is in line with plan and actions continue to secure this position. • The forecast scenario highlights that a forecast surplus greater than £3.2m will be achieved. A surplus of £3,454k seems the most likely outcome. This is £276k higher than plan. • Details on risks and mitigation assumptions are included in the paper. • DW asked if there is anything we are looking at doing that could cause challenges with Auditors. RA replied, one thing is the Adult secure deferred income and the process around this, he confirmed this has now been escalated up to the national audit teams in terms of the Trusts approach to deferring income linked to collaboratives and these conversations with continue. RA stated he did not feel there was anything else in the position that would cause work. • AS commented that as Board members are aware there are particular challenges with Cheswold Park Hospital and RA and the team have accrued the position as per our interpretation of the contracts,. AS did not feel this was an audit risk but an area of variability as discussions continue with Cheswold, he remarked we do need to be mindful of their vulnerability. • The year to date, and forecast, positions are driven by a number of key factors and the report includes current forecast positions, by care group, and scenarios which will impact on the overall forecast position. • With only 1 month remaining in the financial year the focus is on ensuring that the forecast position is achieved and preparing for the year end accounts and audit process. • Year to date position remains driven by workforce. WTE worked has increased again with a stepped substantive increase in in month, but due to the 2022/23 workforce profile the unfilled gaps has increased. • Out of Area placements remain volatile and higher than previously forecast. This presents a continued financial risk going into 2023/24. DW commented that a lot of effort has gone in to this and he thanked everyone for the good work. **Collaborative financial updates** RA provided the update stating he was conscious that this paper went to various committees and highlights where we are with each of the collaboratives including ones where we are not the coordinating provider. He explained that ultimately there is money within those collaboratives that flows within the overall forecast both for CAMHS who recieved additional money from NHS England, also the West Yorkshire Adult Secure who received extra money from NHS England plus the training position. He remarked we are assuming that South Yorkshire is break-even as we prudently cover off as much risk as we can around Cheswold.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		Costing Update RA provided the update confirming that the window for the national cost collection will be open no earlier than the 18th September. He stated there was a considerable delay as this is normally completed by June, he explained the fact we have not received the outputs of last year's cost collection as of yet means doing anything as it becomes out of date is difficult, he confirmed the team are still preparing everything internally. He explained there is a whole national pressure on the national cost collection due to staff shortages. AS commented that we are still transitioning to PLICs from service line reporting and we always recognised that there was a dependency on the national cost collection, he asked RA if we are having to look at this again if there is slippage in the national cost collection. RA replied that he is pushing to focus on the internal stuff and making this more meaningful. DW remarked when this is next on the agenda would it be worth providing a bit more information on the progress of the timeline. AS agreed yes this is a good idea and also that he has had conversations with CH around broader benchmarking and he is keen to bring some of this costing information through as part of benchmarking, also as another source of information.		
10.	Performance benchmarking update	AS provided the update stating what he is hoping to do is set an annual plan and understand what benchmarking reports are available and when, and what costing reports we have and any other data sources that feed through, as the national benchmarking reports that come in are quite chunky and we get slightly overwhelmed with receiving them all at once and not knowing what to. He stated he needed to do a little bit of work with the team to understand the timing of some of these flows and set that plan so that we can align the plan to FIP reports around the annual report for this committee as well. DW asked if it would be worth bringing back a flow of what we will see and when either to the next meeting or the following one. AS replied yes if this could be left with him he will confirm which meeting he will bring this to. **Action: AS to bring flow report back to future meeting**	AS	**AS**
11.	FIP annual report	**Annual report** AS provided the update stating that the format is standing for all Board sub committees. He confirmed that he has updated this based on what he had seen in previous versions and he has asked AL to review this to ensure it makes sense around the timelines etc. He asked that members look at this and either feedback any comments now or before feedback to the Board.	AS	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• DW commented that on people role it should state for himself from 1st May. • DW commented that on the second page of the report there were a few references to the monthly reviews, and as this has now been changed to 8 can we please update the report for consistency. DW remarked other than those minor points he was happy with the rest of the report. The committee members were happy to review and approve the content of the report following the suggested amendments. **FIP Terms of reference** • DW made reference to the fact that these had only been reviewed recently, the only change from his point of view was it makes reference to the meetings still being monthly. AS agreed to update this accordingly. The committee members were happy to review and approve the terms of reference subject to the suggested amendment. **FIP Workplan** • DW stated that as this has only been reviewed recently and there had been items deferred whilst we get into the new cycle he did not feel anything needed changing unnecessarily. AS remarked that whilst he appreciated the papers came out late for this meeting due to planning, he was also aware they have been circulated late on other occasions due to the late IPR circulation. He asked if the members are happy he would take an action away from today to upload standard papers to diligent once they are available, as some of today's papers were available early last week, and papers had not been circulated until late on Friday afternoon. DW confirmed he was happy with this suggestion and it would be good if JW emailed when these are updated. KQ asked do we need to show our focus on CIPs, also agency and where do these key issues sit. AS replied that he would intend that CIPs and agency fit within the monthly financial report and he will pick this up with RA offline. He says largely what is brought to FIP is the same detail that goes through to the Board and we may want to bring a sub set of detail that does not flow through to Board.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		The committee members were happy to review and approve the work plan. **FIP survey results** AS stated there was nothing in particular to draw the committee's attention to.		
14.	Any other business	**Capital** DW informed the committee that he had recently carried out a site visit, and he was approached by very frustrated individuals, who stated they had one area of their ward they cannot do anything with as it needs a new kitchen which would cost around £1000. He confirmed he had asked AS if he could have a little more insight into what is going on. He stated that AS had replied that it is complex and he felt a discussion with members whereby he could highlight the complexities around the minor capital works would be beneficial. The committee members agreed this would be very beneficial. AS agreed to organise a brief session with Paul Foster and Nick Phillips, then provide the committee with an overview of all aspects of capital.	AS	**AS**
15.	Confirmations	**Meeting effectiveness** It was agreed that the meeting had been effective, and thanks was also given to those who prepared reports. **Significant issues to report to the Board of Directors** **Advise** • Continuing with surplus • Reviewed and approved draft annual report, terms of reference and work plan • Agency working group, how does it flow into committees to ensure there is an owner • We anticipate there will be challenges in the plan **Alert** • OOA more spend this year than in recent year's **Assure** • Deficit in month is expected • No immediate on sustainability		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• Capital plan coming back to board Bank of England rate, start looking at other options, maintain produce approach and consider wider impact. **Actions** Agency group Confirming plan with Chair Patient level costing progress update to be brought back next month Agency Capital overview meeting to be arranged		
16.	Next meeting	**Next meeting** Monday 17 April 2023 10-12.30 Via MS Teams		

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 10.1

Private/Public paper:	**Public**		
Title:	**Integrated Performance Report (IPR)**		
Paper presented by:	Salma Yasmeen - Director of Strategy & Change and Deputy Chief Executive Adrian Snarr - Director of Finance, Estates & Resources		
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for March 2023.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	The Integrated Performance Report, provides assurance to Trust Board on compliance with standards, identifying emerging issues and actions being taken for all strategic risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Trust performance management framework and integrated performance report provides the Integrated Care Boards (ICBs) with assurance that the Trust has an effective performance management system to contribute to the delivery of the ICB's strategic priorities and delivery plans.		
Any background papers / previously considered by:	The IPR is reviewed at public Trust Board eight times a year. On months when public meetings are not held, it is circulated to Board members, and published on the Trust website. The IPR is reviewed monthly by the Executive Management Team (EMT) The IPR is reviewed monthly at the Organisational Management Meeting (OMG)		
Executive summary:	This executive summary provides an overview of key points from the IPR for March 2023 and is the final report for 2022/2023. Executive directors have reviewed all priority programmes and how they should be reported in the 2023/23 IPR, these will be presented to the Finance, investment and performance committee and implemented on approval. **Priority programmes** • The Trust demonstrates good progress against the majority of its priority programmes, with the majority of key milestones reporting delivery of actions within agreed timescales.		

	• A key priority for the Trust is to improve the recording and collection of protected characteristics across all services. There is one national indicator which is for ethnicity, the Trust is performing at 96.3% against a target of 90%. For the Trust derived indicators, as at March 2023, 70.2% of service users have had their equality data recorded (disability 41.9%, sexual orientation 42.2% and postcode 99.8%). Whist recording postcode is not technically part of equality data it does help identify referrals from areas with higher levels of deprivation, which could indicate inequalities in relation to healthcare access, experience and outcomes. Work continues to ensure data capture will be extended to all services, this work is monitored by the Trust's Equality, Inclusion and Involvement Committee. • Specific actions the Trust is taking to address inequalities include co-designing services with communities, ensuring representation is reflective of the population and covers all protected groups and carers. Approaches being used include community reporters and researchers to capture patient stories, offering enhanced equality and diversity training and ensuring health assessments for people with a learning disability. • A series of metrics and measurements for the Great Place to Work programme have been devised and the data collated to show the impact of the work that has taken place during 2022/23 on this programme. • Community Learning disability services have commenced work on creation of a management tool for reporting, measuring, and managing waiting lists and undertaken a pathway mapping exercise which has identified areas for improvement to flow of patients to reduce numbers waiting. **NHS England Indicators (national)** The Trust continues to perform well against the majority of national metrics. The following performance should be noted: • Inappropriate out of area bed days continue to be above trajectory with 511 days in March. This remains high and mainly relates to increased acuity, Covid-19 outbreaks and challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 15 people placed in out of area beds at the end of March (a reduction of 2, February 2023). The inpatient improvement programme is aiming to address the workforce challenges. Systems are in place to manage and unblock barriers to discharge as well as effective coordination of out of area placements so that people can be repatriated as quickly as possible. • The percentage of service users seen for a diagnostic appointment (paediatric audiology) within 6 weeks decreased to 79.8% in March from 91.6% reported in the previous month, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service which is a small service and there have been a number of staffing issues that have impacted on clinic availability. Performance is not expected to reach 99% until October 23 with additional pressures related to increased number of referrals also impacting. • The percentage of children and young people with an eating disorder designated as urgent cases who require access to NICE concordant treatment within one week remained below target to 87.5% (target 95%) - In March 7 out of 8 urgent cases were seen within 1 week. The case that breached was due to patent cancellation.

Quality

Local Quality Indicators

The Trust continues to perform well against the majority of quality indicators; however, the following improving/exceptions and actions being taken should be noted:

Care Planning

Work continues in front line services to adopt collaborative approaches to care planning. The March data is provisional however, this is showing an improved position of 75.1% compared to 58.6% in February. The improvement group continue to support operational services and further improvements to compliance are expected during quarter one 23/24.

Risk Assessments

March data is provisional however, an improvement across both inpatient (89.9%) and community (83.2%) areas can be seen against a target of 95%. All areas continue to work to improve performance. Issues with data capture, service pressures and data quality are being addressed but have proved to be more complex. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality.

Waiting Lists

- CAMHS continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period.
- Waiting times and waiting numbers for neurodevelopmental services within CAMHS continue to remain high. As previously reported, waiting list initiatives are in place to work towards stabilising this position. Children do not need to have a diagnosis in order to receive a CAMHS service and services will be provided to meet their presenting needs.
- Waiting times continue to be an issue due to staffing/operational pressures in community learning disability services, with 76.2% (against a target of 90%) of Learning Disability referrals where patients have had a completed assessment, care package and commenced service delivery within 18 weeks. People on waiting lists are receiving regular welfare phone calls to ensure they remain well and have not escalated in need due to their wait.
- Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels higher than pre-pandemic – cases are triaged and prioritised according to need.

Patient Safety Indicators

96% of patient incidents reported in March 2023 resulted in no harm or low harm or were not under the care of the Trust, an overview of key indicators is below:

- The number of restraint incidents has decreased slightly to 203 compared to 223 in February. Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month is stable, not showing any cause for cause concern and is within expected range. This is described as common cause variation within the report.
- 100% of prone restraint incidents were for a duration of three minutes or less which is an improved position from 87% reported in February.
- There was one pressure ulcers that related to a lapse in the Trust's care during March. Further details on the cases are within the main report. The

Chief Nurse is ensuring a thorough review of all cases and the outcome will be reported to the Clinical Governance Clinical Safety Committee as part of the Chief Nurse report.

- The number of inpatient falls in March was 39, which is a further decrease compared to 49 in February and 51 in January and is the lowest number of reported falls since June 22. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated.

Our People

- Our substantive staff in post position continues to remain stable and has increased slightly in March. The number of people joining the Trust outnumbered leavers in March.
- Overall turnover rate in March was 13.5% which is the lowest level it has been at throughout the financial year. This is monitored against a target of between 10 to 12%.
- Last year we had 561.3 new starters compared to 658 (10% increase) this year and conversely 612.8 leavers last year compared to 559.2 this year, demonstrating an improvement in recruitment and retention of existing staff. It should be noted that this is the overall Trust figure and some services have not seen the same trend.
- Sickness absence in March was 5.1%, which is a slight decrease from the February position. The year-to-date sickness absence position is 5.3%.
- Rolling appraisal compliance rate for March increased marginally from 71.5% to 71.8%. Actions are in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.
- Overall mandatory training is at 90.2% compliance which exceeds the Trust target of 80%, this has increased marginally from 90.1% reported in February. However, 4 subjects out 17 reported are below the Trust target, which are cardiopulmonary resuscitation, food safety, information governance and reducing restrictive practice interventions. Targeted actions are in place and compliance is reported monthly to the Executive Management Team (EMT) with hot spot reports reviewed by the Operational Management Group (OMG).

Care Groups

Staffing vacancies and absence and ongoing industrial action continue to impact on the Trust and our partners resulting in significant challenges across our local places and integrated care systems.

The care group summary section describes the “hotspot” performance areas and mitigating actions for the month of March, these are as follows:

- No care group is meeting the compliance rate for information governance mandatory training. The IG manager is providing additional face to face training sessions. Managers are receiving weekly lists of non-compliant staff so that progress can be monitored, and actions can be taken to address compliance. This is monitored at operational management group and executive management team.
- Mental health acute wards have continued to manage high levels of acuity and have been impacted by covid outbreaks.
- High occupancy levels across mental health wards and capacity to meet demand for beds remains challenging.

	• Workforce challenges have continued, with staff absences due to sickness and difficulties sourcing bank and agency staff on top of vacancies leading to staffing shortages across the wards. Workforce challenges are being supported through Trust wide recruitment and retention programme. • Challenges with demand outstripping capacity in the Single Point of Access (SPA) services remains high with referrals being risk screened to ensure that urgent demand is met. This increases the risk of routine triage and assessment being delated. Work to maintain patient flow continues, with the use of out of area beds being closely managed, however usage continued to be high and remained at a high level in March. • During March, there was a slight decrease in the overall number of delayed transfers of care, reducing from 4.5% to 3.5%, however this is still identified as a risk due to the availability of options to support people with complex needs on discharge. Work with systems partners at place continues to explore and optimise all community solutions to get people home as soon as they are ready. We continue to work towards the standards in the 100 Day Discharge Challenge and working at Integrated Care Board level to share improvements and collaborative approaches. • The children's eating disorder pathways remain under demand pressure as a consequence of increasing referrals and limited staff capacity. This is consistent with national trends and has contributed to difficulties in achieving national response targets. • Access to tier 4 beds and specialist residential care for children remains a risk and currently more challenging due to pressures within a current provider. Work is taking place across local systems to ensure that care is provided in the best place for children who are waiting for a bed. **Finance** • At year end, the Trust reported a surplus of £3.2m which was achieved in line with the plan. • Agency spend in March was £1.1m, with a full year spend of £10m which is £2.2m more than cap. • Actions are in place to address agency spend, which is being overseen by the Trust's agency group. • The capital forecast was revised during 2022/23 to take account of the Trust decision to pause a major scheme. Significant work has been completed in year including works on inpatient areas, safety, fire and compliance areas and investment in IM&T. The full year capital spend was £7m. • Cash in the bank remains positive. As is traditional this has reduced in March with the payment of Public Dividend Capital (PDC) made in month. The final cash position was £74.6m. • Pay costs were £37.6m in March, compared to last month which was £19.7m. March figures includes notional pension contributions and proposed pay award for 22/23. • Out of area bed costs were £573k in March, an increase compared to £508k in February. • Performance against the Better Payment Practice Code remains at 95%.
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

March 2023

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Table of Contents

Click on each section heading to navigate to that section

Introduction

Please find the Trust's Integrated Performance Report (IPR) for March 2023. The development of the IPR will continue to evolve to reflect any changes in the operational environment.

The Trust has developed care group summary reports for inclusion in the IPR. This is to provide an overview of performance against key indicators by care group in order to give assurance regarding the quality and safety of the care we provide. These have been added to the start of the care groups section.

Many of the agreed metrics identified to monitor performance against our strategic objectives have been populated, whilst others are in development with indicative timescales provided. Executive directors have reviewed all priority programmes and how they should be reported in the 2023/23 IPR, these will be presented to the Finance, investment and performance committee and implemented on approval.

With reference to key information relating to Covid-19, where possible the most up-to-date information is provided, as opposed to the March month-end data. This will ensure that Trust Board can have a discussion on the most current position available. Given the fact different staff provide different sections of the report, there may be some references to data from slightly differing dates.

It is worth reminding the reader of the report of the Trust's four strategic objectives against which our performance metrics are designed to measure progress. These are:
- Improving health
- Improving care
- Improving resources
- Making SWYPFT a great place to work

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
- Executive summary
- Priority programmes
- Covid-19 response
- Emergency preparedness, resilience and response (EPRR)
- Quality
- People
- National metrics
- Care groups
- Finance & contracting
- Systemwide monitoring

The priority programmes section has been updated to reflect the Trust's priorities and associated metrics for 2022/23. The national metrics section has also been updated to reflect changes in the NHS oversight framework, long-term planning metrics and NHS standard contract metrics. We also need to consider how Trust Board monitors performance against the reset and recovery programme. The Trust is also keen to include performance data related to the West Yorkshire and South Yorkshire Integrated Care Systems (ICSs) – this is an iterative process as work is underway within the ICSs to determine how performance against their key objectives will be assessed and reported. Our Integrated Performance Strategic Overview Report is publicly available on the internet.

This section has been developed to demonstrate progress being made against the Trust objectives using a range of key metrics. More detail is included in the relevant sections of the Integrated Performance Report.

Priority programmes

• The Trust demonstrates good progress against the majority of its priority programmes. With the majority of key milestones reporting delivery of actions within agreed timescales.
• A key priority for the Trust is to improve the recording and collection of protected characteristics across all services. There is one national indicator which is for ethnicity, the Trust is performing at 96.3% against a target of 90%. For the Trust derived indicators, as at March 2023, 70.2% of service users have had their equality data recorded (disability 41.9%, sexual orientation 42.2% and postcode 99.8%). Whist recording postcode is not technically part of equality data it does help identify referrals from areas with higher levels of deprivation, which could indicate inequalities in relation to healthcare access, experience and outcomes. Work continues to ensure data capture will be extended to all services, this work is monitored by the Trust's Equality, Inclusion and Involvement Committee.
• Work continues to ensure data capture will be extended to all services, this work is monitored by the Trust's Equality, Inclusion and Involvement Committee.
• Specific actions the Trust is taking to address inequalities include co-designing services with communities, ensuring representation is reflective of the population and covers all protected groups and carers. Approaches being used include community reporters and researchers to capture patient stories, offering enhanced equality and diversity training and ensuring health assessments for people with a learning disability.
• A series of metrics and measurements for the Great Place to Work programme have been devised and the data collated to show the impact of the work that has taken place during 2022/23 on this programme.
• Community Learning disability services have commenced work on creation of a management tool for reporting, measuring, and managing waiting lists and undertaken a pathway mapping exercise which has identified areas for improvement to flow of patients to reduce numbers waiting.

Quality

NHS England Indicators (national)

The Trust continues to perform well against the majority of national metrics. The following performance should be noted:
• Inappropriate out of area bed days continue to be above trajectory with 511 days in March. This remains high and mainly relates to increased acuity, Covid-19 outbreaks and challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 15 people placed in out of area beds at the end of March (a reduction of 2, February 2023). The inpatient improvement programme is aiming to address the workforce challenges. Systems are in place to manage and unblock barriers to discharge as well as effective coordination of out of area placements so that people can be repatriated as quickly as possible.
• The percentage of service users seen for a diagnostic appointment (paediatric audiology) within 6 weeks decreased to 79.8% in March from 91.6% reported in the previous month, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service which is a small service and there have been a number of staffing issues that have impacted on clinic availability. Performance is not expected to reach 99% until October 23 with additional pressures related to increased number of referrals also impacting.
• The percentage of children and young people with an eating disorder designated as urgent cases who require access to NICE concordant treatment within one week remained below target to 87.5% (target 95%) - In March 7 out of 8 urgent cases were seen within 1 week. The case that breached was due to patent cancellation.

Quality continued

Local Quality Indicators

The Trust continues to perform well against the majority of quality indicators; however, the following improving/exceptions and actions being taken should be noted:

Care Planning

Work continues in front line services to adopt collaborative approaches to care planning. The March data is provisional however, this is showing an improved position of 75.1% compared to 58.6% in February. The improvement group continue to support operational services and further improvements to compliance are expected during quarter one 23/24.

Risk Assessments

March data is provisional however, an improvement across both inpatient (89.9%) and community (83.2%) areas can be seen against a target of 95%. All areas continue to work to improve performance. Issues with data capture, service pressures and data quality are being addressed but have proved to be more complex. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality.

Waiting Lists

• CAMHS continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period.

• Waiting times and waiting numbers for neurodevelopmental services within CAMHS continue to remain high. As previously reported, waiting list initiatives are in place to work towards stabilising this position. Children do not need to have a diagnosis in order to receive a CAMHS service and services will be provided to meet their presenting needs.

• Waiting list times continue to be an issue due to staffing/operational pressures in community learning disability services, with 76.2% (against a target of 90%) of Learning Disability referrals where patients have had a completed assessment, care package and commenced service delivery within 18 weeks. People on waiting lists are receiving regular welfare phone calls to ensure they remain well and have not escalated in need due to their wait.

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96% of patient incidents reported in March 2023 resulted in no harm or low harm or were not under the care of the Trust, an overview of key indicators is below:

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• 100% of prone restraint incidents were for a duration of three minutes or less which is an improved position from 87% reported in February.

• There was one pressure ulcers that related to a lapse in the Trust's care during March. Further details on the cases are within the main report. The Chief Nurse is ensuring a thorough review of all cases and the outcome will be reported to the Clinical Governance Clinical Safety Committee as part of the Chief Nurse report.

• The number of inpatient falls in March was 39, which is a further decrease compared to 49 in February and 51 in January and is the lowest number of reported falls since June 22. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated.

Our People

• Our substantive staff in post position continues to remain stable and has increased slightly in March. The number of people joining the Trust outnumbered leavers in March.

• Overall turnover rate in March was 13.5% which is the lowest level it has been at throughout the financial year. This is monitored against a target of between 10 to 12%.

• Last year we had 561.3 new starters compared to 658 (10% increase) this year and conversely 612.8 leavers last year compared to 559.2 this year, demonstrating an improvement in recruitment and retention of existing staff. It should be noted that this is the overall Trust figure and some services have not seen the same trend.

• Sickness absence in March was 5.1%, which is a slight decrease from the February position. The year-to-date sickness absence position is 5.3%.

• Rolling appraisal compliance rate for March increased marginally from 71.5% to 71.8%. Actions are in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.

• Overall mandatory training is at 90.2% compliance which exceeds the Trust target of 80%, this has increased marginally from 90.1% reported in February. However, 4 subjects out 17 reported are below the Trust target, which are cardiopulmonary resuscitation, food safety, information governance and reducing restrictive practice interventions. Targeted actions are in place and compliance is reported monthly to the Executive Management Team (EMT) with hot spot reports reviewed by the Operational Management Group (OMG).

Care Groups

Staffing vacancies and absence and ongoing industrial action continue to impact on the Trust and our partners resulting in significant challenges across our local places and integrated care systems.

The care group summary section describes the “hotspot” performance areas and mitigating actions for the month of March, these are as follows:

• No care group is meeting the compliance rate for information governance mandatory training. The IG manager is providing additional face to face training sessions. Managers are receiving weekly lists of non-compliant staff so that progress can be monitored and actions can be taken to address compliance. This is monitored at operational management group and executive management team.

• Mental health acute wards have continued to manage high levels of acuity and have been impacted by covid outbreaks.

• High occupancy levels across mental health wards and capacity to meet demand for beds remains challenging.

• Workforce challenges have continued, with staff absences due to sickness and difficulties sourcing bank and agency staff on top of vacancies leading to staffing shortages across the wards. Workforce challenges are being supported through Trust wide recruitment and retention programme.

• Challenges with demand outstripping capacity in the Single Point of Access (SPA) services remains high with referrals being risk screened to ensure that urgent demand is met. This increases the risk of routine triage and assessment being delated. Work to maintain patient flow continues, with the use of out of area beds being closely managed, however usage continued to be high and remained at a high level in March.

• During March, there was a slight decrease in the overall number of delayed transfers of care, reducing from 4.5% to 3.5%, however this is still identified as a risk due to the availability of options to support people with complex needs on discharge. Work with systems partners at place continues to explore and optimise all community solutions to get people home as soon as they are ready. We continue to work towards the standards in the 100 Day Discharge Challenge and working at Integrated Care Board level to share improvements and collaborative approaches.

• The children’s eating disorder pathways remain under demand pressure as a consequence of increasing referrals and limited staff capacity. This is consistent with national trends and has contributed to difficulties in achieving national response targets.

• Access to tier 4 beds and specialist residential care for children remains a risk and currently more challenging due to pressures within a current provider. Work is taking place across local systems to ensure that care is provided in the best place for children who are waiting for a bed.

Finance

• At year end, the Trust reported a surplus of £3.2m which was achieved in line with the plan.

• Agency spend in March was £1.1m, with a full year spend of £10m which is £2.2m more than cap.

• Actions are in place to address agency spend, which is being overseen by the Trust’s agency group.

• The capital forecast was revised during 2022/23 to take account of the Trust decision to pause a major scheme. Significant work has been completed in year including works on inpatient areas, safety, fire and compliance areas and investment in IM&T. The full year capital spend was £7m.

• Cash in the bank remains positive. As is traditional this has reduced in March with the payment of Public Dividend Capital (PDC) made in month. The final cash position was £74.6m.

• Pay costs were £37.6m in March, compared to last month which was £19.7m. March figures includes notional pension contributions and proposed pay award for 22/23.

• Out of area bed costs were £573k in March, an increase compared to £508k in February.

• Performance against the Better Payment Practice Code remains at 95%.

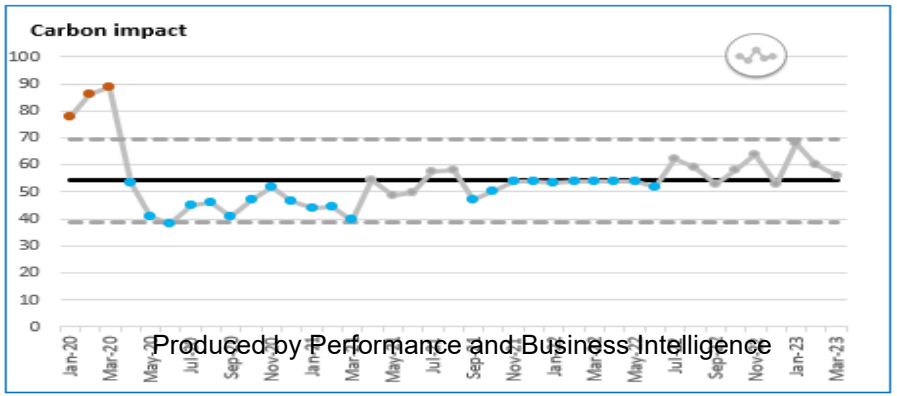
The following section highlights the performance against the Trust's strategic objectives and priority programmes for 2022/23.
For some metrics, we have identified when we anticipate this data to be available. Some of the identified metrics will be reported quarterly.
We will also incorporate statistical process control charts in each section as relevant to identify improvement or areas that require further work or investigation.
Key agreed milestones have also been identified and reporting against these will be provided at the identified date or by exception.

We have added a column which will identify variation and assurance where we are monitoring against a threshold. See appendix 2 for key to the icons used.

Improving health

Priority programme	Metrics	Threshold	Jan-23	Feb-23	Mar-23	Variation/ Assurance	Notes
Ensure that equality, involvement and inclusion is central to everything we do to reduce inequalities, tackle stigma & eliminate discrimination	Percentage of service users who have had their equality data recorded (ethnicity, disability, sexual orientation, deprivation, carers)	*90% (ethnicity only)*	70.2%	70.2%	70.0%		Figures shown are the combined percentage for completion of ethnicity (96.3%), disability (41.9%), sexual orientation (42.2%) and from July 2022 postcode (99.8%). The threshold is currently based on the national target for ethnicity recording only, which is already in place and being achieved. This is subject to review by the Chief Operating Officer. We are looking at developing a phased target to monitor our progress against this metric.
	Referrals and admissions by ethnicity, disability, sexual orientation, deprivation, carers	N/A	See reducing inequalities section of the report for detail				
	Timely completion of equality impact assessments (EIAs) in services and for policies (Quarterly)	100%	47.5% Service 92.9% Policy	49.7% Service 92.9% Policy	77.6% Service 95.3% Policy		EIAs for services are reviewed annually. This means all services have an EIA in place. The data describes the EIAs that require an annual update. Due to winter pressures and the holiday periods, we know that some services have an outstanding review date and work is being undertaken to support services with the updates.
	Completion of equality mandatory training (Quarterly)	>=80%	94.6%	95.1%	95.1%		
Support social responsibility & sustainability in the Trust & our communities	Carbon Impact (tonnes CO2e) - business miles	76	68	60	56		Data showing the carbon impact of staff travel / business miles. In March staff travel contributed 56 tonnes of carbon to the atmosphere.
Work in partnerships at System & Place to improve the health of our communities	Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	55%	Due May 2023				Q3 - 64.3% Reported 6 weeks in arrears. A weighted average is used given there are different targets in different places.
	Forensic lead provider: % of patients in service with a physical health check and % with a care improvement and maintenance plan in place	100%	Medium Secure - 100% & 100% Low Secure - 100% & 100%				Q3 - England position for Medium Secure is 95% and 97% respectively and for Low Secure is 92% and 99% respectively. Q4 information will be published in May 2023.

What the data is telling us. Statistical process control charts will be inserted here to alert the reader to charts which identify improvement or that require further work or investigation



The SPC chart shows that as at March 2023 we remain in a period of common cause variation. The drop in mileage figures are a direct consequence of Covid-19 and now that restrictions are being lifted and face to face activity is increasing we should anticipate that this will rise. Levels are not expected to return to those seen pre-Covid-19 as there should be a more blended approach to working going forward. The performance against this measure will continue to be monitored and if required, the upper and lower control limits re-calculated to include post-Covid-19 levels only.

	Variation Icons The icon which represents the last data point on an SPC chart is displayed.						Assurance Icons If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.		
ICON									
SIMPLE ICON	• • •	• ? H L •	• H •	• L •	• H •	• L •	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass

Below we have set out progress against the key agreed milestones. Reporting against these milestones is provided at the identified date or by exception.

Implementation deliverables	
	On Target to deliver within agreed timescales
	On Trajectory but concerns on ability/confident to deliver within agreed timescales
	Off Trajectory and concerns on ability/capacity to deliver within agreed timescales
	Action will not be delivered within agreed timescales
	Action Complete

Improve health

Key Milestones - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales)

Support social responsibility & sustainability in the Trust & our communities	Phase 1, developing the social responsibility and sustainability action plan, to be completed by July 2023		The draft metrics for measurement of delivery against the strategy were presented to the April EMT where they were well received. This is on track to enable compilation of the opening quarterly report to cover the first quarter of 2023/24, which is in line with the plan. The eBikes for staff pilot has been delivered to our partner Barnsley Cycle hub, protocols and user agreement documents have been drafted and launch is scheduled for early Summer as soon as the garage on the Kendray site has finished refurbishment. We are confident that the successful social responsibility and sustainability (SRS) session and guest speaker at the March extended EMT, will stimulate discussion and even more activity across all areas, and plans are well underway for the launch of the SWYPFT Green Team and a co-ordinating SRS oversight group.
Work in partnerships at System & Place to improve the health of our communities	Forensic lead provider, West Yorkshire: • Progress the repatriation plan for West Yorkshire residents, achievement of annual targets against strategic repatriation ambition (quarterly update)		Review of those out of area and repatriations is included in weekly meetings of the Single Point of Access.
	Forensic lead provider, West Yorkshire: • Achieve annual financial plan (quarterly update)		The provider collaborative is operating with financial surplus. Oversight is via the Trust collaborative committee.
	Forensic lead provider, South Yorkshire: • Achieve annual financial plan (quarterly update)		For the 12 months to March 2023, the provider collaborative operated at breakeven. However there is financial risk associated with the agreement of contract with one independent sector provider. Oversight is via the Trust collaborative committee.
	Community Mental Health transformation: Identify actions for SWYPFT to support implementation of next phase. April 2023		Work continues on developing an understanding of the requirement of SWYPFT in the next phase of transformation and internal coordination of this activity to support implementation.
	Community Mental Health transformation: Develop internal and external communication messages to raise awareness and promote understanding of SWYPFT role in next phase of transformation. May 2023		Work has commenced in February following alignment work.

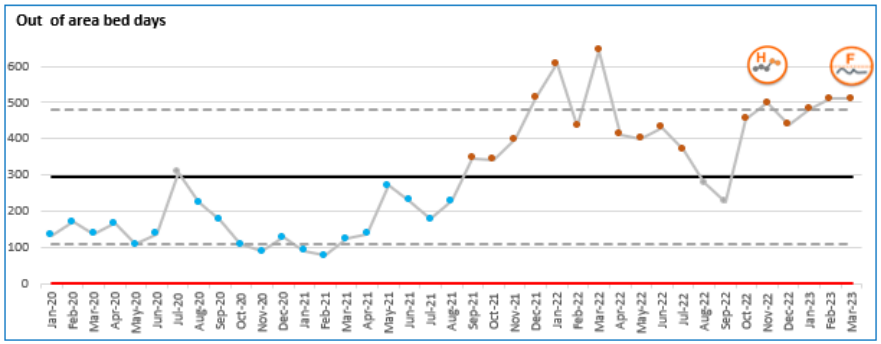
Improve Care

Priority programme	Metrics	Threshold	Jan-23	Feb-23	Mar-23	Variation/ Assurance	Notes
Deliver safe care including our quality priorities to improve coproduction of care plans and risk management	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	83.6%	87.8%	*89.9%*	H F	March data is provisional and will be refreshed next month, though initial figures show a continued improvement moving into special cause improving variation.. All areas are working to improve performance. Issues with data capture, service pressures and data quality are being addressed but have proved to be more complex. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality. Trajectory to achieve full performance not been achieved but shows continued improvement throughout the year.
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	95%	68.2%	67.0%	*83.2%*	H F	
	% Service users on CPA offered a copy of their care plan	*Jan - 60%* *Feb - 70%* *Mar - 80%*	50.5%	58.6%	75.1%	H F	All areas continue working to improve performance and the impact of this can be seen through the data improvements. It is recognised that we continue to be below the targeted threshold, however improvement has been complex due to issues with data capture, service pressures and data quality. The actions in place at each care group plus the change ideas being tested through the improvement group are supporting continued improvements, further improvements are expected in the next reporting period. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality.
Continually improve the care we provide, ensuring it is responsive, inclusive & timely	Number of staff in post on adult acute mental health inpatient wards	323.2	244.5	248.2	244.5	H	April 22 to March 23 we have gained 18.3 whole time equivalents on substantive or fixed term contracts. 80% of those were nursing and midwifery registered
	Average length of stay in adult acute mental health inpatient wards	*32 (national benchmark)*	47	29	49		Data based on adult acute discharges only. Individuals are being admitted at a higher level of acuity, taking longer to reach recovery as well as the challenge with delayed transfers of care. Length of stay is continuously monitored through the patient flow team.
	Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	12	23	20		These were spread across all mental health inpatient areas, with more incidents reported across this time period in Wakefield's mental health wards. In forensic services the majority of race related incidents against staff were reported in medium secure in the time period, with the highest number of incidents reported on Hepworth ward.
	Inappropriate out of area bed placements (days)	Q4 - 630	482	511	511	H F	See statistical process chart below for further detail.
	Percentage of video consultations	Trend monitor	1.6%	1.6%	1.7%		Performance has plateaued reflecting new ways of working post-Covid
	Percentage of telephone consultations	Trend monitor	28.8%	28.2%	29.8%		
	Percentage of face to face consultations	Trend monitor	69.6%	70.2%	68.5%		
	CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	416	645	607		Clients are seen in order of need and not according to how long they have waited. The longest wait for those seen in the month was 989 days, the shortest was 41 days both of these were appropriate given the needs of the clients. The number on the waiting list at the end of March was 295. Waiting list initiatives in place, we will not reach a steady state until Q1 of 2023/24. Please see locality section for further detail on neurological waiting times.
	CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	478	493	495		Clients are seen in order of need and not according to how long they have waited. The longest wait for those seen in the month was 657 days, the shortest was 107 day, both of these were appropriate given the needs of the clients. The number on the waiting list at the end of March was 1483. Waiting list initiatives in place, we will not reach a steady state until Q1 of 2023/24
	Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	80.0% 44/55	78.7% 37/47	76.2% 64/84	?	Barnsley achieved target. Calderdale – 2 breaches of 10 referrals (OT – staff sickness; SALT/Nursing – problems making contact with patient). Kirklees 14 of 30 breached (2 Dietetics cases to have welfare calls this week (no dieticians – out to recruitment); rest have had welfare calls as there are vacancies include nursing, physio & psychology – some posts have been recruited to and awaiting start dates. Wakefield - 3 cases in Psychology – all on waiting lists; two had Welfare Calls, one to be done.

Improve Care Continued							
Priority programme	**Metrics**	**Threshold**	**Jan-23**	**Feb-23**	**Mar-23**	**Variation/ Assurance**	**Notes**
Continually improve the care we provide, ensuring it is responsive, inclusive & timely	Referral to assessment within 2 weeks (external referrals)	75%	88.9%	82.6%	67.7%		Demand into the single point of access (SPA) and capacity issues has lead to ongoing pressures in the service which have impacted on previous months performance. Workforce challenges are continuing to compound these problems and have been increasing. SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed in all areas, with particular pressures across Calderdale, Kirklees and Barnsley. The situation is being kept under close review by general managers and teams and all possible mitigations are in place.
	Assessment to treatment within 6 weeks (external referrals)	70%	98.8%	99.1%	88.9%		

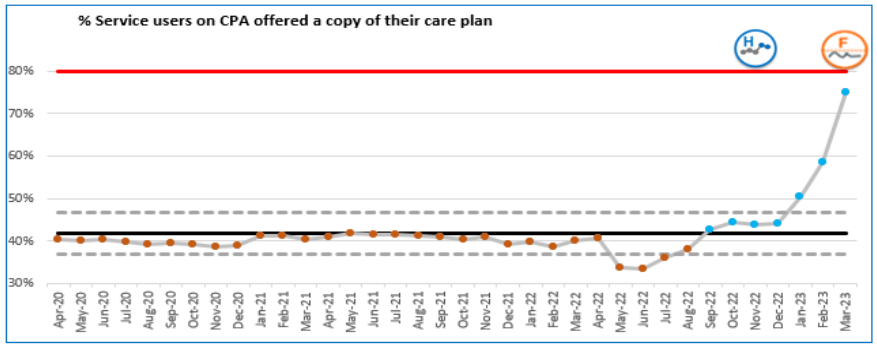
Glossary	
CAMHS	Child and adolescent mental health services
CPA	Care Programme Approach
WTE	Whole time equivalent

What the data is telling us. Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)



There has been a step change increase in out of area bed usage from summer 2021 onwards. There are several reasons for the increase including staffing pressures across the wards, increased acuity, covid outbreaks and challenges to discharging people in a timely way.

The inpatient improvement programme is aiming to address many of the workforce challenges. Systems are being put in place to manage and unblock barriers to discharge as well as effective coordination of out of area placements so that people can be repatriated as quickly as possible. Many of these challenges are happening across other providers nationally. NHSE have recognised this, and provider Trusts have submitted trajectories to zero out of area placements by the end of the 2023/24 financial year. The Trust had 15 people placed in out of area beds at the end of March 2023.



Performance against the percentage of service users offered a copy of their care plan remains in special cause improving variation. Work continues in front line services to adopt collaborative approaches to care planning. A new person-centred metric has been identified and work is being undertaken to implement this in the coming months which will improve performance. The SPC chart shows that we have entered a period of special cause improving variation which is indicative of the changes to the process that have been made.

	Variation Icons The icon which represents the last data point on an SPC chart is displayed.						Assurance Icons If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.		
ICON									
SIMPLE ICON	• • •	• ? H L •	• H •	• L •	• H •	• L •	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass

Improve Care

Key Milestones - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales)			
Deliver safe care including our quality priorities to improve coproduction of care plans and risk management	Use the Patient Safety Incident Response Framework (PSIRF) to analyse our data and intelligence to identify the Trust's patient safety priority areas. Phase one: orientation by 30/11/2022 completed Phase two: diagnostic and discovery by 31/5/2023 Phase three: governance and quality monitoring by 31/5/2023 Phase four: patient safety response planning by 30/06/2023 Phase five: curate and agree patient safety policy and plan by 31/8/2023 Go Live: develop comprehensive improvement plans by Autumn 2023 (NHS England have revised the go live date)		PSIRF Phase two: Diagnostic and discovery is well under way and will be complete by the end of May. All other phases have commenced. It should be noted although dates are given, these are estimates as the phases are not linear and aspects are expected to continue throughout our journey.
	Six stage QI process to be used as part of the care planning and risk assessment improvement programme to March 2023		Completed
Continually improve the care we provide, ensuring it is responsive, inclusive & timely	Improving Access to Care (IATC): Update on improvement work to reduce waits delivered to EMT March 2023.		On behalf of Trustwide community learning disability services, Calderdale local delivery group has commenced work on creation of a management tool for reporting, measuring, and managing waiting lists. A pathway mapping exercise has been completed and areas for improvement identified to improve flow of patients to reduce numbers waiting. They have also commenced development of a standardised welfare check process including checklist for completion to support measurement and assurance reporting and commenced configuration of SystmOne waiting list functionality. In children's mental health neurodevelopmental services in Kirklees and Calderdale, quality improvement focused work on transition pathway has commenced with adult Attention Deficit Hyperactivity Disorder/Autistic Spectrum Disorder services. Workshops have been planned and scheduled. The first workshop to be held in April will focus on development of standardised SystmOne transition form. In adult community services, core psychology improvement action plan is in development. SystmOne waiting list project continues to support services in using the functionality correctly and preparing other services such as learning disability community for setup. Working with integrated change team and health intelligence, a data framework is in development to support improvements in data capture
	Out to public consultation on Older People inpatient services by Summer 2023		First draft business case complete and shared with steering group, EMT and programme board in late February, for feedback in mid March. Timeline for governance in development. Briefing for overview and scrutiny committee being updated in March Work to agree capital and review information for the business case to take place – March Presentation to Trust Board – 28 March Further edit and finalisation of business case Mar-May Integrated care board governance and NHS England assurance processes – Spring 23 Resourcing for consultation process to be agreed Apr 2023 Draft consultation document developed during Spring 2023

Improve resources

Priority programme	Metrics	Threshold	Jan-23	Feb-23	Mar-23	Variation/ Assurance	Notes
Spend money wisely & increase value	Surplus/(deficit) against plan	£3,178k	£294k	(£554k)	(£546k)		The unaudited financial position for 2022/23 is a surplus of £3.2m in line with plan
	Capital spend against plan	£13.1m	£836k	£840k	£2721k		Total capital spend for 2022/23 is £7.0m. The main variance to plan is the pause agreed for the Bretton Centre scheme. This pause has enabled additional IM&T investment to be made in year.
	Agency spend managed within the overall workforce (Monthly)	3.5%	5.5%	4.2%	5.7%		Total agency spend is £10.0m. Continued usage of agency staffing as part of the overall workforce solution. Monthly performance higher than target. Additional focus and scrutiny being placed on agency spend.
	Overhead costs	TBC	15%	15%	15%		Threshold to be confirmed
	Financial sustainability and efficiencies delivered over time	£6,350k	£469k	£469k	£471k		Savings in line with plan although majority are non-recurrent. Key elements are lower than previous out of area placements and the impact of workforce numbers.
Use our estates to enable effective ways of working to support staff & deliver best care	Please see below table for performance against a number of estates metrics.						
Use digital approaches to deliver best care and support to service users, carers, staff and the wider community	Communication preferences of service users captured/recorded on SystmOne		Questionnaire to collect this information is live on SystmOne				
	Percentage of wards live with EPMA over time	96.5% by March 2023	86%	90%	100%		All wards now live.

Glossary

EMPA	electronic prescribing and medicines administration

What the data is telling us. Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)

Improve resources

Key Milestones - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales)

Spend money wisely and increase value	Final 2023/24 plan, including financials, delivered to the Trust Board March 2023		Completed. Submitted to Trust Board in March.
	Patient Level Costing Implementation (PLICS): Engagement process (clinical and finance) by January 2023		On track
	Patient Level Costing Implementation (PLICS): Data quality review by February 2023		On track
Use our estates to enable effective ways of working to support staff & deliver best care	Estates strategy to be approved at Trust Board by Early 2023		Initial draft has been circulated for review and comments.
Use digital approaches to deliver best care and support to service users, carers, staff and the wider community	To oversee and facilitate the introduction, configuration, and development of digital access to personal health records for service users by mid-June 2023		The 'Patient Knows Best' project board in March agreed to revise the go live timescale to a realistic timeframe accounting for numerous bank holidays and staff availability. This has been revised to Mid-June 2023 to ensure appropriate time for user testing and pre-go live engagement activities.
	Implementation of a Trust wide approach to digital dictation submission for Board approval July 2023.		On track. Currently out to tender with supplier evaluations due to commence in May. Phase 2 implementation procurement is underway.

We have added some additional metrics from November 2022 to allow the board to review and monitor performance against a number of key estates metrics. These can be seen in the table below.

Estates	Objective	CQC Domain	Threshold	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	-	3			8			7			7		
Estates Urgent Response Times - SLA 1 & 2	Improving Resources	Effective	95%	Reporting commenced November 2022							97.1%	98.1%	97.6%	97.6%	95.6%
Premise Assurance Model (PAM)	Improving Resources	Effective	Good								Good	Good	Good	Good	Good
Statutory Compliance 3	Improving Resources	Effective	100%								100%	100%	100%	100%	100%

Notes:
1 - SLA 1 & 2 are the priorities given to Emergency and Urgent work which has a 2 day response time
2 - PAM is a report measuring how well the Trust is run and includes Estates, Facilities, Governance, Patient Safety, Efficiency & Effectiveness
3 - Includes Water, Gas, Electricity, Refrigeration, Pressure, LOLER (Lifting Operations and Lifting Equipment Regulations) and Asbestos
Riddor - Four of the seven reported incidents relate to violence and aggression, two following staff slips, trips & falls and one case concerning Injuries/concerns following restraint. The Injuries/concern incident following restraint incident was late being notified to the Health and Safety Executive following delays in passing accurate details to the Datix and Health & Safety Teams from people involved in the incident. In all seven incidents, staff have been supported throughout their recuperation.

Make SWYPFT a great place to work

Priority programme	Metrics	Threshold	Jan-23	Feb-23	Mar-23	Variation/ Assurance	Notes
Make SWYPFT a great place to work, supporting staff & addressing workforce challenges	Vacancy rate (Overall)	<10%	17.9%	18.0%	17.6%		Vacancies have decreased by 17.9 whole time equivalent within month to 926.9 whole time equivalent currently open vacancies.
	Turnover external (12 month rolling)	>10-12<	14.3%	13.7%	13.5%		Rolling turnover has dropped by 0.2% to 13.5%
	Sickness absence - Month	<=4.4%	5.3%	5.3%	5.1%		Year to date absence rate is 5.3%, in month decreased by 0.2% to 5.1%.Long term sickness (any absence over 3 weeks) has reduced from 3.8% to 3.7%.
	Workpal appraisals - rolling 12 months	>=90%	69.8%	71.5%	71.8%		For the month of March, the % rate increased by 0.3% to 71.8%.
	Quarterly summary from staff survey. This will include response rate from underrepresented staff groups and narrative report on progress made against workforce strategy	N/A	Report to be made available once results analysed				2022 staff survey results received and under review. Process for wide engagement underway. Some initial feedback has been included in the people section of the report.

What the data is telling us. Statistical process control charts will be inserted here to alert the reader to metrics that require further work or investigation.
(SPC charts to be included here where relevant)

Make this a great place to work

Key Milestones - (report by exception and any concerns on ability and/or capacity to deliver actions within agreed timescales)			
Make SWYPFT a great place to work, supporting staff & addressing workforce challenges	People directorate work plan has been finalised. The Great Place to Work (GP2W) priority programmes are under development.		A series of metrics and measurements for the great place to work programme have been devised, the data collated, and this is scheduled in April to be presented to the executive management team to show the impact of the work that has taken place during 2022/23 on this programme. It will then be used as a baseline and developed further to provide an ongoing mechanism for reporting impact during 2023/24.

Reducing Inequalities

Addressing inequalities and demonstrating we meet the requirements of the Public Sector Equality Duty and our legal obligations under the Equality Act 2010 and NHS Constitution is a Trust priority. We know there are differential impacts on protected groups and carers and we use the joint needs assessment (JNA) data in each of our places as a baseline so we can understood the local population and meet the needs of local people:

- Every service in the Trust, and every strategy and policy have an Equality Impact Assessment (EIA)
- We have a Trust dashboard in line with NHSE and CORE20PLUS5 to track out progress for workforce and people in our services
- We are using the King's Fund approach to address inequalities and are testing this model out in service areas
- We continue to co-design services with our communities ensuring representation is reflective of the population and covers all protected groups and carers.
- We work proactively with the voluntary and community sector to reach grass roots communities
- We have started to roll out enhanced equality and diversity training to create the right conditions and culture

Key actions the Trust are taking to address inequalities are:

- Data - improving data collection gaps – addressed using the ‘All of You’ campaign, and staff development.
- Information - literature bank for equality and diversity and community films to support insight and understanding of diverse groups.
- Monitoring – the use of translation services at a service level against patient profile, and ensuring service information is in the right format and accessible
- Improving access - Identifying digital access as part of initial assessment via SystmOne.
- Involving - capturing patient and staff feedback, and equality monitoring responses to highlight specific issues.
- Development – through mandatory and enhanced training and lunch time talks we are developing our staff
- Our People - ensuring reflective and representative workforce and leadership. Removing the requirement for Maths and English qualifications.
- Stories - Using tools to capture patient stories, and approaches such as community reporters and researchers.
- Creative approaches - developed through ‘Recovery Colleges’ and ‘Creative Minds’.
- Faith - spiritual support through ‘Spirit in Mind’.

Specific examples include:

- Creative Minds worked with ‘Lead the Way’s Art Group’ to develop a piece of work that helped people with learning disabilities share their own experiences of the pandemic
- Staff at Kirklees Improving Access to Psychological Therapy (IAPT) services received training on delivering ‘Transcultural Therapy' combined with a focus on providing culturally sensitive supervision.
- IAPT are working in partnership with the voluntary organisation ‘Solace’ in Calderdale to better understand the psychological needs of asylum seekers to ensure we can improve access to services
- Recovery College Kirklees is working with the south Asian community for people with lived experience to become partners and co-facilitators delivering culturally informed groups.

Reducing Inequalities

Specific examples continued:

• Perinatal pathways include peer support workers as key members of staff within the new pathway design
• The Trust has an updated Transgender policy and Accessible Information Policy. Both policies have been co-designed with the voice and views of staff, lead managers, staff side, staff networks and service users, carers, and families.
• The Trust delivered a 'Disability Matters' event in August 2022.
• Wakefield CAMHS Mental Health Support Team have developed leaflets in a variety of languages based on their target audience.
• Young people were involved in the co-creation, design and development of a choose well campaign
• Kirklees carers of people with a learning disability project (funded by SWYPFT) have mapped what support is available to carers of people with a Learning Disability so people can access the support they need to continue their caring role
• In Barnsley mental health services, a gender specific role works specifically with women to focus on physical health in the recovery college and support them to access community services.
• Paediatric SALT has established a Facebook page, You Tube and Twitter feed where parents can send messages via social media, this is proving popular with service users as they can access peers and the support they need.
• The Trust increased the take up of health checks in Calderdale for people with severe mental illness by creating letters that were beautifully illustrated and less formal, so people felt engaged as soon as the letter arrived
• The Trust has developed a consent to care, treatment, and discharge tool within SystmOne to ensure the child's voice is captured in decisions around their care
• A 'Respect Project' was set up to tackle trends in negative language and behaviours relating to ethnicity, sexual orientation, and gender. The project ran an art competition across the wards to promote positive identity and celebrate diversity

This section of the report will continue to be developed as more data becomes available and further analysis is undertaken. Some key metrics have been initially identified, with a focus on recruitment of staff into the Trust and referrals and admissions into Trust services. A key priority for the Trust is to improve the recording and collection of protected characteristics across all services - this will be monitored by the Trust's Equality, Inclusion and Involvement Committee. A campaign is being launched related to the collection and recording of protected characteristics and we anticipate this will have a positive effect on the quality of this data.

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Reducing Inequalities

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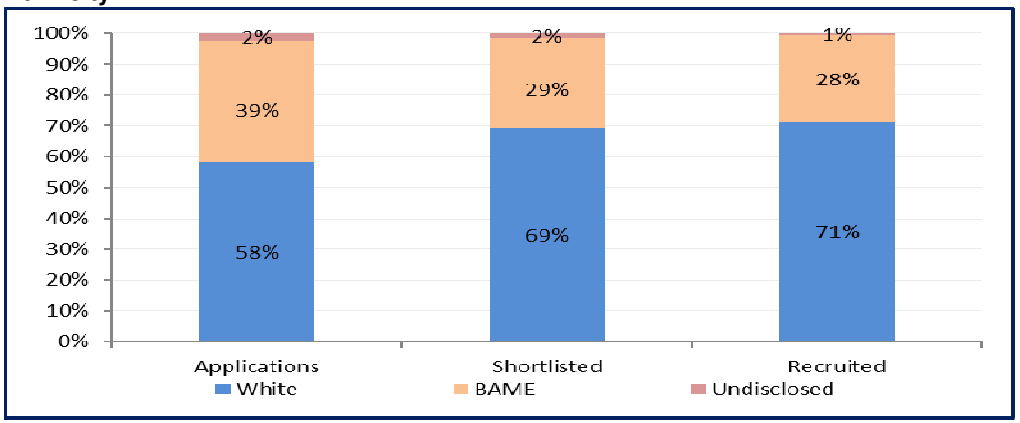
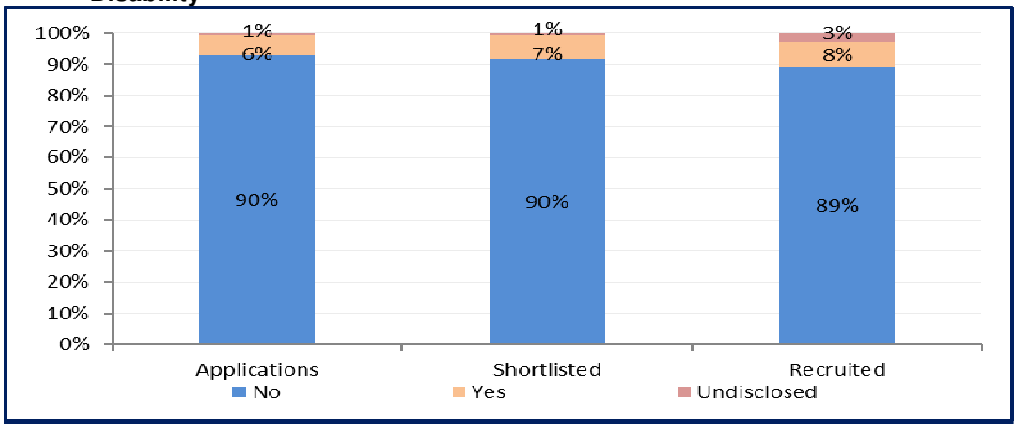
Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 4 2022-2023

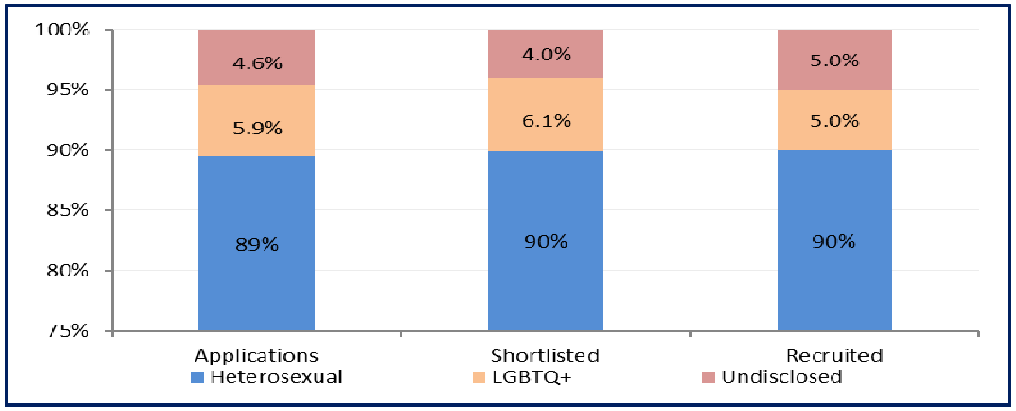
Ethnicity



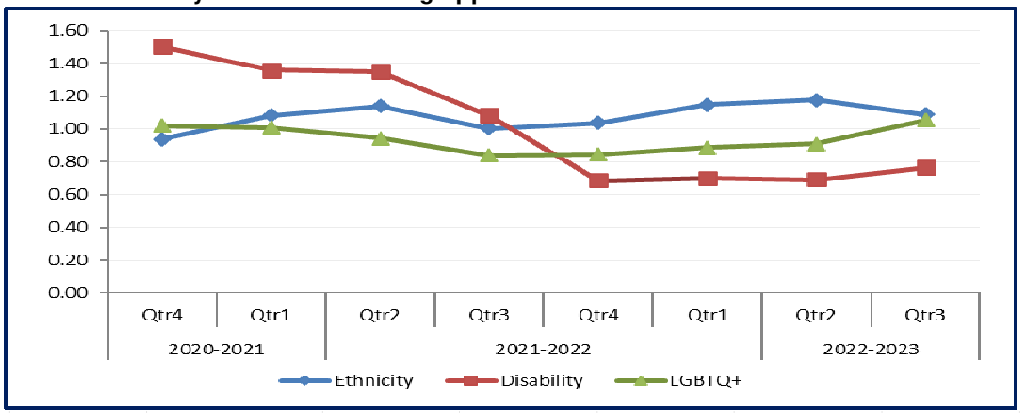
Disability



Sexual Orientation



Relatively likelihood of being appointed



Relative Likelihood YTD Quarter 4 2022-2023:	BAME:	Disability:	LGBTQ+:
	1.08	0.92	1.22

Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 4 2022-2023 Continued…

Notes:
We are now showing the trend for the relative likelihood. Including Trust population would not be helpful as we are looking at new staff entering existing population. Including local population (census) data will not be helpful as people apply for posts from outside Trust catchment area.

Undisclosed data is not used in the relative likelihood calculation for any of the three categories.

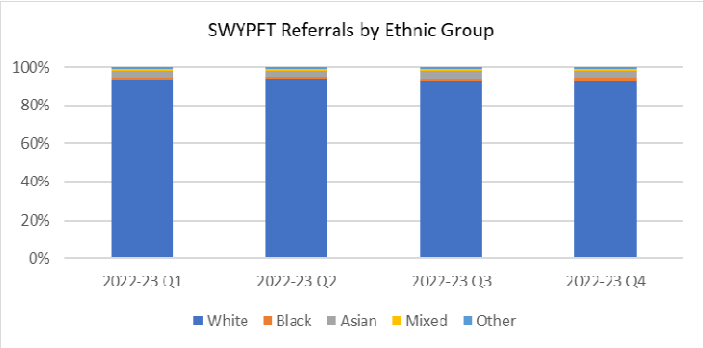
BAME - relative likelihood of being appointed compared to white applicants this quarter = 1.08
Disability - relative likelihood of being appointed compared to non-disabled applicants this quarter = 0.92
LGBTQ+ - relative likelihood of being appointed compared to heterosexual applicants this quarter = 1.22
NB Relatively large proportions of undisclosed could unintentionally skew the data

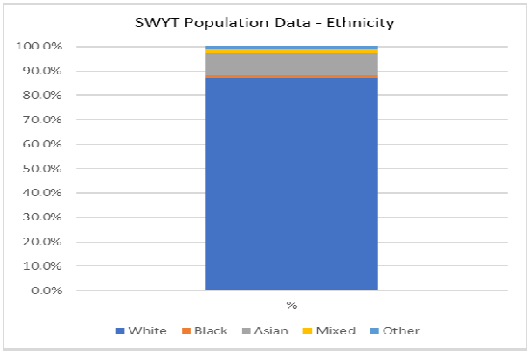
Relative likelihood key
1.00 = target figure, equally as likely to be appointed.
Greater than 1.00 = less likely to be appointed
Lower than 1.00 = more likely to be appointed

Action
Recruitment & Selection policy in the process of being reviewed
Review Recruitment & Selection training
Work with staff networks around action planning

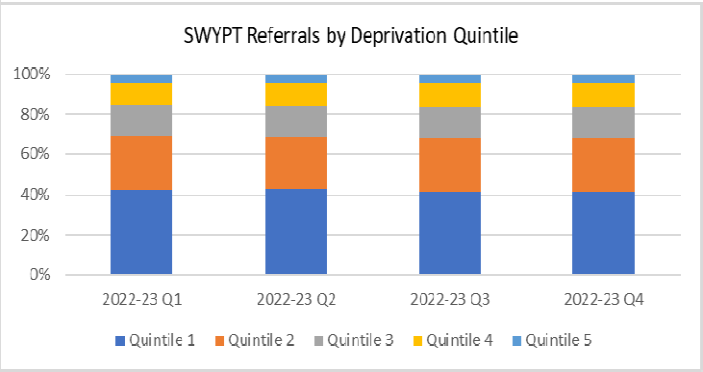
Reducing Inequalities

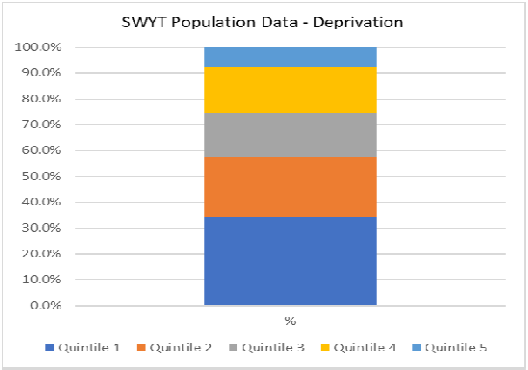
Referrals - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4	Local Population
White	97.5%	97.7%	93.1%	93.2%	87.1%
Black	1.2%	1.1%	1.0%	1.2%	1.4%
Asian	3.3%	3.3%	3.8%	3.5%	8.9%
Mixed	1.2%	1.0%	1.1%	1.2%	1.6%
Other	0.9%	0.9%	0.9%	0.9%	1.1%



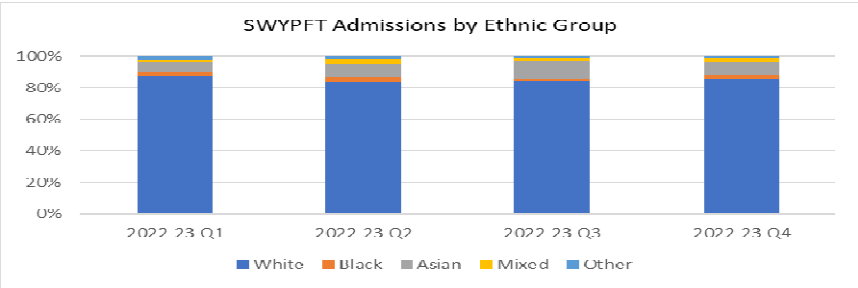


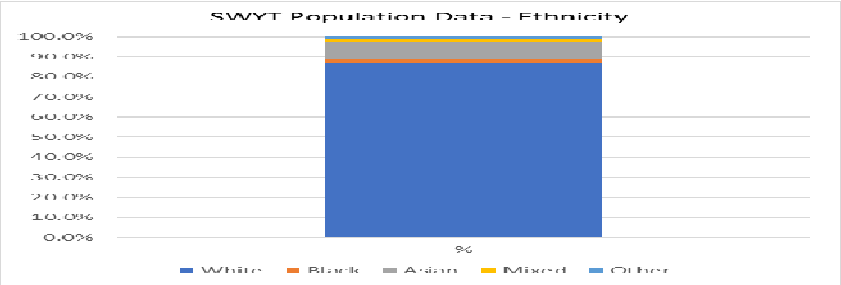
Quintile	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4	Local Population
Quintile 1	42.9%	42.8%	41.7%	41.8%	34.1%
Quintile 2	27.2%	26.4%	26.5%	26.6%	23.4%
Quintile 3	15.7%	15.2%	15.6%	15.2%	17.0%
Quintile 4	11.1%	11.0%	11.5%	11.6%	17.8%
Quintile 5	4.5%	4.7%	4.7%	4.8%	7.8%

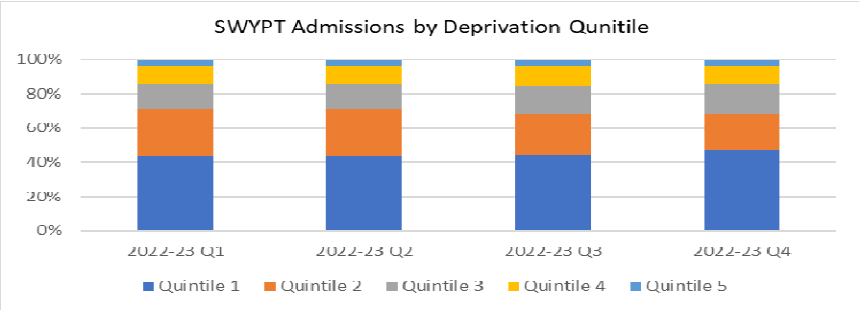
Notes:
- Percentage breakdowns for comparison exclude unknown/unrecorded
- Quintile 1 represents the top 20% most deprived households, based on the Indices of Multiple Deprivation
- Charts above relate to local population data
- The Trust continues to receive more referrals for people from a white ethnic background.
- When comparing the referrals to the Trust against the ethnic make up of the local population, the proportion of people from a white ethnic background in the local population is lower that the proportion of referrals to the Trust for people from a white ethnic background.

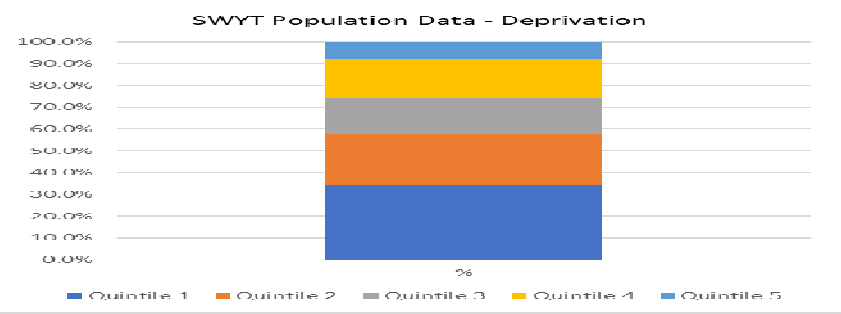
Reducing Inequalities

Admissions - (Includes physical health, mental heath, learning disability and forensics)









Notes:

- Percentage breakdowns for comparison exclude unknown/unrecorded
- Quintile 1 represents the top 20% most deprived households, based on the Indices of Multiple Deprivation
- Charts above relate to local population data
- Admissions during quarter 3 for people from a white ethnic group were at a lower proportion than that of the population the Trust serves.
- Admissions for people with a mixed ethnic group were slightly lower than the mixed population of the population the Trust serves - these are small numbers and so can impact on the overall percentage.
- There were a significantly greater number of admissions from the quintile 1 (most deprived) compared to the proportion of the Trust's population that are in quintile 1. 44.8% of the Trust's admissions were for people from the most deprived areas of the population the Trust serves.
- There has been a decrease in the number of admissions from the least deprived areas (quintile 5) compared to the last 2 quarters.

Work is taking place through the Adults and Older People Mental Health Equality, Inclusion and Involvement Care Group to interpret data and identify actions to address any health inequalities using the health inequalities improvement report. The initial focus has been on service users admitted and detained under the Mental Health Act where nationally a disproportionately high number of people from BAME populations are detained. A framework to support improvements in data capture and reduce health Inequalities has also been developed with the focus initially being placed on the perinatal service - where the UK has one of the highest rate of maternal mortality in Europe - and learning disability services, where the median age of death for people with a learning disability is 20 years younger than the general population and where 49% of deaths were classified as "avoidable" compared with 22% for the general population. This framework has started to identify areas where there may be gaps in our data such as digital poverty, or where improvements to care could be made such as completion of physical health screenings.

Covid-19 response

This section of the report focuses on a number of components of the Trust's response to Covid-19 including testing, support to the system and personal protective equipment (PPE).

Managing the clinical response

PPE position

Supplies of and access to PPE remain good, as they have been for the last two years. This report will now only report on PPE levels by exception

Testing

KPI	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
No of Service users Covid-19 positive and now recovered	2	7	21	23	17	21	6	16	17	18	28
No of Service users Covid-19 positive and still within 28 days, monitoring not completed	0	0	0	0	0	0	0	0	0	0	29
No of Service users Covid-19 positive and deceased within 28 days of positive test	0	0	1*	3*	0	1	0	1*	1*	1	0
No of wards with outbreaks	0	1	1	2	2	3	1	2	3	4	8

There is a lag in reporting data particularly if service user is discharged from care and/or notification of death awaiting registration.
*relate to community acquired infections
The patient that sadly passed away in February had severe underlying physical health issues.

Patient testing and pathway/Outbreak response and management

In March 2023 there has been an increase in ward outbreaks and areas being monitored, which has increased the numbers of inpatient cases (53 out of 57 of inpatient cases, related to outbreaks).

Testing approach - Current position

No change to patient or staff testing procedures.
Covid-19 testing for staff and patient changed from 31st August, inline with the Covid-19 testing in periods of low prevalence advice from NHS England.

Supporting the system

Care home support offer

- Significant support to care homes continues to be provided from the general community team in Barnsley.
- Support also includes direct care from community staff including our specialist palliative care teams, district nurses and matrons and our out of hours nurses.
- Mental health and learning disability support has also been provided into care homes across the whole of the Trust footprint to support the residents.

Emergency Preparedness

This section of the report identifies the Trust's response to the Covid-19 pandemic.

Supporting the system

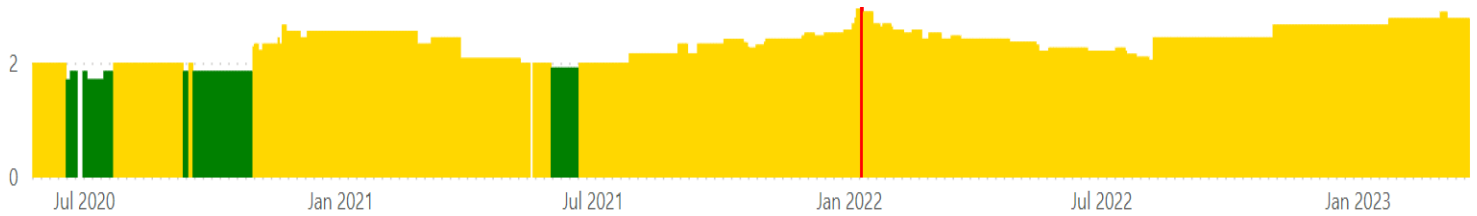
Integrated care system (ICS) stress test and outbreak support

• The Trust continue to work closely with partners in outbreak support responses in each of our four places. The Trust has fully engaged with system command structures and other relevant meetings.
• Strong leadership from the infection prevention & control (IPC) team continues so the Trust can ensure appropriate IPC measures are in place.
• The Trust is supporting and engaged with partners across our places in the event a spike/wave of Covid re-emerges to allow suitable and effective response.

Standing up services

Emergency preparedness, resilience and response (EPRR) update including OPEL levels

• The Moving Forward Group continues to meet fortnightly, and monitors Covid-19 prevalence, measures and guidance in the Trust. Advising and makes decisions regarding Covid-19 arrangements, risk assessment and staffing. Any decision made by this group are escalated to the Operational Management Group (OMG) and from there to the executive management team (EMT)
• The Trust OPEL level remains at an average of 2.8 with two service areas operating at OPEL 2. Seven service areas are now at OPEL 3.



Current average OPEL level

2.78

Key	
OPEL Level 1	
OPEL Level 2	
OPEL Level 3	
OPEL Level 4	

Quality Headlines

Section	KPI	Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	TBC	61.3%	57.2%	60.0%	53.0%	66.0%	68.0%	70.0%	72.0%	74.0%	78.0%
Complaints	% of feedback with staff attitude as an issue 12	< 20%	19% 4/21	18% 4/22	20% 4/20	25% 5/20	15% 4/26	9% 2/22	20% 4/20	0% 0/16	11% 2/18	0% 0/21
Service User Experience	Friends and Family Test - Mental Health	85%	85%	88%	85%	85%	84%	86%	85%	83%	85%	83%
	Friends and Family Test - Community	95%	93%	93%	92%	93%	93%	93%	94%	93%	95%	97%
Quality	Number of compliments received	N/A	25	31	10	13	5	28	39	83	22	26
	Notifiable Safety Incidents (where Duty of Candour applies) 4	trend monitor	26	31	19	35	32	33	31	40	31	34
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	trend monitor	3	0	0	0	2	2	2	3	2	1
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	0	0	0	1	2	1	0	0	0	2	0
	% Service users on CPA offered a copy of their care plan	80%	33.5%	36.1%	38.2%	42.8%	44.3%	43.8%	44.1%	50.5%	58.6%	75.1%
	Number of Information Governance breaches 3	<12	19	10	9	13	11	13	8	12	8	13
	Delayed Transfers of Care 10	3.5%	2.1%	2.6%	3.0%	2.8%	3.3%	2.7%	3.8%	4.3%	4.5%	3.5%
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	72.1%	78.0%	82.0%	71.3%	71.3%	79.1%	76.6%	83.6%	87.8%	*89.9%*
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	95%	72.2%	54.2%	81.7%	62.9%	68.0%	69.5%	74.3%	68.2%	67.0%	*83.2%*
	Total number of reported incidents	trend monitor	1129	1179	1254	1168	1244	1307	1187	1242	1195	1233
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) 9	trend monitor	24	27	11	32	26	30	24	34	27	35
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) 9	trend monitor	1	4	3	3	3	7	7	3	3	3
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	trend monitor	1	0	5	2	3	0	3	3	1	1
	Safer staff fill rates	90%	116.6%	115.8%	115.6%	118.4%	117.4%	119.1%	118.1%	122.1%	121.4%	119.3%
	Safer Staffing % Fill Rate Registered Nurses	80%	85.0%	84.7%	83.1%	87.5%	91.0%	90.8%	85.6%	90.5%	89.1%	89.7%
	Number of pressure ulcers which developed under SWYPFT care (1)	trend monitor	44	50	26	43	49	48	39	55	46	39
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	0	2	0	1	1	1	3	0	2	1
	Eliminating Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0
	% of prone restraint with duration of 3 minutes or less 8	90%	87.5%	80.0%	91.0%	100%	100%	92.0%	100.0%	95.2%	87.0%	100.0%
	Number of Falls (inpatients)	trend monitor	37	70	63	58	68	63	59	51	49	39
	Number of restraint incidents	trend monitor	152	171	161	160	169	223	189	212	223	203
	% people dying in a place of their choosing 14	80%	85.7%	100.0%	85.3%	85.7%	91.7%	93.3%	78.1%	93.8%	83.3%	100.0%
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	0	0	0	0
	C Diff avoidable cases	0	0	0	0	0	0	0	0	0	0	0
Improving Resource	NHSEI Oversight Framework metric 13	2	2	2	2	2	2	2	2	2	2	2
	CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green

** See key included in glossary*
Figures in italics are not finalised
*** - figures not finalised, outstanding work related to 'catch up' activities in relation to the SystmOne implementation impacting on reported performance.*

1 - Attributable - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary
2 – Lapses in care - A pressure ulcer (Category 2 and above) that has developed after the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage
3 - The IG breach target is based on a year on year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches
4 - Notifiable Safety Incidents are where Duty of Candour is applicable.
5 - CAMHS referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Work to establish a target for 22/23 is underway which takes into account non-compliance based on individual child and families needs but also ongoing data quality work which is expected to improve performance. Excludes autistic spectrum disorder waits and neurodevelopmental teams.
8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.
9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.
9 - Patient safety incidents resulting in death (subject to change as more information comes available). All incident data is reviewed using SPC charts to identify any special cause variation, if this occurs this will be reported by exception. Otherwise reporting rates remain within normal variation.
10 - Trust monitors performance against 3.5% target as set in the mandate to NHS England from the Department of Health in 2017.
11 - Number of records with up to date risk assessment. Up to and including September 2020 the criteria used is - 'Older people and working age adult Inpatients' - we are counting how many Sainsbury's level 1 assessments were completed within 48 hours prior or post admission and for 'community services for service users on care programme approach' - we are counting from first contact then 7 working days from this point. Given the recent implementation of the FIRM risk assessment tool, from October 2020 onwards - 'Older people and working age adult inpatients' - we are counting how many staying safe care plans were completed within 24 hours and for 'community services for service users on care programme approach' - we are counting from first contact then 7 working days from this point.
12 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return.
13 - The NHSEI Oversight Framework was updated in June 22 . Further detail regarding the framework and the metrics monitored can be seen in the national metrics section of the report.
14 - This metric relates to the Macmillan service, end of life pathway

Quality Headlines

• Number of restraint incidents - during March decreased to 203 from 223 reported in the previous month. Further detail is provided in the relevant section of this report.
• Duty of Candour - 2 breaches in February 2023 - There was a Duty of Candour breach where a community patient self harmed. The patient was taken to accident and emergency and admitted to intensive care unit. Duty of Candour was delayed as patient was in intensive care and whilst the care coordinator had been in contact with the patient and family it was not felt to be an appropriate time due to mental state. Apology given when patient was more stable. There was a duty of candour breach where a community patient self harmed. The patient was transferred to the acute hospital and was treated in intensive care. The clinical judgement was to deliver the apology at the next appointment with the therapist. However, the patient did not attend the appointment, a letter was therefore sent offering a further appointment with duty of candour being completed within the letter.
• Performance for CAMHS Referral to Treatment - services have highlighted that sustained increases in referrals will negatively impact on the length of wait. A review of support for people on waiting lists is being monitored through the Trustwide Clinical Governance Group.
• Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care - 1 in March. Category 2 ulcer not identified. Learning to review treatment and notification.
• The number of people with a risk assessment/staying safe plan in place within timescale has improved again this month and further improvement is expected to continue. See the Priority Programmes section for further details.
• The percentage of service users on care programme approach offered a copy of their care plan has improved again this month, and further improvement is expected to continue. See Priority Programmes section for further details.
• Delayed transfers of care - This has dropped back within threshold in March 2023. We are continuing to experience pressures linked to patients being medically fit for discharge but who are subsequently delayed. We are working with systems partners at place to develop crisis provision including safe places to stay away from home, and exploring and optimising all community solutions to get people home as soon as they are ready – utilising roles such as discharge coordinators, and improving links with homeless services and housing providers.
• Patient safety incidents that resulted in a degree of harm of moderate harm, severe harm or patient safety related death tend to fluctuate over time, and data is constantly refreshed as further information is available. This results in some changes to the level of harm, severity and categories of incidents. We encourage staff to report with an upwards bias initially especially when the outcome is unknown. These are adjusted subsequently. Incident data is regularly analysed using SPC to explore any potential higher or lower rates than would usually be considered acceptable. Where there are outlying areas, these will be reported on by exception.
• The percentage of prone restraints with a duration of 3 minutes or less increased to 100% target during March.

Patient Safety Incident Response Framework (PSIRF)
As reported in the previous integrated performance report (IPR), NHS England launched the new Patient Safety Incident Response Framework on 16 August 2022. The transition work commenced in September 2022. We are in a 12 month transition period working towards going live in Autumn 2023. An internal stakeholder soft launch event was held on 7th October. The orientation phase of work concluded successfully at the end of November. We are progressing through various phases of work, including discussions with our integrated care board and provider collaborative colleagues, mapping our services, data analysis and improvement activity. Our intranet page has been updated with an overview of PSIRF https://swyt.sharepoint.com/sites/Intranet/Patientsafetystrategy/Pages/Patient-Safety-Incident-Response-Framework.aspx

Learn from Patient Safety Events (LFPSE)
As reported in the previous IPR, learn from patient safety events (LFPSE) will be a new national system that is being introduced to replace:
• National reporting and learning system (where we send our patient safety incidents)
• Strategic executive Information system (StEIS -where serious incidents are reported)
NHS England have recently extended the transition timescales as below:
A) By 31/03/2023 - to have our Datix test system updated with the LFPSE functions - Achieved
B) By 30/09/2023 - to go live with Datix LFPSE recording - this will be implemented following thorough testing of (A) above.
During March we have had a project manager working on our LFPSE arrangements. We will require a further upgrade to Datix in June/July to activate further system enhancements before promoting with staff.

Patient Safety Training
We have developed a proposal to seek agreement and funding for level 3 patient safety training to be essential to job role.
It sets out the national requirement for level 3 patient safety training (levels 1 and 2 are already agreed and underway in the Trust). This supports the NHS patient safety strategy and standards set out in the PSIRF.
The training will include:
a) investigation training for lead investigators
b) oversight of investigation training
c) Engagement and involvement of those affected by patient safety incidents
The paper has been agreed by the Education and Training governance group and will now be presented to our Executive Management Team.

Safety First

Summary of Incidents

Incidents may be subject to re-grading as more information becomes available

Incidents that occur within the Trust will have different levels of impact and severity of outcome. The Trust grades incidents in two ways.

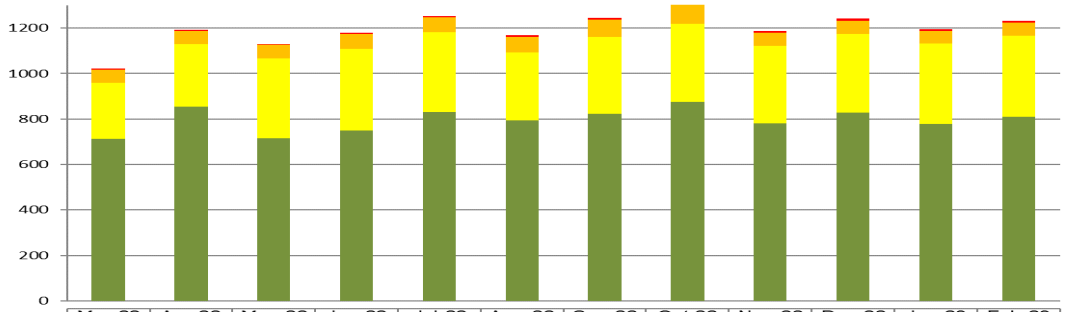
The 'Degree of Harm' is used by all Trusts to grade the actual level of harm to ensure consistency of recording nationally. When staff report incidents, they will complete the degree of harm to rate the actual harm caused by the incident. Where this is not yet known, they will rate this as what they expect the harm level to be. It will be reviewed and updated at a later point. This differs from the incident severity (green, yellow, amber, red), which is how we grade incidents locally in the Trust. Incident severity takes into account actual and potential harm caused and the likelihood of reoccurrence (based on the Trust's risk grading matrix).

A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety). There continues to be a positive reporting culture and triangulation of incidents with support from specialist advisors. Violence and aggression incidents remain significantly high and the Deputy Director of Operations for Forensics, Learning Disability and ADHD services and the Associate Director of Nursing, Quality and Professions have recently met with the Head of Safety and Resilience to ensure that Health and Safety and Clinical Safety concerns are managed safely and in a timely manner.

96% of incidents reported in March 2023 resulted in no harm or low harm or were not under the care of the Trust. This is based on the degree of actual harm.

Incident reporting levels have been checked using SPC and remain within the acceptable range, any areas with higher or lower rates than normal are explored further.

Reporting of deaths in line with the Learning from Healthcare Deaths policy has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances. All serious incidents are investigated using systems analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx



	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Red (should not be compared with SIs)	6	5	2	6	6	8	6	3	8	10	7	9
Amber	57	58	60	65	66	68	76	85	58	58	56	59
Yellow	245	274	351	358	350	299	339	345	341	347	354	355
Green	714	855	716	750	832	793	823	874	780	827	778	810
Total	1072	1022	1192	1129	1179	1254	1168	1244	1307	1187	1242	1195

Risk panel meets weekly and scans for themes that require further review or enquiry. The operational management group continues to receive a monthly report, the format and content is regularly reviewed.

No never events reported in March 2023

Safety First cont…

Summary of Patient Safety Incidents resulting in moderate or severe harm or death

This section relates to the patient safety incidents that resulted in a degree of harm of moderate harm, severe harm or patient safety related death. Please note this is different to severity as described above. Initial incident reporting is upwardly biased and staff are encouraged to report incidents and near misses. Once incidents are reviewed by managers and further information gathered and outcomes established, incident details such as severity, category and degree of harm can change, therefore figures may differ in each report. This is a constantly changing position within the live Datix system. Incident reporting levels have been checked and remain within the acceptable range, any areas with higher or lower rates than normal are explored further.

Breakdown of incidents in March 2023:

35 moderate harm incidents:
17 Pressure ulcer category 3 incidents
10 self harm incidents
3 Tissue viability
1 Vehicle incident
1 Sexual assault (in supported housing)
1 Slip, trip or fall - patient
1 Administration/supply of medication from a clinical area
1 Assessment, treatment and intervention issues

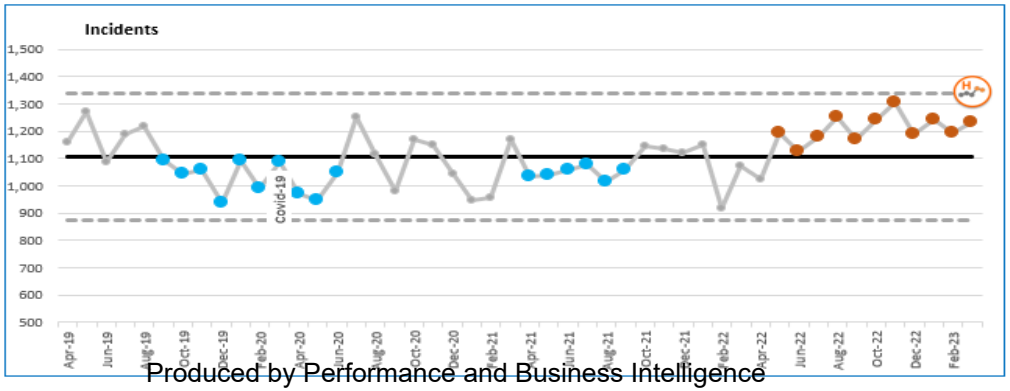
3 Severe harm incidents:
2 pressure ulcer category 4 incidents
1 Self harm (actual harm)

1 patient safety related deaths:
1 Suicide (including apparent)

Please note, the total number may decrease once the care group management teams have reviewed the incidents and confirmed the grading.

Mortality - No new updates.

Incidents



We remain in a period of special cause concerning variation, though it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting of incidents and near misses. An increase in reporting is a positive where the percentage of no/low harm incidents remains high as it does which is evidenced on the previous page. All incidents are reviewed by the care group management team and then by the Patient Safety Datix team to review the actual degree of harm to ensure consistency with national reporting. All Amber and Red incidents are monitored through the weekly Trust Clinical Risk Panel and all serious incidents are investigated using systems analysis techniques. Learning is shared via a number of routes; care group learning events following a Serious Incident, specialist advisor forums, quarterly trust wide learning events, briefing papers and the production of Situation Background Assessment Recommendation (SBARs).

Learning Library

The learning library has been developed as a way to gather and share examples of learning from experience.
Click the following link for further details of the examples which include information around sexual safety, learning from a serious incident/deaths, recording escapes and inappropriate use of 'toaster bags': https://swyt.sharepoint.com/sites/Intranet/learning-from-experiences/Pages/Learning-library.aspx

On 8 February 2023, a Trustwide learning forum was held to share learning between care groups and specialist advisors. The virtual event was very well attended and many positive examples of learning were shared. Presentations are available here https://swyt.sharepoint.com/sites/Intranet/learning-from-experiences/Pages/Learning-Events.aspx

Content, including presentations, is available on the intranet.

The next event is on Wednesday 3rd May 2023 at 2.30pm - 4pm. If you would like to attend or share your learning from experience, please email learninglibrary@swyt.nhs.uk.

Bluelight alerts

March 2023

SBAR Adrenaline accidently injected when training.docx

February 2023

SBAR Under 18 Pregnancy Safeguarding Proforma.docx

SBAR Childrens Therapy Jan 2023.docx

SBAR Learning from inpatient ligature death SI 2021.24159.docx

SBAR Safer Discharge From Hospital Final Version.docx

January 2023

SBAR Learning Review involving deaths where Clozapine is prescribed.docx

Patient Safety Alerts

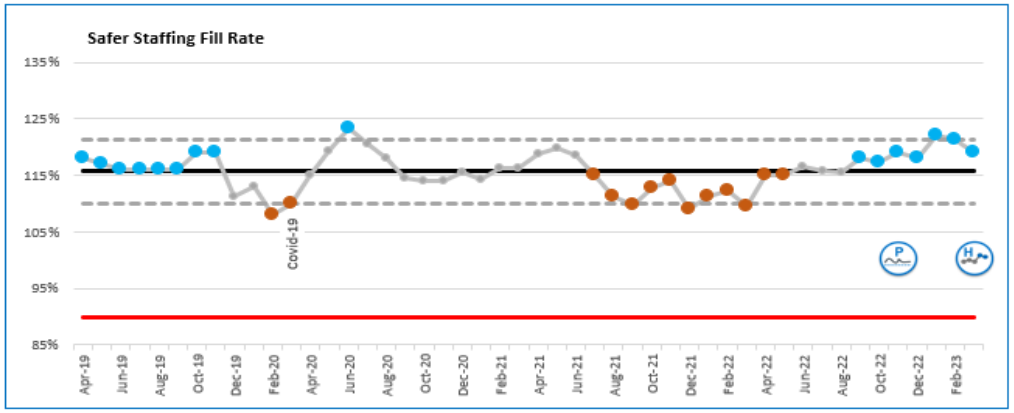
Patient safety alerts issued in March 2023

Alerts are issued by the Central Alerting System (CAS) which is a national web-based cascading system for issuing patient safety alerts. Once received into the Trust, patient safety alerts are fully reviewed for understanding and action, sent to identified Trust clinical leads for reviewing safety alerts for a decision regarding whether it is applicable to the Trust or not, and if so, if it should be circulated. All alerts are entered on to Datix. Information is reported into the Medical Device and Safety Alert group on a monthly basis.

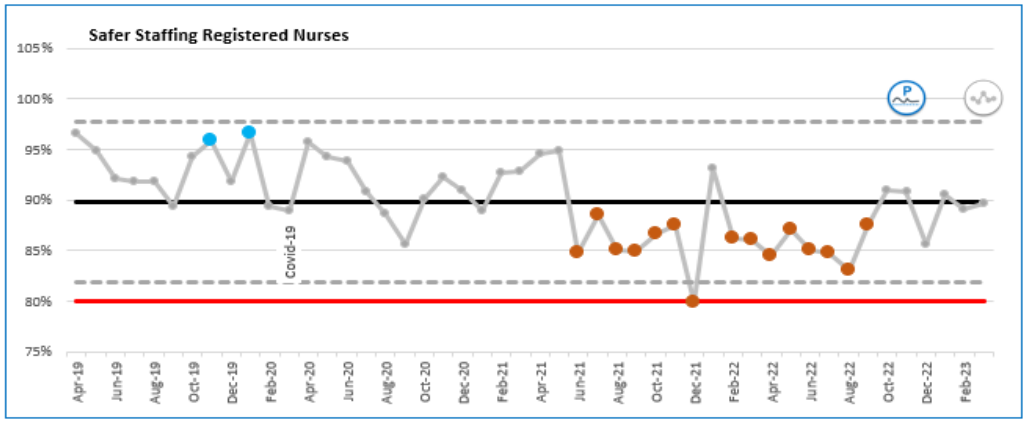
Patient safety alerts not completed by deadline of March 2023 - none.

Reference	Title	Date issued by agency	Alert applicable	Trust final response deadline	Alert closed on CAS
CHT/2023/002	Management of National Patient Safety Alerts	22/03/2023	Yes - circulated for information	11/04/2023	04/04/2023

Safer Staffing Inpatients



The chart above shows that the staffing fill rate has had a number of periods of special cause concerning variation (orange markers) particularly since the outbreak of Covid-19, though performance has remained consistently above the target. As at March 2023 we remain in a period of special cause improving variation.



The chart above shows that the staffing rate for registered nurses has also has had a number of periods of special cause concerning variation (orange markers), particularly since the outbreak of Covid-19. In March 2023 we have entered a period of common cause variation. Further information about staffing levels can be found on the previous page.

March has seen a greater demand placed on the flexible staffing resource than in the previous month. This has been for a number of reasons including; ongoing increased acuity on the inpatient areas, substantive staff utilising their annual leave prior to the year end, ongoing sickness and vacancies. There continues to be fluctuations within most wards with an overall decrease in the total fill rate. We continue to monitor staffing related Datix and hotspots and trend analysis of staffing deficits where possible.

Bespoke adverts and centralised recruitment continues, there are four assessment centers planned throughout April for both substantive and bank staff at band 5 and band 2 (over 200 candidates invited) as well as online interviews for direct applicants from overseas. Band 5 Registered Nurse (RN) field continues with bespoke adverts as well as our international recruitment (IR). To date we have had 54 IR band 5 nurses with 52 being on the wards throughout the Trust, including on the neurological rehabilitation unit. We have had a bid for financial support from NHS England through the first three quarters of the new financial year accepted and hope to realise another 40 candidates before December 2023. We have also attended an in-country recruitment drive which resulted in 102 job offers including 12 registered general nurses for the community, as well as establishing links with nursing and doctor's unions and universities. Based on historical patterns we would expect to convert around 70 of these offers into new starters.

Escalation and continuity plans are utilised to ensure the delivery of safe and effective care, and these are supported by the flexible staffing resource. We continue to monitor the hours that staff do, and any working time directive breeches, to support staff wellbeing.

The Trust has established an agency scrutiny group to look at our agency usage and plan for a reduction of requirement through innovation of sourcing our own staff, reducing processes of staff transferring from agency onto our bank or substantive workforce. There will be a second group which will be looking at actual usage and reasons for this to ensure that we have robust processes in place monitoring agency usage.

The continued roll out of SafeCare and moving all teams onto the health roster system have been progressing with engagement events and resource sourcing.

Safer Staffing Inpatients cont…

Although there has been an overall improvement, we continue to fall short of the registered nurse fill rate for day shift and will continue to look at ways of improving this. The overall fill rate describes the acuity on inpatient areas when looked at in conjunction with the unfilled shifts. Teams continue to deliver a high quality of care, and maintain safe services however staffing has impacted on section 17 leave being taken at times as well as other interventions being delayed. We look at various fill rates in the report which gives a definitive picture of staffing compared to our establishment template – the number of staff that are budgeted for - however this must not be looked at in isolation as it is not a true reflection of the requirement of the teams. This is what is meant by capacity (budgeted staffing numbers) v demand (acuity and requirement).

One ward, for the second month, fell below the 90% overall fill rate threshold which was Enfield Down in Kirklees. Inpatient areas continue to experience increased pressure as identified above. There are ongoing interventions, projects and support in place when a ward has been identified as having ongoing and sustained staffing issues to improve the situation. There were 26 (83.2%) of the 31 inpatient areas who achieved 100% or more overall fill rate. Of those 26 wards, 10 achieved greater than 120% fill rate. The main reason for this being cited as increased acuity, observation, and external escorts. Although safe and effective staffing remains a priority in all our teams as well as the systems wide increase of acuity, the focus for the flexible staffing resources has been Wakefield services and the Oakwell Centre in Barnsley. There have been supportive measures put in place including increased block booking, placing bespoke recruitment adverts, and ensuring that additional resources are placed at their disposal.

Registered Nurses Days: Overall registered day fill rates have increased by 2.5% to 83.4% in March compared with the previous month.
Registered Nurses Nights: Overall registered night fill rates have decreased by 1.4% in March to 96.0% compared with the previous month.
Overall Registered Rate: 89.7% (increased by 0.6% on the previous month)
Overall Fill Rate: 119.3% (decreased by 2.3% on the previous month). Health care assistants showed a decrease in the day fill rate of 6.0% to 135.0% and the night fill rate decreased by 3.3% to 152.5%.

Unfilled shifts
An unfilled shift is a shift that has been requested from the bank office, flexible staffing, and could not be covered by bank staff, agency or overtime. Although not exclusive, there are two main reasons for the creation of these shifts, and they are:
1 - Shifts that are vacant through short or long-term sickness, annual leave, vacancies, or other reasons that impact on the duty rosters.
2 - Acuity and demand of the service users within our services including levels of observation and safety concerns.

Unfilled Shifts				**Filled Shifts**
Categories	No. of Shifts	Total Hours	Unfill Percentage	
Registered	536 (+79)	5,771.83	37.89% (+1.50%)	894 (+92)
Unregistered	630 (+121)	7,059.50	12.84% (+1.55%)	4,215 (+324)
Grand Total	1166 (+200)	12,831.33	18.28% (+1.72%)	

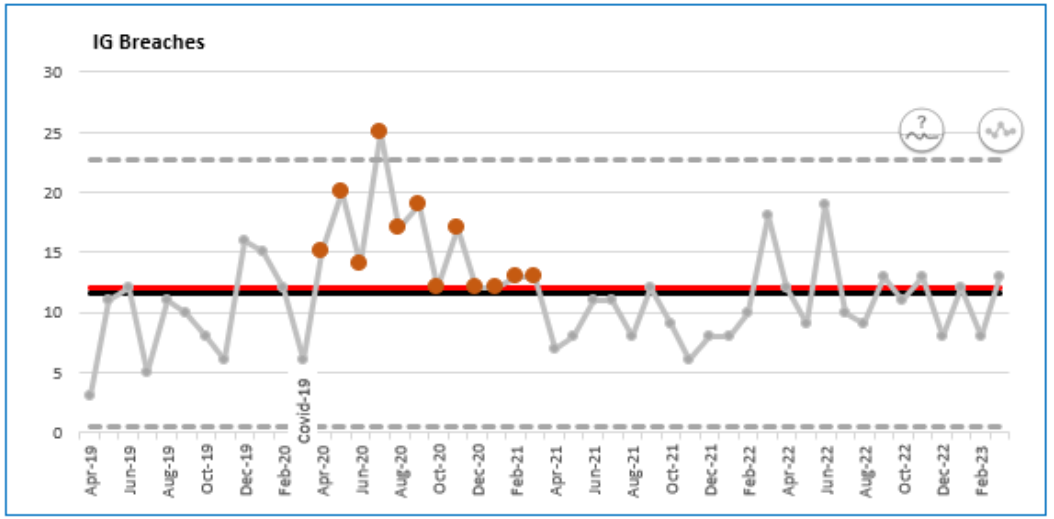
We are continuing to target areas where vacancies are within our recruitment campaigns. Block booking and prioritisation within bank booking varies on a daily/weekly basis dependent on acuity and clinical need.

Information Governance (IG)

13 personal data breaches were reported during March, continuing the trend of fluctuating low and high monthly numbers during the current financial year (common cause variation). An improvement plan has been implemented to reduce the higher numbers of incidents, which includes training, communications and some data quality actions.

7 breaches involved information being disclosed in error. They were largely due to information being shared with the wrong recipient. Security breaches occurred when a PC was left unlocked in a public area, an email with a sensitive document attached was sent externally without password protection and three separate paper documents were lost. A further breach occurred when an employee accessed an inappropriate record on the system.

The Trust does not currently have any open cases with the Information Commissioner's Office.



This SPC chart shows that as at March 2023 we remain in a period of common cause variation.

Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes are in place for 2022/23 contracts. These mainly relate to the Trust's contracts with our place-based commissioners in each integrated care system (ICS). The overall financial value of CQUIN is 1.25% of total contract value.

Performance for the first three quarters has been achieved against all metrics with the exception of:

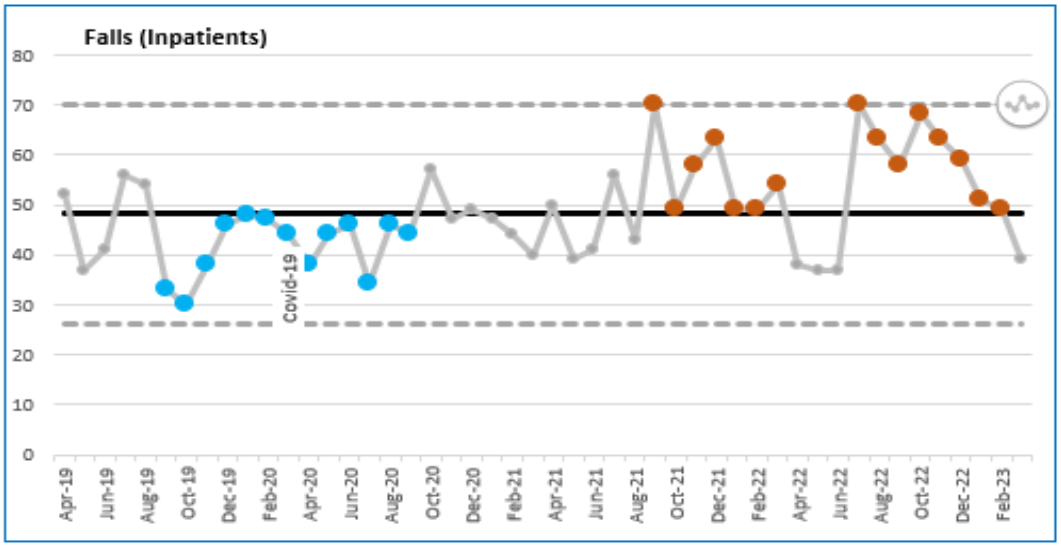
- Assessment and diagnosis of lower leg wounds (Barnsley contract only) and
- Routine outcome monitoring in children and young people and perinatal mental health services.

Partial achievement has been met for these indicators although improvements have been evidenced in quarter three compared to quarter two, this is expected to continue into quarter 4 and therefore some risk in full achievement remains.

Non achievement for Flu vaccinations for frontline healthcare worker is anticipated and the final figure will be reported in the quarter 4 submission which is due at the end of May 23.

Falls (Inpatient)

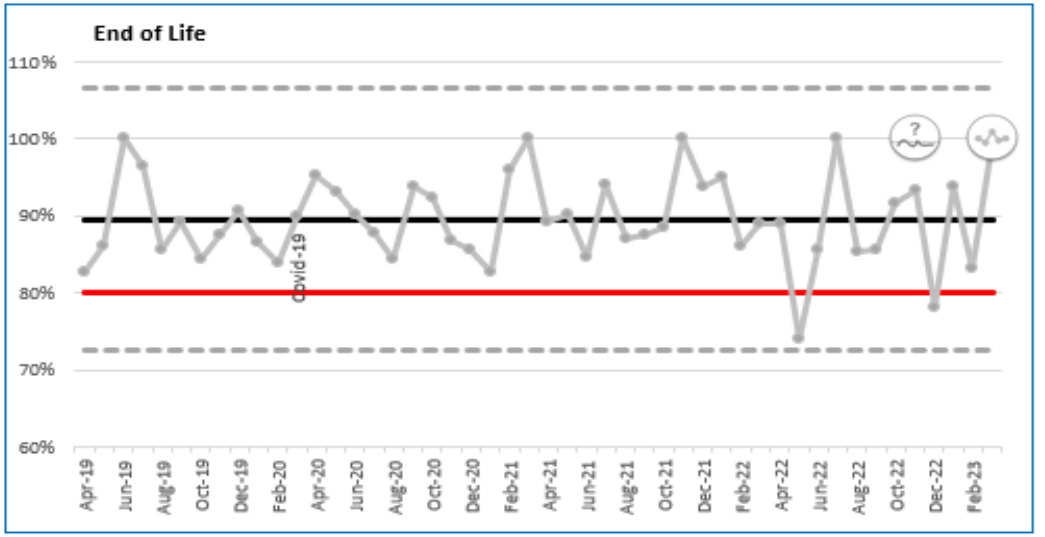
The total number of falls was 39 in March, which is a decrease from the previous month.
A new falls coordinator commenced in February 2023, part of the role is to advise, review and support the clinical teams / staff through education, policy, awareness raising, environmental reviews that may contribute to falls. This will increase staff confidence and will enhance the falls reduction work.



The SPC chart above shows that in March 2023, due to the continued decrease in the number of falls, we have entered a period of common cause variation. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

End of Life

The total percentage of people dying in a place of their choosing was 100% in March.



The chart above shows that in March 2023 the performance against the metric remains in common cause variation and therefore within an acceptable range.

Patient Experience

Friends and family test shows

- 97% would recommend community services
- 83% would recommend mental health services

Mental Health Friends and Family Test Results				
	Target	Jan-23	Feb-23	Mar-23
Community Services	85%	83%	85%	85%
Acute	85%	88%	100%	86%
Secure & Forensics	60%	100%	80%	71%
Other*	85%	84%	92%	93%
Total	**85%**	**82%**	**85%**	**83%**

Specialist Services Friends and Family Test Results				
	Target	Jan-23	Feb-23	Mar-23
ADHD	85%	42%	78%	50%
CAMHS	75%	74%	70%	83%
Learning Disability	85%	88%	91%	100%

Community Services Friends and Family Test Results				
	Target	Jan-23	Feb-23	Mar-23
Children & Families	95%	100%	94%	98%
Inpatient	95%			100%
Nursing	95%	100%	100%	91%
Other	95%		100%	91%
Rehabilitation & Therapy	95%	93%	95%	98%
Specialist**	95%		95%	94%
Total	**95%**	**93%**	**95%**	**97%**

*includes Insight team, perinatal, friends and family team
**includes equipment and adaptation service, neuro physiotherapy, podiatry

Patient Experience

There has been an overall improvement in friends and family test results for community services in March and a slight reduction in results for mental health services. A lot of work is underway to improve access, this includes the use of 'CHATPADS' which make it easy for service user to provide real-time feedback. Any results which suggest improvements are needed in services are feedback to the services and support provided by the patient experience team to improve care in that area.

The results for Attention deficit hyperactivity disorder (ADHD) services are from 10 responses received. There is a project group in place and the service are working with the engagement team to review how to encourage further feedback from service users. The team are establishing a service user group to identify how service users wish to give feedback.

	Top three positive themes	Top three negative themes
Trustwide	1. Staff	1. Staff
	2. Communication	2. Clinical treatment
	3. Patient Care	3. Admission and discharge
Community	1. Staff	1. Admission and discharge
	2. Communication	2. Clinical treatment
	3. Access and waiting times	3. Staff
Mental Health	1. Staff	1. Staff
	2. Communication	2. Clinical treatment
	3. Patient Care	3. Communication

The themes from Friends and Family Test feedback are in the table to the left.

Themes can be both positive and negative in nature.

Safeguarding

The complex cases discussed through safeguarding advice and supervision are considered by the team, along with the teams continued professional development to ensure that the mandatory training packages and the production of Situation, Background, Assessment, Recommendation (SBAR's) are of high quality to ensure that staff are well informed and knowledgeable.

Safeguarding Adults:
In March 2023 there were 40 Datix reported which were categorised as Safeguarding Adults. There were no Datix graded as red, seven were graded as amber, 11 were graded as yellow and 22 were graded as green. The two most common categories of Safeguarding Adult incidents were sexual abuse and physical abuse.

From the seven amber incidents all reasonable actions were taken dependent on and relevant to the issues raised e.g. Domestic Abuse Stalking Harassment and Honour based violence form (DASHH) and Multi Agency Risk Assessment Conference (MARAC) referral completed and a referral was made to the Person in Position of Trust (PiPoT) Lead in the local authority.

Safeguarding Children:
In March 2023 there were 23 reported safeguarding children's incidents. There were no Datix graded as red, two were graded as amber, eight were graded as yellow and thirteen of these were green. The most common was physical violence, followed by sexual abuse and request for services. In most cases advice and support was requested from the Trust safeguarding team and in all cases appropriate actions were taken.

Infection Prevention Control (IPC)

• Surveillance: There has been zero cases of E.coli bacteraemia, C difficile, Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia and Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia.
• Mandatory training figures are healthy:
  Hand Hygiene -Trust wide Total – 91%
  Infection Prevention and Control - Trustwide Total – 90%
• Policies and procedures, 12 month extension request for policies that are for review in 2023, this is to accommodate implementation of the National IPC Manual.

Complaints

The Customer Service improvement programme is supporting the team and the Trust in reducing the waiting time associated with providing a response to a complaint. As such we have started to see a reduction in the number of complaints which are waiting to be allocated to a case handler and investigated and a response being provided to the complainant. This will be reflected within the data provided for April.

- There were no complaints in March which were attributed to staff attitude and this reflects a positive and patient-centred culture within our services.
- Acknowledgement and receipt of the complaint within three working days – 100% for formal complaints.
- Number of responses provided within six months of the date a complaint received – 4 out of 14 (29%)
- Number of complaints waiting to be allocated to a customer service officer – 46
- Number of cases who breach the six months target who have not had a conversation to agree a new timeframe for completion 0% – all complainants are updated and have either received the monthly delay/update letter apologising for the delay (for those waiting to be allocated to a case handler), or for those allocated a case handler are updated regarding the progression of their complaint throughout the complaint process/journey.
- Longest waiting complainant to be allocated to a customer service officer – 22 weeks average. Three recently allocated cases have not been in date order due to higher priority to resolve.
- There were 21 new formal complaints in March 2023
- Of these 8 were closed due to no contact/consent, 4 are awaiting consent, 9 are awaiting allocation.
- 0% of new formal complaints (n=0) have staff attitude as a primary subject.
- 26 compliments were received.
- Customer services closed 14 formal complaints in March 2023, as well as 2 reopened complaints.
- Number of concerns (informal issues) raised and closed in March 2023 – 55
- Number of enquiries responded to in March 2023 - 113

Reducing Restrictive Physical Intervention (RRPI)

There were 203 reported incidents of restrictive physical interventions used in March 2023 this is a reduction of 20 (8.96 %) incidents from February 2023 which stood at 223 incidents.

100% of prone restraints in March 2023 lasted under 3 minutes, see SPC chart below for further information. The measure for monitoring prone restraints under and over 3 minutes is from guidance used by the police and prison service. This was adopted by the Trust and has been reported on for some time. The RRPI team are currently undertaking a review of the current evidence around this figure as within mental health services it may not be relevant to record in this way.

In March 2023 prone restraint (those remaining in prone position and not rolled immediately) was reported 26 times of 333 (7.8%) of total restraint positions, this is a slight increase on last month which stood at 23 of 385 (5.9%). Overall these are in line with usual monthly figures, which fluctuate and do not show a consistent increase or decrease.

Minimising the time a person is in a prone restraint is important to minimise the risk of harm to that person. Therefore, monitoring time in prone restraint can help identify when improvements are needed to support teams with restraint interventions. There has been a notable increase in reported RRPI incidents over the winter period (November to February). This is in line with normal variation although further exploration of this will be undertaken to better understand if there are underlying root causes for this. Horizon has reported the highest number of incidents. Again, this is line with normal data and represents the acuity and complexity of the current in-patient population. There has also been an increase in incidents within older people's services, again representative of the acuity of the patient group at the present time. The use of seclusion reduced slightly in February.

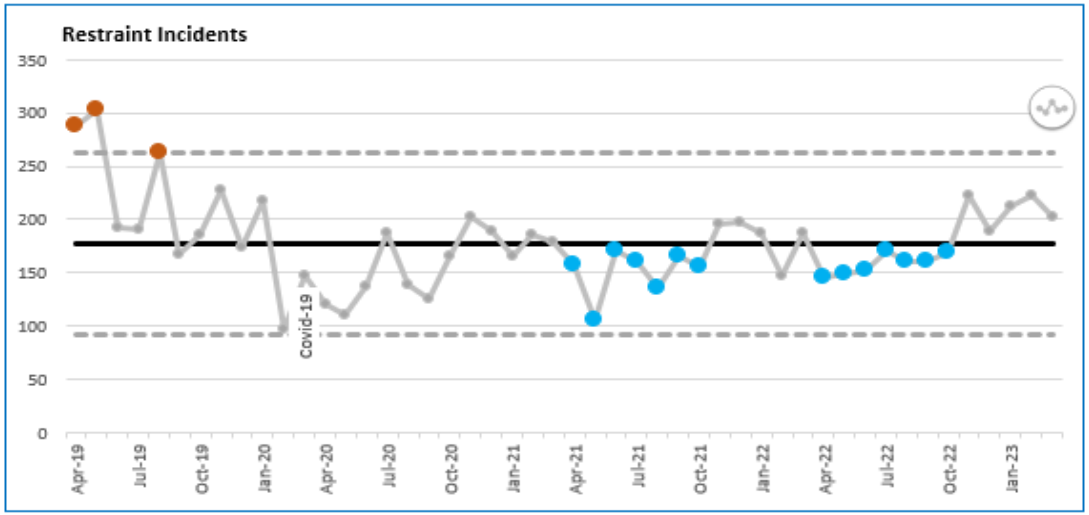
The data demonstrates that training around RRPI supports our services to appropriately manage difficult situations. The RRPI team constantly monitor Datix incidents and provide specialist advice and additional training where needed to team and services. Anything reported which is out of the ordinary is acted on immediately with appropriate escalation.

Restraint Position Used	Number of restraint Positions Used	Percentage of the Type of Restraint Position Used of Total
Standing	116	34.8%
Safety Pod	54	16.2%
Seated	44	13.2%
Supine	32	9.6%
Prone	26	7.8%
Restricted escort	25	7.5%
Side	17	5.1%
Prone then rolled	13	3.9%
Kneeling	6	1.8%

Team Utilising Prone Restraint	Total
Horizon Centre Assessment and Treatment Service	8
Newhaven Forensic Learning Disabilities Unit	4
Walton PICU	4
Beamshaw Ward - Barnsley	3
Stanley Ward, Wakefield	2
136 Suite - Unity Centre, Wakefield	1
Bronte Ward, Newton Lodge, Forensic	1
Elmdale Ward	1
Nostell Ward, Wakefield	1
Ward 18, Priestley Unit	1

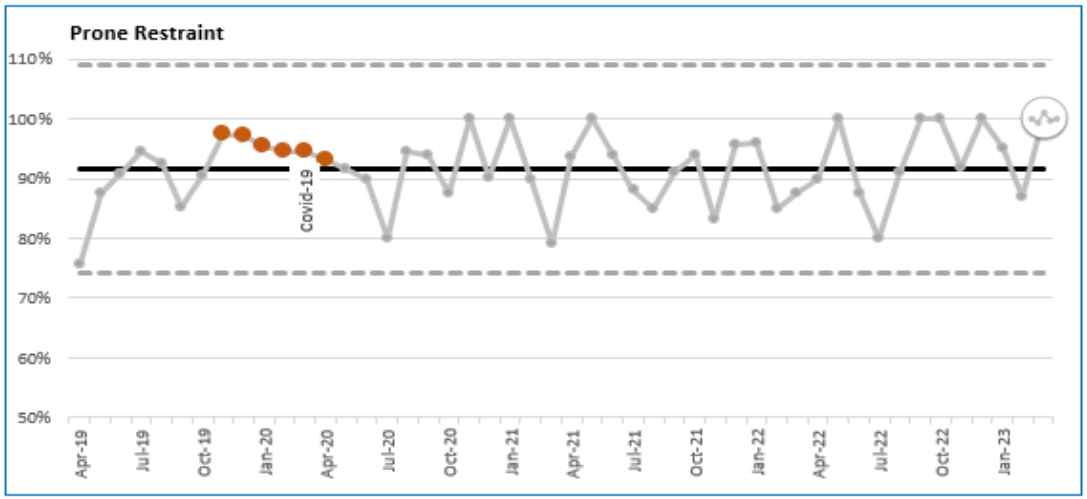
Duration of Prone Restraint	Total
0 - 1 minute	16
1 - 2 minutes	10

Reducing Restrictive Physical Intervention (RRPI)



This SPC chart shows that after a recent period of special cause improving variation (blue markers), in March 2023 we remain in a period of common cause variation.

The chart is based on the assumption that an increase in restraint incidents indicates a deterioration in performance however, as described above this is not always the case.



This SPC chart shows that there was a period of special cause concerning variation in late 2019 and early 2020 (orange markers).

The continued variation in prone restraint incidents in March 2023 means that we are now in a period of common cause variation.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Establishment (ledger excluding vacancy factor)	Improving Resources	Well Led	-	4,918.4	4,891.7	4,960.2	4,933.5	5,011.2	5,039.4	5,145.9	5,156.5	5,197.9	5,237.9	5,246.6	5,267.2	
Employed Staff (ESR last day in the month)			-	4,088.2	4,107.2	4,136.2	4,134.6	4,130.2	4,169.2	4,174.6	4,169.9	4,173.4	4,186.0	4,229.7	4,241.0	
Vacancies			-	750.9	720.8	756.2	723.1	795.3	816.5	881.8	895.2	942.0	936.8	944.8	926.9	
Vacancy rate			<10%	15.3%	14.7%	15.2%	14.7%	15.9%	16.2%	17.1%	17.4%	18.1%	17.9%	18.0%	17.6%	↔
Turnover external (12 month rolling)			>10 - <12	15.5%	15.4%	15.4%	15.5%	15.2%	14.8%	14.4%	14.4%	14.2%	14.3%	13.7%	13.5%	↔
Starters			-	45.8	54.0	56.5	46.4	58.1	69.5	56.9	50.5	26.6	65.4	70.2	58.1	
Leavers			-	59.7	39.6	37.0	56.9	56.3	51.6	48.2	40.6	27.5	60.1	38.5	43.1	
Sickness absence - Year-to-date			<=4.4%	4.6%	4.6%	4.6%	4.9%	4.8%	4.9%	5.0%	5.1%	5.3%	5.3%	5.2%	5.3%	↔
Sickness absence - Month			<=4.4%	4.6%	4.5%	4.8%	5.5%	4.7%	4.8%	5.7%	5.9%	6.3%	5.3%	5.3%	5.1%	↔
Employees with long term sickness over 12 months			<=25%	-	-	-	-	0	2	2	2	2	4	2	2	
Appraisals - rolling 12 months			>=90%	-	-	59.7%	55.8%	61.3%	57.3%	56.0%	60.7%	62.9%	69.8%	71.5%	71.8%	↔
Employee Relations - Suspensions (over 90 days)				0	0	1	1	2	2	2	2	3	3	1	1	
Mandatory Training - TOTAL	Improving Care		>=80%	86.8%	86.2%	86.9%	87.2%	90.7%	89.8%	89.5%	89.5%	89.2%	89.4%	90.1%	90.2%	↔
Mandatory Training - Reducing Restrictive Practice Interventions				75.5%	73.7%	73.6%	73.8%	73.8%	72.0%	70.3%	68.4%	66.4%	71.9%	74.5%	74.6%	↔
Mandatory Training - Cardiopulmonary Resuscitation				73.4%	74.4%	74.2%	74.6%	75.7%	75.0%	72.5%	72.1%	72.0%	73.0%	75.1%	75.0%	↔
Mandatory Training - Clinical Risk				95.9%	95.6%	96.2%	96.2%	96.4%	96.6%	96.3%	96.2%	96.0%	95.7%	94.9%	95.9%	↔
Mandatory Training - Display Screen Equipment				92.9%	92.8%	93.9%	94.3%	94.9%	95.5%	95.1%	95.4%	95.8%	96.0%	96.3%	96.4%	↔
Mandatory Training - Equality & Diversity				94.3%	94.0%	93.9%	94.1%	93.9%	94.3%	93.8%	94.2%	94.1%	94.6%	95.1%	95.8%	↔
Mandatory Training - Fire Safety				90.3%	88.6%	87.1%	87.4%	87.1%	86.4%	87.3%	87.7%	87.5%	88.3%	88.4%	89.4%	↔
Mandatory Training - Food Safety				77.9%	76.6%	79.4%	79.3%	79.8%	79.2%	78.6%	79.9%	79.5%	79.6%	79.8%	79.4%	↔
Mandatory Training - Freedom To Speak Up (FTSU)				84.9%	84.4%	85.5%	86.8%	88.2%	89.8%	90.5%	91.3%	91.7%	92.0%	92.4%	92.5%	↔
Mandatory Training - Infection Control & Hand Hygiene				89.5%	87.3%	87.0%	87.3%	87.7%	88.2%	88.4%	88.6%	88.4%	88.4%	88.6%	90.2%	↔
Mandatory Training - Information Governance (Data Security)			>=95%	92.4%	93.1%	92.9%	92.9%	92.5%	92.2%	91.2%	89.8%	87.6%	87.3%	84.8%	86.5%	↔
Mandatory Training - Moving & Handling			>=80%	96.3%	95.5%	95.6%	95.7%	95.3%	95.2%	95.3%	95.8%	95.6%	93.0%	93.4%	95.5%	↔
Mandatory Training - Nat Early Warning Score 2 (New S2)				80.6%	81.3%	82.6%	84.3%	85.6%	86.3%	87.4%	88.1%	89.6%	91.1%	92.0%	92.4%	↔
Mandatory Training - Mental Capacity Act/Dols				93.2%	92.5%	93.4%	93.3%	93.5%	93.8%	93.5%	93.4%	93.3%	95.6%	95.3%	94.0%	↔
Mandatory Training - Mental Health Act				89.6%	88.5%	89.4%	89.5%	90.4%	90.9%	90.7%	91.0%	91.2%	90.4%	91.6%	92.2%	↔
Mandatory Training - Prevent				94.1%	93.9%	94.4%	94.6%	95.1%	95.3%	95.0%	94.6%	94.4%	94.7%	95.2%	95.6%	↔
Mandatory Training - Safeguarding Adults				89.1%	88.2%	88.8%	89.1%	89.7%	89.5%	89.4%	89.5%	89.0%	89.1%	89.9%	90.0%	↔
Mandatory Training - Safeguarding Children				90.3%	89.9%	89.9%	89.9%	89.7%	90.2%	88.7%	88.9%	88.6%	88.8%	89.3%	89.8%	↔

Notes:

• Employed Staff (Electonic Staff Record - (ESR) last day in the month) - Employed staff in post are staff on temporary or permanent contracts within ESR. This does not include staff on secondments or other recharges such as local authority staff and junior doctors.

• The figures reported here differ to the figures included in the finance appendix 'WTE (whole time equivalent) worked' as this reflects contracted employment and therefore does not include overtime, additional hours worked or agency.

• Starters/Leavers - variation in alignment to establishment exists due to a number of factors such as, data taken as a snapshot so will not reflect any changes made on the system after the extraction date as well as changes in contractual hours that cannot be retrospectively applied.

• Turnover - Quarterly reports from feedback of leavers are being appraised in the Trusts operational management group with reporting and actions from quarterly reports to care groups.

• Response rates from leavers giving feedback up to 53% over the last 12 months.

• Employed staff - There has been an increase of 152.8 whole time equivalent staff employed by the Trust since April 22. We are seeing much higher conversion rates of staff moving from bank contracts to substantive than previous years (74.1 WTE since April). We are also seeing much higher health care support worker appointments via our assessment centres and this driving higher starters numbers.

International nurse recruitment

• International nurse recruitment joining our inpatient areas with 6 starting in March totalling 42 this financial year (April to March). This is above the target of 40. Our project pipeline for 23/24 is estimating this number will increase to over 100 in general and mental health nursing.

• We have a total of 54 international nurses in the Trust. 52 are now allocated and working in wards. We also have 35 nurses still in recruitment process from direct recruitment/agency feed.

Additional metrics to highlight response to and impact of Covid-19

KPI	Target	As at 23rd August 2022	As at 20th September 2022	As at 20th October 2022	As at 18th November 2022	As at 19th December 2022	As at 25th January 2023	As at 20th February 2023	As at 21st March 2023	As at 17th April 2023	Trend
No of staff off sick - Covid-19 not working	N/A	23	23	53	20	29	9	20	17	21	
No of staff working from home - Covid-19 related		10	9	14	6	16	8	10	16	4	

Stability of the Workforce

• Substantive staff in post has risen by 0.2% (11.3 whole time equivalents (WTE)) in March and 3.6% (152.8 WTE) since April 2022.
• Last year we had 561.3 new starters compared to 658.0 (10% increase) this year and conversely 612.8 leavers last year compared to 559 this year, demonstrating an improvement in recruitment and also retention of existing staff.
• Vacancies have decreased by 17.9 WTE within month to 926.9 WTE currently open vacancies, establishment has decreased by 20.6 WTE within month, totalling 5267.2 overall. Establishment increase is due to the monthly phasing in funding from new developments.
• Rolling and year to date (YTD) turnover is 13.5% this is better than our projected rate of 13.7% for the end of year. When compared to the latest figures published by NHS England on digital.nhs.uk (Dec 2022) the Trust turnover rate is the lowest against the Trusts of our type for both integrated care systems.

Keep Fit & Well

Absence

• Year to date absence rate is 5.3%, in month decreased by 0.2% to 5.1%.
• Cold and flu numbers continue to reduce, by 1.8% to 4.4% in March. However, Covid-19 has increased again by 1.9% to 9.7%
• Forensics absence continues to decrease this month by 1.1% to 6.8% YTD. Forensic absence has reduced because of focused support with managers on long term sickness, thus resulting in returns to work.
• Estates and facilities absence has reduced from 8.2% to 6.4% YTD after a renewed focus on sickness meetings, monthly reports to individual managers and increased people directorate support. In month sickness dropped by 0.6% to 5.2%.
• Stress related absences still account for the largest absence reason increasing by 1.0% in month to 34.6% YTD.
• Sickness absence benchmarking data from December 2022 shows the Trusts sickness levels to be one of the lowest out of a group of 7 local peer organisations with the highest level being reported as 7.2% and lowest at 5.3%.

Supportive Teams

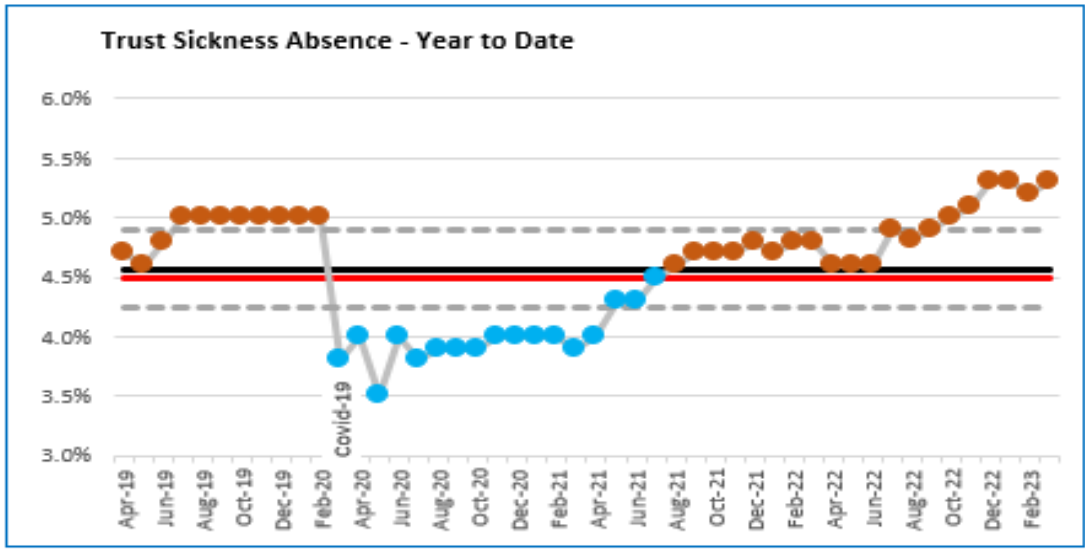
Appraisals

• The rolling appraisal compliance rate for March increased again to 71.8%, with the interventions taken starting to show an improving trend.
• Compliance and appraisals due are monitored and reviewed at least monthly at team level.
• The Trust has benchmarked itself against local peers and out of 5 Trusts, the Trust has the second highest rate of appraisal compliance. The highest being 84.4% and lowest being 59.2%.

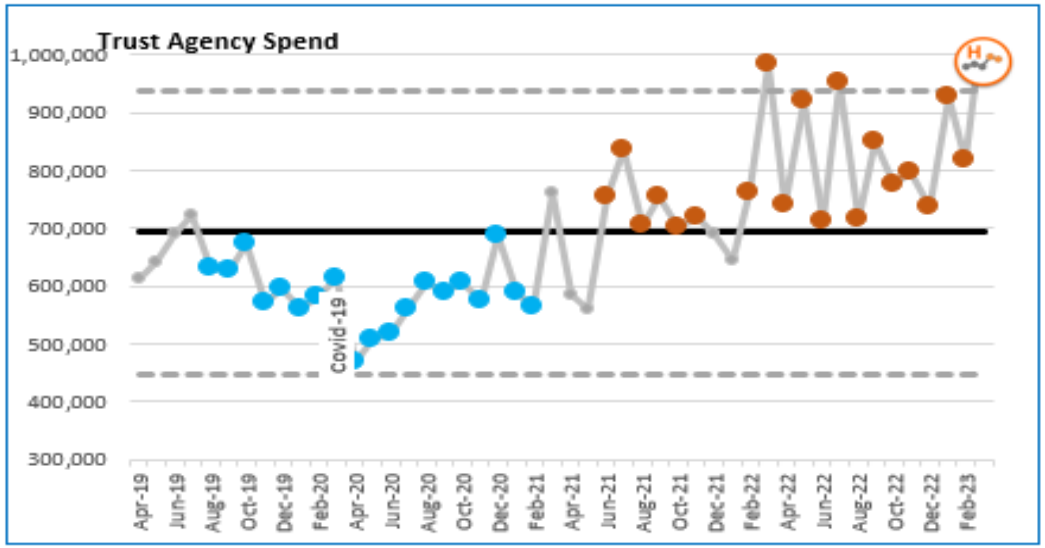
Mandatory Training

• Overall mandatory training reports 90.0% which is above Trust target. Compliance by care group is reported monthly to the executive management team with hot spot reports reviewed by the operational management group.
• Four subjects out seventeen reported are below the Trust target - these are resuscitation, food safety, information governance (IG) and reducing restrictive physical interventions (RRPI). Actions being taken to address these areas include use of third-party providers to increase capacity to deliver, introduction of an e-learning suite to increase accessibility and reduce the need for face-to-face training and project plan being delivered in close partnership with the Nursing, Quality & Professions directorate. Regarding IG training, the IG manager is going out to teams to provide face to face training. Managers are receiving weekly lists of non-compliant staff. Progress is being monitored at operational management group and executive management team.
• A continued focus on driving compliance for local induction had resulted in an increase however following the increase in new starters over the last two months this number dipped by 1.9% to 77.2%. As the recording form isn't returned until up to 4 weeks after starting we will follow up to ensure that local inductions are recorded.

Analysis



The chart above shows that as at March 2023 we remain in a period of special cause concerning variation (orange markers). From July 2022 this also includes absence due to Covid-19.



The chart above shows that in March 2023 we remain in a period of special cause concerning variation (orange markers). This is being monitored in workforce/finance. Actions being taken include:

- the re-introduction of agency scrutiny group who are leading on agency spend reduction plan to meet 23-24 agency cap (£7.8m) – Targeting reduction of high cost individual long term areas of agency spend with bespoke plans to reduce (medical roles).
- Alternative marketing campaigns to engage wider markets.
- Review of admin agency usage toward zero tolerance.
- Significant increase in assessment centre recruitment events – 4 in April (usually 1 per month) over 200 potential candidates into bank and substantive healthcare support worker and nurse posts. This will have a positive impact upon agency provision in future months.

MEDICAL APPRAISALS	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Number expected to be undertaken in period	31	24	43	37
Number undertaken in period	29	22	41	34
Number not undertaken for which the RO accepts postponement is reasonable	2	2	1	1
Percentage of appraisals taken place	94%	94%	95%	92%
Percentage of appraisals signed off in period as satisfactory	94%	94%	95%	92%

MEDICAL REVALIDATIONS	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Number of revalidation recommendations due in period	5	5	1	8
Number of positive recommendations	5	5	1	8
Number of deferrals	0	0	0	0
Number of non-engagements	0	0	0	0
Percentage of revalidation recommendations made	100%	100%	100%	100%

RESPONDING TO CONCERNS	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Number of active cases under Maintaining High Professional Standards procedures	0	0	0	0

This section of the report outlines the Trust's performance against a number of national metrics relating to operational performance.

• The NHS Oversight Framework - From 1 July 2022 integrated care boards (ICBs) have been established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their integrated care system (ICS). NHS England will work with ICBs as they take on their new responsibilities, the ambition being to empower local health and care leaders to build strong and effective systems for their communities. 2022/23 will be a year of transition as Integrated Care Boards ICBs are formally established and new collaborative arrangements are developed at system level. Over the course of 2022/23 NHS England will consult on a long-term model of proportionate and effective oversight of system-led care. The oversight framework has been updated for 22/23. It aligns to the priorities set out in the 2022/23 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of ICBs and the merging of NHS Improvement (comprising Monitor and the NHS Trust Development Authority) into NHS England. Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs. ICBs will lead the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate.
•This table only includes operational metrics, there are a number of other workforce and quality metrics that are reported in the relevant section of the IPR.
• NHS Long Term Plan - the Trust fed a number of operational/data lines into the ICS planning programme with associate trajectories. Performance against those metrics will be reported at Trust level in the below dashboard and will be monitored by place in appropriate business delivery performance monitoring.
• NHS Standard Contract against which the Trust is monitored by its commissioners. The below table has been updated to reflect metrics included in the contracts for 22/23. In addition to the national metrics, there are a number of local metrics within each contract that is monitored within the appropriate care group/service. Metrics from these categories may already exist in other sections of the report.

National Metrics - NHSEI systems oversight framework, NHS long term plan, NHS standard contract

KPI	Objective	CQC Domain	Owner	Source	Target	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Data quality rating [8]	Variation/ Assurance
The number of incomplete Referral to Treatment (RTT) pathways of 52 weeks or more at the end of the reporting period.	Improving Care	Responsive	CH	SC	0	0	0	0	0	0	0	0	0	0	0		
Inappropriate out of area bed days	Improving Care	Responsive	CH	SOF/LTP		1245	874	1359	1504	437	483	439	482	511	511		
Community health services two hour urgent response standard	Improving Health	Responsive	CH	SOF/LTP	70%	Reporting to commence January 2023							87.5%	85.0%	83.8%		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	LTP	60%	85.5%	90.1%	91.5%	89.5%	93.6%	94.6%	84.8%	92.6%	94.4%	81.3%		
IAPT - proportion of people completing treatment who move to recovery	Improving Health	Responsive	CH	LTP/SC	50%	53.4%	53.9%	47.1%	*54.9%*	51.4%	41.0%	52.6%	57.1%	53.9%	*53.7%*		
IAPT - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period - Barnsley	Improving Health	Responsive	CH	LTP	Per Quarter - 1563	1379	1202	1224	1441	392	455	377	500	461	480		
IAPT - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period - Kirklees	Improving Health	Responsive	CH	LTP	No Target Set	2437	2383	2457	2648	849	910	698	978	792	878		
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	LTP	92%	98.5%	88.5%	93.5%	97.5%	86.9%	89.5%	93.5%	95.1%	95.7%	97.5%		
Number of people accessing IPS services as a rolling total each quarter	Improving Care	Responsive	CH	LTP	19 per Qu - Calderdale 15 per qu - Kirklees 5 per qu - Wakefield	Reporting commenced Q1 2022				18 Calderdale 33 Kirklees 29 Wakefield			40 Calderdale 37 Kirklees 31 Wakefield				
Number of individuals accessing specialist community PMH and MMHS services in the reporting period	Improving Care	Responsive	CH	LTP	Apr-Sep 318 per Qu Oct-Mar 336 per Qu	480	285	225	221	72	69	84	81	57	83		
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	Improving Care	Responsive	CH	SC	99%	91.7%	95.9%	86.2%	79.8%	98.7%	100.0%	86.2%	88.0%	91.6%	79.8%		
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care				SC	80%	84.6%	89.0%	88.1%	87.8%	87.8%	89.6%	88.9%	87.9%	89.6%	86.6%		
IAPT - Treatment within 6 Weeks of referral	Improving Health	Responsive	CH	SC	75%	94.7%	97.5%	98.4%	*97.8%*	98.0%	98.6%	98.5%	97.7%	97.6%	*98.1%*		
IAPT - Treatment within 18 weeks of referral	Improving Health	Responsive	CH	SC	95%	100.0%	100.0%	99.8%	*99.9%*	100.0%	99.9%	99.5%	99.8%	100.0%	*99.8%*		
The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week	Improving Health	Responsive	CH	SC	95%	95.5%	78.6%	95.2%	84.6%	100.0%	90.0%	100.0%	87.5%	80.0%	87.5%		
The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks	Improving Health	Responsive	CH	SC	95%	90.1%	77.7%	80.2%	95.2%	78.4%	79.3%	88.2%	88.6%	100.0%	100.0%		
Data Quality Maturity Index	Improving Health	Responsive	CH	SC	95%	98.5%	99.5%	*99.4%*	*98.7%*	99.5%	99.6%	*99.1%*	*99.4%*	*98.2%*	*98.5%*		

KPI	Objective	CQC Domain	Owner	Source	Target	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Data quality rating [8]	Variation/ Assurance
Total bed days of children and younger people under 18 in adult inpatient wards	Improving Care	Safe	CH	O	0	16	44	23	52	13	10	0	8	31	44		
Total number of children and younger people under 18 in adult inpatient wards	Improving Care	Safe	CH	O	0	1	2	4	3	2	2	0	2	2	2		
Number of detentions under the Mental Health Act (MHA)	Improving Care	Safe	CH	O	Trend Monitor	183	179	161	184	161			184				
Proportion of people detained under the MHA who are BAME	Improving Care	Safe	CH	O	Trend Monitor	18.0%	21.2%	22.4%	19.6%	22.4%			19.6%				
% Admissions gate kept by crisis resolution teams	Improving Care	Responsive	CH	O	95%	96.2%	99.3%	99.6%	98.7%	100.0%	98.7%	100.0%	98.9%	99.0%	98.2%		
% Service users on care programme approach (CPA) having formal review within 12 months	Health & Wellbeing	Safe	SR/KT	O	95%	96.1%	94.3%	96.9%	96.2%	95.6%	94.9%	96.9%	95.8%	95.4%	97.6%		
% clients in settled accommodation	Improving Health	Responsive	CH	O	60%	88.3%	87.2%	85.7%	*84.5%*	86.0%	85.8%	85.2%	84.4%	84.4%	*84.7%*	⚠	
% clients in employment	Improving Health	Responsive	CH	O	10%	11.1%	11.8%	11.7%	*11.4%*	12.0%	11.6%	11.4%	11.6%	11.4%	*11.3%*	⚠	
Completion of improving access to psychological therapies (IAPT) minimum data set outcome data for all appropriate service users, as defined in contract technical guidance 1	Improving Health	Responsive	CH	O	90%	98.2%	98.1%	98.1%	*97.7%*	98.8%	97.4%	98.5%	98.1%	99.1%	*98.9%*		
Completion of a valid NHS number field in mental health and acute commissioning data sets submitted via SUS, as defined in contract technical guidance	Improving Health	Responsive	CH	O	99%	100.0%	100.0%	100.0%	*100.0%*	100.0%	100.0%	100.0%	100.0%	100.0%	*100.0%*		
Completion of mental health services data set ethnicity coding for all service users, as defined in contract technical guidance	Improving Health	Responsive	CH	O	90%	99.1%	99.3%	99.3%	*99.4%*	99.4%	99.3%	99.3%	99.4%	99.4%	*99.4%*		

Glossary			
SOF	NHSEI System Oversight Framework	O	Other national metric
SC	NHS Standard Contract	SU	Service user
LTP	NHS Long Term Plan	CPA	Care programme approach

Variation Icons
The icon which represents the last data point on an SPC chart is displayed.

Assurance Icons
If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.

ICON									
SIMPLE ICON	● ● ●	● ? H L ●	● H ●	● L ●	● H ●	● L ●	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass

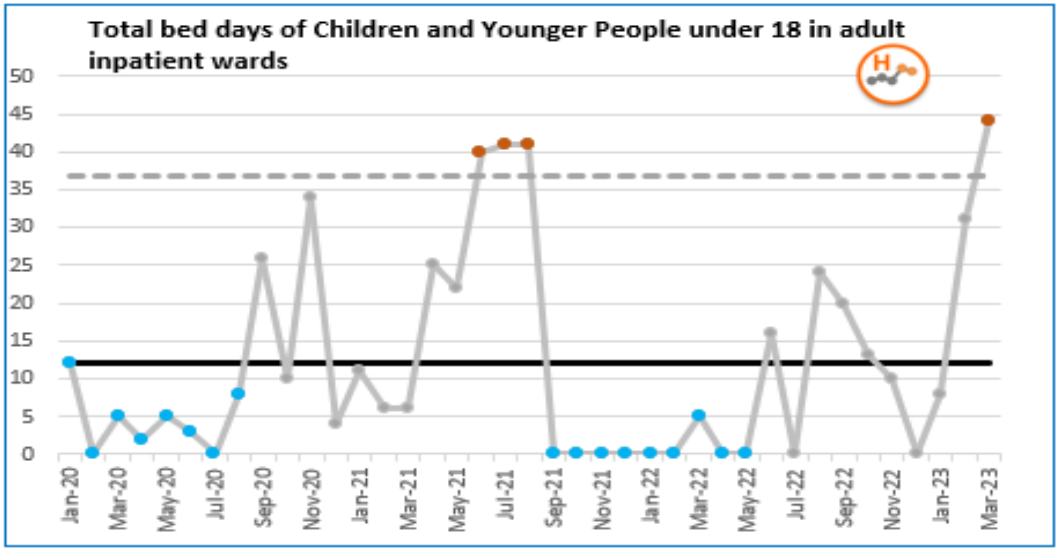
Headlines:

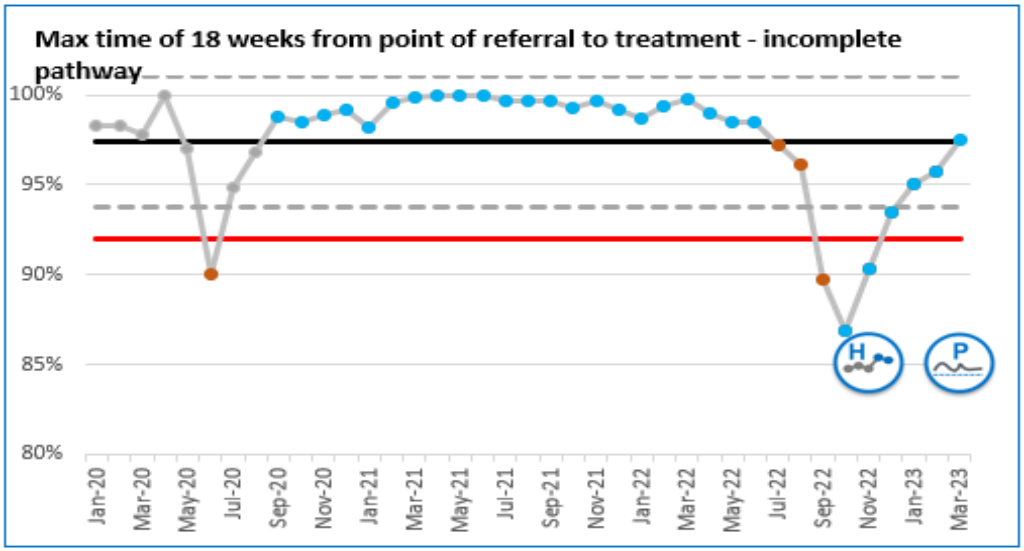
- The Trust continues to perform well against national metrics with performance against the majority within acceptable variance.
- The percentage of service users waiting less than 18 weeks from point of referral to treatment remains above the target threshold at 97.5%
- 72 hour follow up remains above the threshold at 86.6%. We are in a period of special cause improving varation due to continued (more than 6 months) performance above the mean.
- The percentage of service users seen for a diagnostic appointment within 6 weeks in the paediatric audiology service has decreased to 79.8% in March and remains below threshold. This is a small service and there have been a number of staffing issues that have impacted clinic availability. Due to the large increase in referrals from January 2023, it is unlikely we will have any capacity to run additional clinics over spring and summer and therefore we do not anticipate we will hit the 99% target until October 2023. Please see SPC chart on the next page for more analysis.
- The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week - small numbers impact on the achievement of the 95% threshold. In March 7 out of 8 urgent cases were seen within 1 week, this has taken the performance below threshold at 87.5%. The reason behind the breach related to the service user having to cancel the original appointment that was scheduled to take place within timescale due to being ill.
- During March 2023, there were two services users aged under 18 years placed in an adult inpatient ward. One of those patients was under 16 years old and admitted and discharged during the month with a length of stay of 13 nights. The duration of this episode was extended because there was an unclear discharge pathway. The other is under 18 and was originally admitted in January but remains on the ward. The combined bed days for these two clients during the month was 44 days and is the highest reported in at least the last 3 years and beyond the acceptable range, please see SPC chart on next page. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment reviews.
- Percentage of clients in employment and percentage of clients in settled accommodation - there are some data completeness issues that may be impacting on the reported position of these indicators.
- Data quality maturity index - the Trust has been consistently achieving this target. This metric is in common cause variation and we are expected to meet the threshold.
- IAPT proportion of people completing treatment who move to recovery is now above the 50% target at 53.7% for March. This metric remains in common cause variation however fluctuations in the performance mean that achievement of the threshold cannot be estimated.
- Percentage of service users on the care programme approach (CPA) having formal review within 12 months remains above threshold during the month of March. This metric remains in common cause variation however fluctuations in the performance mean that achievement of the threshold cannot be estimated.

Data quality:
An additional column has been added to the tables on the previous pages to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.
For the month of February the following data quality issues have been identified in the reporting:

- The reporting for employment and accommodation for March shows 15.4% of records have an unknown or missing employment and/or accommodation status. This a decrease on February which showed 16.0% of records have an unknown or missing employment and/or accommodation status. This has therefore been flagged as a data quality issue and work is taking place within care groups to review this data and improve completeness.

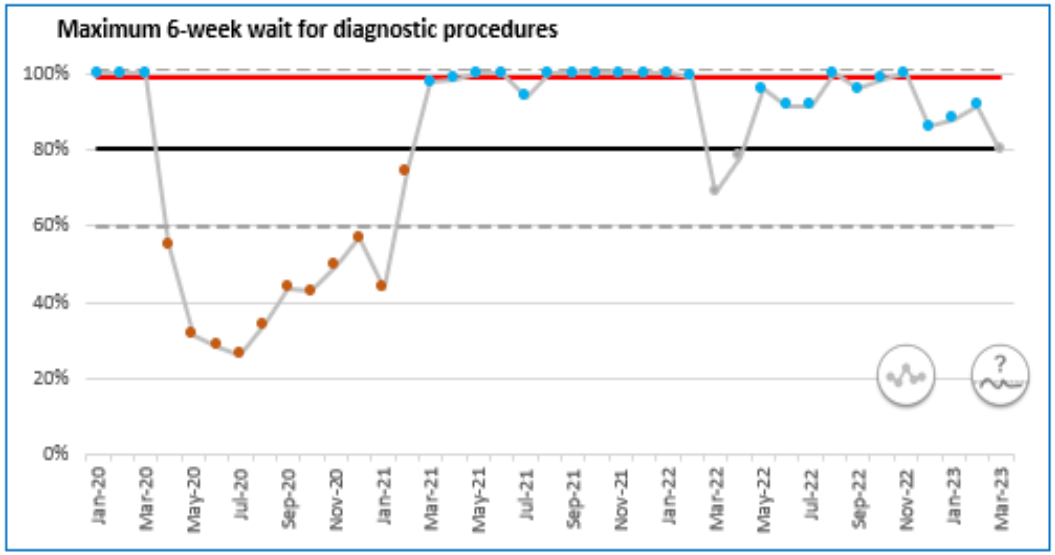
Analysis

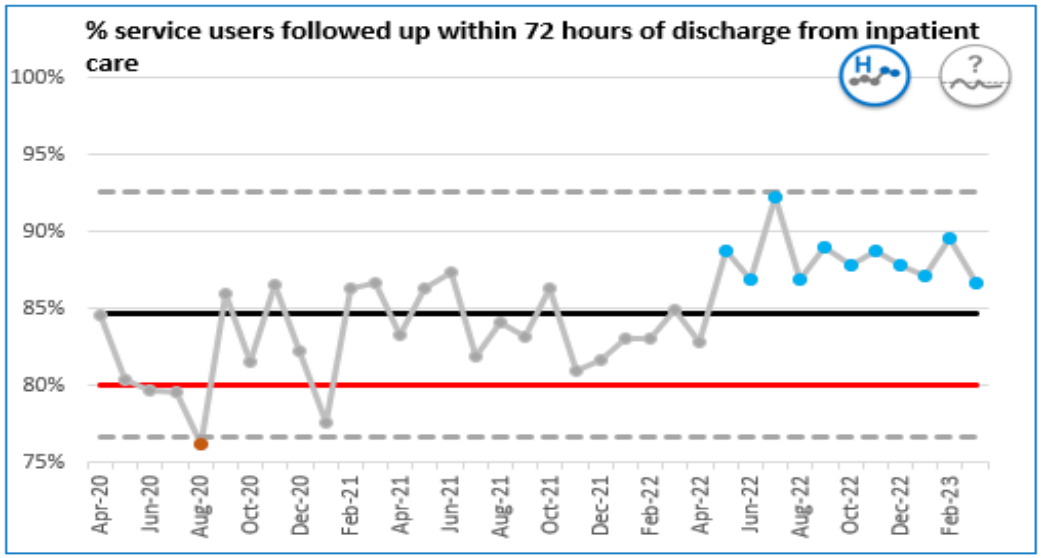




The statistical process control charts (SPC) above show that we have entered a period of concerning variation regarding the number of beds days for children and young people in adult wards. Whilst there were only 2 clients that contributed to this total, the combined bed days (44) is the highest reported in at least the last 3 years and beyond the acceptable range. After three consecutive periods of improvement against the referral to treatment metric we remain in a period of special cause improving variation and we are expected to meet the target.

Analysis





The SPC charts above show that for clients waiting for a diagnostic procedure we have entered a period of common cause variation and due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated. We are currently in a period of improving variation for clients discharged from inpatient care being followed up within appropriate timescales but again due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated.

The following section of the report has been created to give assurance regarding the quality and safety of the care we provide. A number of key metrics have been identified for each care group and performance for the reporting month is stated along with variation/assurance for each metric where applicable. Figures in bold and italics are provisional and will be refreshed next month.

Mental Health Community (Including Barnsley Mental Health Services)

Metrics	Threshold	Feb-23	Mar-23	Variation/ Assurance
% Appraisal rate	>=90%	72.1%	72.4%	
% Assessed within 14 days of referral (Routine)	75%	82.6%	67.7%	
% Assessed within 4 hours (Crisis)	90%	99.2%	99.3%	
% Complaints upheld with staff attitude as an issue	< 20%	60% (3/5)	20% (2/10)	
% service users followed up within 72 hours of discharge from inpatient care	80%	89.6%	86.6%	
% Service Users on CPA with a formal review within the previous 12 months	95%	95.8%	98.4%	
% Treated within 6 weeks of assessment (routine)	70%	99.1%	88.9%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.8%	73.3%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	67.0%	***82.8%***	
Information Governance training compliance	>=95%	85.0%	84.4%	
No of staff off sick - Covid-19 not working	N/A	5	3	
Reducing restrictive practice interventions training compliance	>=80%	71.9%	72.0%	
Sickness rate (Monthly)	4.5%	5.5%	5.4%	

Barnsley General Community Services

Metrics	Threshold	Feb-23	Mar-23	Variation/ Assurance
% Appraisal rate	>=90%	77.7%	77.9%	
% Complaints upheld with staff attitude as an issue	< 20%	0% (0/3)	50% (1/2)	
% people dying in a place of their choosing	80%	83.3%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.7%	77.4%	
Delayed transfers of Care (DTOC)	3.5%	0.0%	0.0%	
Information Governance training compliance	>=95%	87.6%	89.9%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	95.7%	97.5%	
Maximum 6 week wait for diagnostic procedures	99%	91.6%	79.8%	
No of staff off sick - Covid-19 not working	N/A	2	5	
Reducing restrictive practice interventions training compliance	>=80%	50.0%	33.3%	
Safer staffing (inpatient)	90%	111.0%	108.3%	
Sickness rate (Monthly)	4.5%	4.6%	4.6%	

Mental Health Inpatient

Metrics	Threshold	Feb-23	Mar-23	Variation/ Assurance
% Appraisal rate	>=90%	27.1%	39.9%	
% Bed occupancy	85%	88.1%	85.1%	
% Complaints upheld with staff attitude as an issue	< 20%	0% (0/3)	29% (2/7)	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.3%	70.4%	
Delayed transfers of Care (DTOC)	3.5%	6.7%	5.0%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	87.8%	***89.9%***	
Inappropriate Out of Area Bed days	276	511	511	
Information Governance training compliance	>=95%	84.6%	87.8%	
No of staff off sick - Covid-19 not working	N/A	3	4	
Physical Violence (Patient on Patient)	Trend Monitor	16	14	
Physical Violence (Patient on Staff)	Trend Monitor	77	51	
Reducing restrictive practice interventions training compliance	>=80%	79.3%	79.5%	
Restraint incidents	Trend Monitor	99	***17***	
Safer staffing	90%	124.8%	122.6%	
Sickness rate (Monthly)	4.5%	6.1%	5.8%	

Forensic

Metrics	Threshold	Feb-23	Mar-23	Variation/ Assurance
% Appraisal rate	>=90%	67.2%	65.3%	
% Bed occupancy	90%	89.7%	88.5%	
% Complaints upheld with staff attitude as an issue	< 20%	0% (0/0)	0% (0/0)	
% Service Users on CPA with a formal review within the previous 12 months	95%	87.1%	83.5%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.6%	78.8%	
Delayed transfers of Care (DTOC)	3.5%	0.0%	0.0%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	N/A	N/A	
Information Governance training compliance	>=95%	84.7%	86.5%	
No of staff off sick - Covid-19 not working	N/A	3	5	
Physical Violence (Patient on Patient)	Trend Monitor	2	2	
Physical Violence (Patient on Staff)	Trend Monitor	8	8	
Reducing restrictive practice interventions training compliance	>=80%	84.7%	81.9%	
Restraint incidents	Trend Monitor	12	***3***	
Safer staffing	90%	112.0%	111.0%	
Sickness rate (Monthly)	5.4%	6.2%	6.8%	

LD, ADHD & ASD

Metrics	Threshold	Feb-23	Mar-23	Variation/ Assurance
% Appraisal rate	>=90%	68.6%	72.7%	
% Complaints upheld with staff attitude as an issue	< 20%	0% (0/2)	0% (0/1)	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	59.8%	51.2%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.4%	79.9%	
Delayed transfers of Care (DTOC)	3.5%	18.8%	23.3%	
Information Governance training compliance	>=95%	87.4%	83.6%	
LD – First face to face contact within 18 weeks	90%	78.7%		
No of staff off sick - Covid-19 not working	N/A	1	0	
Physical Violence - Against Patient by Patient	Trend Monitor	0	1	
Physical Violence - Against Staff by Patient	Trend Monitor	48	27	
Reducing restrictive practice interventions training compliance	>=80%	77.5%	76.6%	
Safer staffing	90%	153.4%	141.5%	
Sickness rate (Monthly)	4.5%	5.5%	5.3%	
Restraint incidents	Trend Monitor	51	***10***	

CAMHS

Metrics	Threshold	Feb-23	Mar-23	Variation/ Assurance
% Appraisal rate	>=90%	87.9%	88.3%	
% Complaints upheld with staff attitude as an issue	< 20%	0% (0/4)	0% (0/1)	
CAMHS - Crisis Response 4 hours	N/A	96.5%	90.9%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.7%	75.3%	
Eating Disorder - Routine clock stops	95%	100.0%	100.0%	
Eating Disorder - Urgent/Emergency clock stops	95%	80.0%	87.5%	
Information Governance training compliance	>=95%	82.0%	84.4%	
No of staff off sick - Covid-19 not working	N/A	0	0	
Reducing restrictive practice interventions training compliance	>=80%	71.3%	73.6%	
Sickness rate (Monthly)	4.5%	3.6%	3.0%	

This section of the report is populated with key performance issues or highlights as reported by each care group.

Child and adolescent mental health services (CAMHS):

Alert/Action

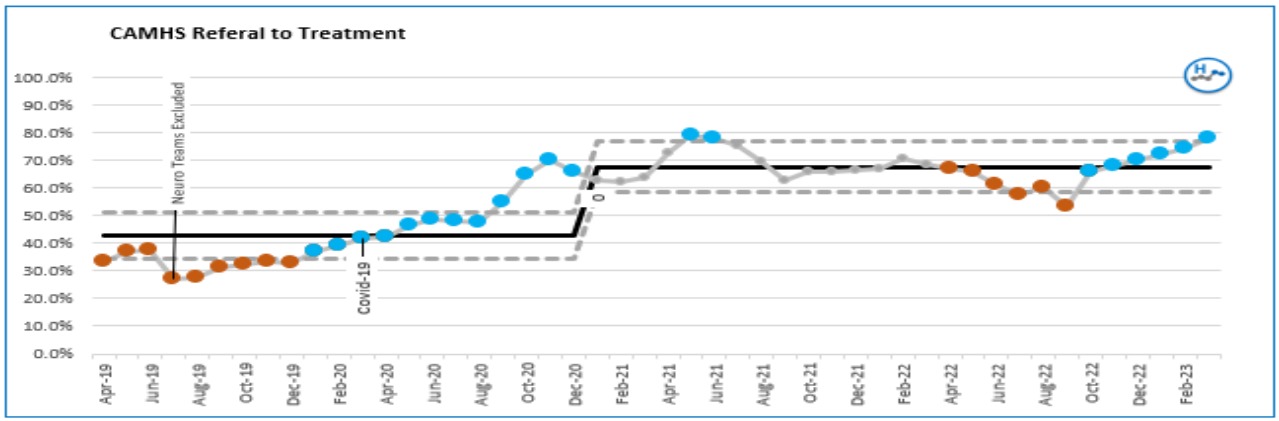
• The senior leadership team recognise that further work is required to improve mandatory training compliance in relation to reducing restrictive practice (73.6% - threshold 80%), cardio pulmonary rehabilitation (75.3% - threshold 80%) and information governance (84.4%- threshold 95%). Specific child focussed training has been requested where access to training is challenging.
• Neurodevelopment diagnostic service waits in Calderdale/Kirklees remain problematic. Robust action plans in place but a shortfall between commissioned capacity and demand remains. Clinical governance clinical safety committee receive further details through the waiting list report.
• Access to specialist residential and Tier 4 inpatient care remains challenging and has been the subject of a number of recent MP enquiries. Work continues with the provider collaborative to improve patient flow.
• The focus on maintaining staffing levels in Wetherby Young Offenders Institution and Adel Beck secure children's home continues with specific challenges in relation to recruitment of band 6 nursing staff.
• Eating disorder pathways remain under demand pressure as a consequence of increasing referrals and limited staff capacity. This is consistent with national trends and has contributed to difficulties in achieving national response targets.

Advise

• Waiting times from referral to treatment in Wakefield remain an outlier. Referral rates remain a key factor. Brief intervention and group work service offer strengthened and medium term improvement anticipated.
• A number of environmental issues have been escalated with respect to staff working conditions at Wetherby young offenders institute. Progress being made in implementing action plan.
• Work on improving the transition between services for children and the adult attention deficit hyperactivity disorder service is underway. This links in with the work of West Yorkshire mental health and learning disability partnership board transition project group.

Assure

• Staff wellbeing remains a focus. Hybrid models of working and flexible working policies are being proactively utilised.
• Proactively engaged with provider collaboratives in South and West Yorkshire to strengthen interface with inpatient providers and improve access to specialist beds.



The upper and lower control levels for this measure have been re-calculated from January 2021 following a sustained period of significant improvement, in order to better determine if current performance is within expected variation.

As you can see in March 2023, following a period of special cause concerning variation, we have now entered a period of special cause improving variation. For further information see narrative above.

Barnsley general community services:

Alert/Action

• Health Integration Team (Urban House) – Band 7 Nurse Prescriber left the service in November 2022 leaving only one Nurse Prescriber (lead nurse who is currently working from home due to their clinical vulnerability). This creates pressure and some risk within the service. To date we have been unable to recruit through bank/agency. We are currently working with pharmacy and the walk-in centre in Wakefield, to provide cover for the service as necessary.
• A district nurse was contacted and made aware of a 'bogus' district nurse in the South Yorkshire area. The source came from an email from Yorkshire Ambulance Service (YAS) team member. This information had been shared on social media on a local community group.

Barnsley general community services continued:

Advise

• Live Well Wakefield - a decision tree will be presented to the executive management team regarding the new tender for the service. The bid is to be submitted by the 24th April and awarded 26th June.
• Health Integration Team Urban House (UH) – The commissioner is reviewing current health provision for the six resettlement programmes in Wakefield including UH. Following the meeting with the commissioners in January 2023, a discussion paper was submitted as to how we can work collaboratively with primary care to ensure the delivery of equitable services for all those clients within the resettlement programmes in Wakefield. We have since met with the commissioner and discussed a potential collaborative approach to service delivery with primary care. The commissioner will now arrange further meetings with partner organisations as to next steps.
• Referral rates to children's therapy have remained high.
• Referral rates to paediatric audiology have been particularly high over the past couple of months and this is impacting upon waiting times. Most of these relate to sensory needs and are generated from the local autism assessment pathway, rather than being specific concerns around hearing impairment.
• Integrated Neighbourhood Teams - SystmOne single module rollout continues.

Assure

• SWYPFT Intermediate Care Engagement event held in Barnsley in March – collaborative working across partners from an AHP perspective.
• Excellence Awards – colleagues shortlisted in both individual and team categories.
• Recognition of our response to the Cost of Living Crisis (More Money in Your Pocket) – Barnsley council hosted event in March in Barnsley. Our colleagues attended in relation to SWYPFT's response and contribution.
• The managers for Live Well Wakefield and Yorkshire Smokefree Doncaster have both been successful in gaining distinctions in Level 5 management and leadership.
• NHSE visit to health integration team UH. The Government has tasked NHS England with setting up large accommodation centres (2000-3000 people in each centre). NHSE wanted to understand the potential risks, challenges etc. that they would need to consider from a health perspective and our suggestions as to how they could manage them on such a large scale.
• Children's Speech and Language Therapy team have been invited to present at the Clinical Governance Clinical Safety Committee, following on from their Excellence award nomination. They will share with the committee examples of good practice and how using digital media has benefited our service users.
• Children's Speech and Language Therapy team are working with learning and development to devise a Trustwide stammering training package. This is aimed at increasing the knowledge and skills of all staff around this neuro difference.
• School Aged Immunisation Service (SAIS) - Childhood flu programme uptake 22/23 – UKHSA (Health Security Agency) reports show that Barnsley is fourth out of 28 Local Authority (LA) areas in North East and Yorkshire for primary school uptake and fifth for secondary school uptake. The team achieved the highest uptake in South Yorkshire. Nationally Barnsley was 17th out of 151 LA areas. SAIS are team finalists in the Trust's Excellence awards.
• Urgent Community Response (UCR) Clinical Lead, Registered General Nurse (RGN) Lead and Neighbourhood Nursing Service (NNS) Clinical Lead all now in post with effect from April 2023.
• The Barnsley Healthcare Federation (BHF) have secured ownership of the Priory Campus property – this will provide opportunities for collaborative working with services including IHeart 365 and Home Visiting Service, and further develop the Alliance partnership with Barnsley council central call and reablement, virtual ward and Right Care Barnsley (RCB).
• New defibrillators have been delivered. There will be a process to remove/replace and train relevant areas across the Trust by our resuscitation team. This resolves the ongoing issues regarding batteries.
• Regional stroke conference to take place in May – SWYPFT team has been successful in submissions to present on Stroke Café, BP@Home (blood pressure) and Life After Stroke Group (6 week programme at Tesco).

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) services:

Alert/Action

• Friend & Family Test – for March, performance is 50% which has reduced compared to previous months. The care group quality and governance lead is undertaking focused improvement activity and this represents the service experienced a significant rise in performance last month but this has not been sustained and further improvement work is being considered currently.
• ADHD Waiting Lists: Remains a high priority for the service with cases being triaged and prioritised using data available. We have 3257 people waiting for an ADHD assessment. The maximum number of people the service can see is 560 per year (when fully staffed).
• Autism (ASD): The screening and triage process (as recommended in the recently published NHS England guidance for integrated care boards) to ensure that only clinically appropriate referrals are accepted for assessment means there is a short waiting list. 24 people are currently waiting for assessment – all have been invited, 14 of these already have an appointment booked. Two have waited longer than 12 weeks due to cancelled appointments.

Advise

Bradford Autism Pathway - Collaboration with Bradford District Care Trust (BDCFT)
• The waiting list project is progressing as planned.
• The new autism electronic referral system has launched across Bradford and Craven.
• Two of the posts required to deliver the sustainable pathway in Bradford have been recruited to.
• Since the approval of the service specification in January mobilisation is being implemented.

Assure

• All key performance targets are being met.
• All training is above the threshold.
• Relationship with Bradford working very well.
• Excellent levels of supervision and appraisal across the team (100%).

Learning disability services:

Alert/Action

Community Services
• Work on the reduction of waiting times continues. During this phase of the work Calderdale has been the focus with the intention to role out the improvements across all localities.

ATU (Assessment & Treatment Unit)
• Horizon improvement programme continues to make progress.
• Repeat Quality Monitoring Visit (QMV) has now taken place with an improved position noted although there is acknowledgement that further improvements are required.
• Recruitment to posts which were previously shared posts (with Bradford) is underway.
• Delayed Transfers of Care currently 23.3% and reflects system challenges in provision of bespoke packages of care to meet complex needs.

Advise

Community & ATU (Assessment & Treatment Unit)

- Workforce review is now concluded and the focus will now be the mobilisation of the plan.
- Service is working with the executive sponsor (Dr Thyiagesh) with the priority set as collaborative working across the Trust re Green Light Toolkit.
- Community Improvement Programme will commence in the next few weeks.
- Working with Creative Minds to improve sensory environment on Horizon.
- Bid to create a sensory room at the Calderdale hub successful.
- Appraisal currently 63.1%
- No mandatory training in red information governance 79.9% action plan in place to address.
- Training in amber: reducing restrictive intervention practice 77.6%, cardio pulmonary resuscitation 75.7, Food Safety 76.3%.

Assure

ATU (Assessment & Treatment Unit)

- Recruitment continues to progress.
- Robust plans in place to address mandatory training, supervision, and appraisal shortfall and progress is being monitored closely.
- Benchmarking against CQC 'Outstanding' rated services planned.

Community

- Waiting List mitigation includes more frequent data cleansing and the establishment of an early alert system which will help teams to potentially avoid delays in appointments.
- Annual health checks across all 4 localities are continuing to improve.
- Although recruitment challenges remain, some further key posts have now been recruited, key posts are the Calderdale nurse lead, Intensive support team nurse lead, dietician, Wakefield out of hours

Forensic services:

Alert/Action

• Acuity remains high – the service has suffered significant patient damage to the estate (seclusion rooms) losing all seclusion rooms in low secure at one point. Estates have supported the service to repair all except Gaskell which will require more extensive work.
• Bed Occupancy – Newton Lodge 87.4↓, Bretton 90.4%↓, Newhaven 91.6%↓.
• Sickness absence/covid absence – remains above the care group target at 8.3%.
• Vacancies & Turnover – Turnover remains high 14%↑. Recruitment & Retention remains a priority.
• Care Programme Approach - under target at 83.5↑ remedial action in place to address this and further work to remove out of area service users from our records will be undertaken with Performance and information colleagues.
• Quality network for Forensic mental health services (QNFMHS) - The service has received an updated report from the Quality Network for Forensic Mental Health Services (QNFMHS (overseen by the Royal College of Psychiatry)). The service had currently challenged the rating from last years reports. It has been amended favourably and the service is currently preparing for this year's visit early May.

Advise

• Regular meetings continue to assimilate Forensic Child and Adolescent Mental Health Services (FCAMHS) into the West Yorkshire Provider Collaborative.
• Mandatory training overall compliance:
  Newton Lodge – 89.5%
  Bretton – 87.5%
  Newhaven – 88.2

The above figures represent the overall position for each service. Hotspots across the service are food safety, information governance, local Induction and safeguarding adults (Newhaven only).
• The roll out of trauma informed care is going well and training sessions for staff have commenced with some staff having completed all 4 modules. Phase 2 of the roll out will be discussed in April.
• The West Yorkshire Provider Collaborative held a stakeholder event to discuss the future of forensic community services.
• Appraisal & supervision remain a priority.
• The well-being of staff also remains a priority within the service.

Assure

• No delayed discharges recorded across all three services.
• High levels of data quality across the care group (100%).
• 100% compliance for HCR-20 assessment being completed within 3 months of admission.
• Friends and family test is positive at 71%
• All Equality Impact Assessments (EIA) across forensic services have been completed for 23/24.
• Positive feedback received from the commissioning hub relating to our quarterly submissions and presentations at contract meetings.

Adults and Older People mental health:

Alert/Action

• Acute wards have continued to manage high levels of acuity and several wards have been impacted by Covid-19 outbreaks.
• We have had high occupancy levels across wards and capacity to meet demand for beds remains difficult.
• Workforce challenges have continued.
• The work to maintain effective patient flow continues, with the use of out of area beds being closely managed, and the actual number placed out of area at the end of March has reduced slightly to 15.
• We are working actively with partners to reduce the length of time people who are clinically ready for discharge spend in hospital and to explore all options for discharge solutions / alternatives to hospital care, underpinned by the work on the 100 Day Discharge Challenge.
• Demand into the Single Point of Access (SPA) and capacity issues have lead to ongoing pressures in the service, workforce challenges are continuing to compound these problems and have been increasing.
• SPA is prioritising risk screening of all referrals to ensure any urgent demand is met within 24 hours, but routine triage and assessment has been at risk of being delayed in all areas, particularly in Barnsley.
• Intensive Home Based Treatment (IHBT) teams in Calderdale and Kirklees are experiencing additional workforce challenges and are looking at innovative remedial and improvement approaches as part of a rapid action plan.
• We currently have higher than usual levels of vacancies in community teams for qualified practitioners and proactive attempts to fill these have had limited success with action plans in place for certain teams and continue to be proactive and innovative in approaches to recruitment and workforce modelling.
• All areas are focussing on improving performance for FIRM risk assessments, and performance is improving in all areas for those on care programme approach who have had a staying-well plan within 7 days and those who have had a formulation within 7 days.
• Progress has been made in all areas on ensuring care plans are produced collaboratively and shared with service users.
• Care Programme Approach (CPA) review performance is above target in all areas, with Barnsley demonstrating significant improvement across the quarter, action plans and support from quality and governance leads remain in place.

Advise

• Senior leadership from matrons and general managers remains in place across seven days.
• We are currently reviewing weekend working for senior managers to ensure we can build a sustainable model going forward that offers the required support to front-line 24/7 services.
• Intensive work to consider how we maintain quality and safety on our wards and improve the well-being of staff and service users and encourage recruitment and retention is underway.
• We are actively expanding creative approaches to enhance service user experience and the general ward environments. We are building identified challenges and priorities into the workforce strategy and the inpatient improvement priority programme.
• Work continues in front line community services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home including providing robust gatekeeping, trauma informed care and effective intensive home treatment.
• We are participating in the Trustwide work on how we measure and manage waits in terms of consistent data and performance measurement.
• We continue to work in collaboration with our places to implement the community mental health transformation.
• We recognise the key role of supervision and appraisal in staff wellbeing and are ensuring time is prioritised for these activities and that where we need to improve action plans are in place.
• We continue to work towards required concordance levels for cardio pulmonary resuscitation training and aggression management - this has been impacted by some issues relating to access to training and levels of did not attends.
• We are working closely with specialist advisors and we also have plans in place across inpatient services to ensure appropriately trained staff are on duty across all shifts at all times.

Assure

• All acute wards are now live on Electronic Prescribing and Medicines Administration (EPMA) which will contribute towards improving patient safety through reduction in prescribing and administration errors.
• We are performing well in gatekeeping admissions to our inpatient beds.
• We are performing well in 72 hour follow up for people discharged into the community.
• We are looking at specific input into inpatient areas to support rapid improvement with trauma informed approaches, targeting female wards in the first instance.
• Friends and Family Test – remains positive and above threshold for all areas.
• Our lead matron is participating in NHS England's Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme, a review in response to the concerns raised around the culture within mental health inpatient services. A series of three national events are being undertaken to develop principles of what quality inpatient care should look like.

Engagement, Equality and Volunteering Update

• Equality and involvement annual action plans for 2023/2024 now signed off by EII Committee at the March meeting
• A Trust wide framework to support staff to review equality data is now being evaluated for use by our BI/PI teams to build on what is already in place
• Monthly themed lunch box talks –focus on Young carers
• The 'All of You' equality data collection campaign continues to improve data collection for equality
• The Older peoples service transformation is moving towards a formal consultation. Consultation documents, plan, full equality impact assessment and outline business case are now being developed. Formal consultation planned for launch after Purdah in Spring 2023
• All of You: Race forward is now to be delivered through a programme approach, a 3 month plan to launch has been approved at the first meeting in March
• The Flair survey has now closed. The final response rate is 23%. A paper on how we will review the data and early sight of findings will be shared with EMT this month.
• The Trust wide approach to involvement is nearly ready to launch. The training modules to deliver 3 x 2-hour training sessions have been tested this month. A comms plan is now being developed for a full launch in April 2023 and a payment policy is being developed.
• The quarterly insight report was developed this quarter and shared with executive management team to identify a 'you told us we listened' response.
• An 'Electronic Equality impact assessment' is in the final stages of development with the support of information management and technology (IM&T) colleagues. .
• The offer to deliver enhanced training for equality, diversity and inclusion has now been approved and the team are currently looking at resourcing the work so it can be delivered to over 500 senior people across the Trust.
• The volunteer service continues to progress a large-scale piece of work in Barnsley to support community teams with volunteers is underway and 17 new volunteer managers are due to receive training to support these roles.
• Volunteer to career is progressing. Work to understand the befriending role within the Trust will be co-designed and shared with the Trusts operational management group for comment.

Overall Financial Performance 2022/23

Executive Summary / Key Performance Indicators

Performance Indicator		Out Turn 2022/23	Narrative
1	Surplus / (Deficit)	£3.2m	The position reported here is as per the system financial performance measure. The target of £3.2m surplus has been achieved in line with plan.
2	Agency Spend	£10m 4.2%	The Trust allocation of the overall West Yorkshire Integrated Care Board (ICB) 2022 / 23 agency cap is £7.8m. Performance is measured against both this and also as a percentage of total pay expenditure. For 2022 / 23 expenditure is £10.0m which is £2.2m more than cap.
3	Overhead Costs	15%	This key performance indicator is a measurement of corporate / overhead costs as a percentage of income for the year to date.
4	Financial sustainability and efficiencies	£6.4m	As per the NHS Operating Framework the Trust revised annual plan submission included a sustainability and efficiency requirement of £6.4m. This is being managed within the overall financial position and as such has been achieved with delivery of the surplus position in line with plan.
5	Cash	£74.6m	Cash in the bank remains positive. As is traditional this has reduced in March with the payment of Public Dividend Capital (PDC) made in month.
6	Capital	£7m	The capital forecast was revised during 2022 / 23 (originally set as £13.1m) to take account of the Trust decision to pause a major scheme. Significant work has been completed in year including works on inpatient areas, safety, fire and compliance areas and investment in IM & T.
7	Better Payment Practice Code	95%	This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt.

Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

System-wide monitoring

The Trust works in partnership with health economies predominantly in Barnsley, Calderdale, Kirklees, Wakefield, and the Integrated Care Systems (ICS) of South Yorkshire and West Yorkshire. Progress against delivery of the ICS five year strategies can be found by following the links below:

West Yorkshire Health and Care Partnership -

https://www.westyorkshire.icb.nhs.uk/meetings/finance-investment-and-performance-committee

South Yorkshire ICS -

https://syics.co.uk/about/integrated-care-partnerships-meetings-and-minutes

Publication Summary

This section of the report identifies publications that may be of interest to the board and its members.

Community services statistics, January 2023

NHS sickness absence rates, November 2022

NHS staff earnings estimates, December 2022, provisional statistics

NHS workforce statistics: December 2022

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 12 (2022 / 23)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

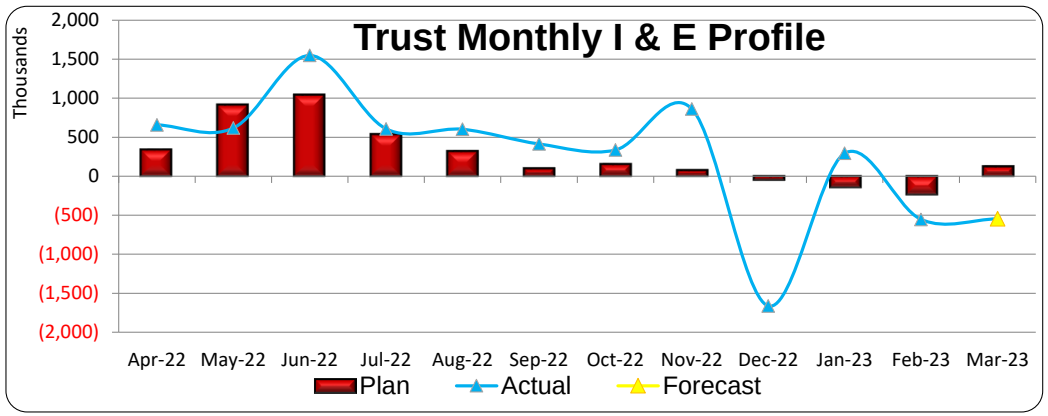
1.0	Executive Summary / Key Performance Indicators		
Key Performance Indicator		**Out Turn 2022 / 23**	**Narrative**
1	**Surplus / (Deficit)**	£3.2m	The position reported here is as per the System financial performance measure. The target of £3.2m surplus has been achieved in line with plan.
2	**Agency Spend**	£10m 4.2%	The Trust allocation of the overall West Yorkshire Integrated Care Board (ICB) 2022 / 23 agency cap is £7.8m. Performance is measured against both this and also as a percentage of total pay expenditure. For 2022 / 23 expenditure is £10.0m which is £2.2m more than cap.
3	**Overhead Costs**	15%	This key performance indicator is a measurement of corporate / overhead costs as a percentage of income for the year to date.
4	**Financial sustainability and efficiencies**	£6.4m	As per the NHS Operating Framework the Trust revised annual plan submission included a sustainability and efficiency requirement of £6.4m. This is being managed within the overall financial position and as such has been achieved with delivery of the surplus position in line with plan.
5	**Cash**	£74.6m	Cash in the bank remains positive. As is traditional this has reduce in March with the payment of Public Dividend Capital (PDC) made in month.
6	**Capital**	£7m	The capital forecast was revised during 2022 / 23 (originally set as £13.1m) to take account of the Trust decision to pause a major scheme. Significant work has been completed in year including works on inpatient areas, safety, fire and compliance areas and investment in IM & T.
7	**Better Payment Practice Code**	95%	This performance is based upon a combined NHS / Non NHS value and demonstrates that 95% of all invoices have been paid within 30 days of receipt.

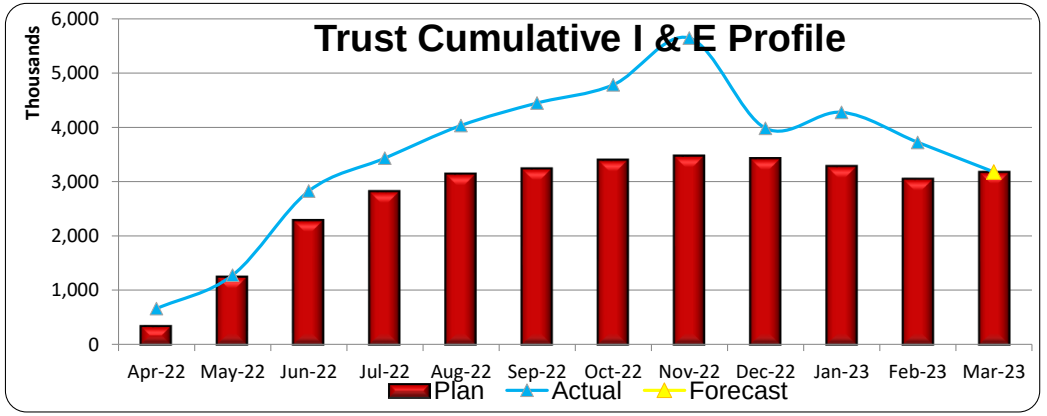
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective
Green	In line, or greater than plan

2.0 Income & Expenditure Position 2022 / 2023

Trust Financial Position

Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				22,071	32,465	10,394	Healthcare contracts	246,953	252,245	5,291	246,953	252,245	5,291
				9,661	19,053	9,392	Other Operating Revenue	109,959	124,156	14,196	109,959	124,156	14,196
				31,732	**51,518**	**19,787**	**Total Revenue**	**356,913**	**376,400**	**19,488**	**356,913**	**376,400**	**19,488**
5,172	4,784	(388)	7.5%	(20,560)	(37,670)	(17,110)	Pay Costs	(233,934)	(239,757)	(5,823)	(233,934)	(239,757)	(5,823)
				(10,503)	(14,253)	(3,750)	Non Pay Costs	(112,956)	(127,452)	(14,496)	(112,956)	(127,452)	(14,496)
				0	0	0	Gain / (loss) on disposal	0	820	820	0	820	820
				0	0	0	Impairment of Assets	0	(787)	(787)	0	(787)	(787)
5,172	**4,784**	**(388)**	**7.5%**	**(31,063)**	**(51,923)**	**(20,860)**	**Total Operating Expenses**	**(346,890)**	**(367,176)**	**(20,286)**	**(346,890)**	**(367,176)**	**(20,286)**
5,172	**4,784**	**(388)**	**7.5%**	**668**	**(405)**	**(1,073)**	**EBITDA**	**10,022**	**9,224**	**(798)**	**10,022**	**9,224**	**(798)**
				(482)	(479)	3	Depreciation	(5,847)	(5,869)	(23)	(5,847)	(5,869)	(23)
				(179)	64	243	PDC Paid	(2,148)	(1,895)	253	(2,148)	(1,895)	253
				118	274	155	Interest Received	1,150	1,718	568	1,150	1,718	568
5,172	**4,784**	**(388)**	**7.5%**	**126**	**(546)**	**(672)**	**Surplus / (Deficit)**	**3,178**	**3,178**	**0**	**3,178**	**3,178**	**0**
				0	(19)	(19)	Depn Peppercorn Leases (IFRS16)	0	(229)	(229)	0	(229)	(229)
				0	0	0	Revaluation of Assets	0	2,225	2,225	0	2,225	2,225
5,172	**4,784**	**(388)**	**7.5%**	**126**	**(566)**	**(691)**	**Surplus / (Deficit)**	**3,178**	**5,174**	**1,996**	**3,178**	**5,174**	**1,996**





Income & Expenditure Position 2022 / 23

The unaudited financial position for 2022 / 23 is £3.2m surplus.
This is in line with plan.

The Trust revised financial plan, submitted June 2022, is a surplus of £3.2m. This is mainly profiled at the start of the year with workstreams such as recruitment and retention of workforce having an impact on the position in Q3 and Q4.

NHS England - monthly submission

The actual financial performance as reported here is consistent with the monthly return made to NHS England and also to that reported into the West Yorkshire Integrated Care System (ICS). This declaration is also included within the self certification section of the return.

Income

The majority of income continues to be received through block payment arrangements with any variances to plan agreed by exception. Additional income has been recorded in March. Elements of this relates to additional income agreed with commissioners to reflect investment and agreements during 2022 / 23. Other significant values relate to implementation of national guidance and reporting requirements. For example this includes notional income (and expenditure) relating to centrally paid pension contributions and income for potential 2022 / 23 pay awards as per national

Pay

As in previous months the pay expenditure run rate has been impacted by one off / non recurrent adjustments such as the pension and pay award adjustments as outlined above. These have been specifically separated out within the additional pay information on page 7. The trend of increasing WTE run rate has continued in March with a stepped change in substantive worked WTE. This includes periodic recruitment into services such as IAPT; recruitment is aligned with training places and timescales.

Recruitment and retention workstreams continue and have been modelled as part of the Trust 2023 / 24 annual plan submission. This will continue to be monitored and reported.

Non Pay

Non Pay spend continues to be predominately Adult Secure Collaborative spend. Inflationary pressures, on areas such as utilities and catering / food costs, continue to be mitigated as far as possible within the overall financial position.

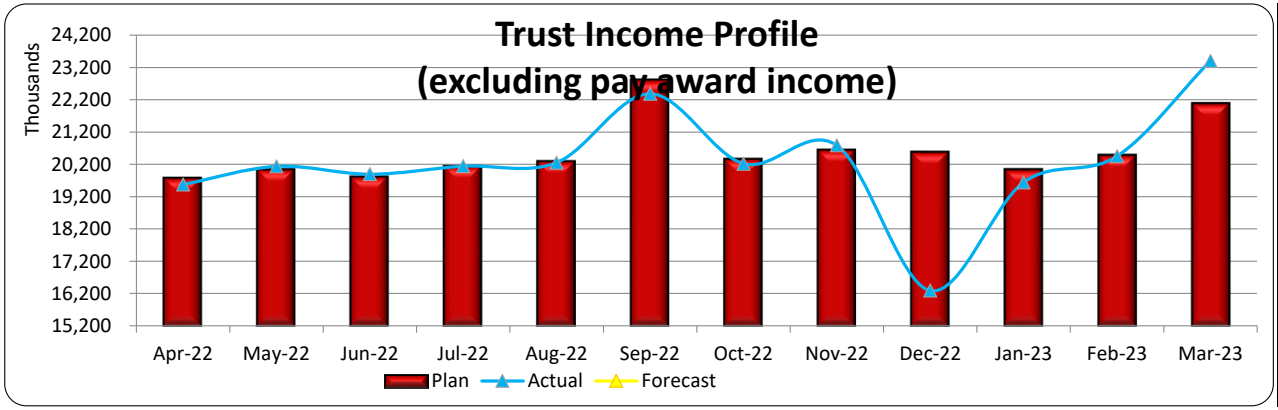
2.1 Income Information

Within the Trust Income and Expenditure position clinical revenue is separately identified. This is income received through contracts to provide clinical services. This does not include other income which the Trust receives such as contributions to training, staff recharges and catering income. This is included as other operating income.

The vast majority of income continues to be received from local commissioners (formerly CCGs, now Integrated Care Boards (ICBs)). For 2022 / 23 a hybrid of the previous year's financial regimes are in place. Formal contracts have resumed and are in place for all of the major commissioners. The financial element remains a block based upon national calculations and tariff changes. The same variation process as 2021 / 22 remains which means that investment in services will be added to contracts as and when agreed.

The block values have been calculated to include all income from NHS commissioners. This includes payment for clinical services, staff recharges and recharges for projects etc. from those organisations although this income is shown as other operating revenue within the Trust income and expenditure position.

Income source	Apr-22 £k	May-22 £k	Jun-22 £k	Jul-22 £k	Aug-22 £k	Sep-22 £k	Oct-22 £k	Nov-22 £k	Dec-22 £k	Jan-23 £k	Feb-23 £k	Mar-23 £k	Total £k	Total 21/22 £k
NHS Commissioners	17,501	18,083	17,285	17,878	18,049	19,848	18,099	18,498	18,270	18,173	18,320	20,251	**220,257**	**199,439**
ICS / System / Covid	854	854	854	854	854	854	854	854	(3,146)	854	854	854	**6,243**	**15,258**
Specialist Commissioner	242	324	320	325	319	356	429	331	324	342	343	413	**4,069**	**45,733**
Pay Award	0	0	0	0	0	0	0	0	0	0	0	9,058	**9,058**	**0**
Local Authority	433	454	484	427	429	460	446	449	463	419	432	414	**5,311**	**5,172**
Partnerships	422	422	395	413	345	399	309	447	232	496	385	786	**5,052**	**7,580**
Top Up / ERF	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**287**
Other Contract Income	124	(0)	555	246	258	470	84	206	146	(642)	118	689	**2,256**	**708**
Total	**19,576**	**20,136**	**19,893**	**20,143**	**20,254**	**22,387**	**20,221**	**20,785**	**16,289**	**19,643**	**20,452**	**32,465**	**252,245**	**274,176**
21/22	20,679	20,725	20,039	20,358	21,057	22,784	24,206	24,485	24,831	24,657	23,559	26,796	**274,176**	



Additional income has been received in March 2023. Some of this was not forecast but has been agreed with commissioners and / or NHS England. For example this includes £9.1m income relating to the potential impact of proposed 2022 / 23 pay awards in March 2023 (excluded from the graph to the left).

Pay expenditure has been included as per Trust calculations which highlights a shortfall against income of c. £0.9m.

Other increased income relates to contract variations now agreed and finalised with commissioners. This, and full year effects, have been reflected in the Trust 2023 / 24 financial plan.

2.2 Pay Information

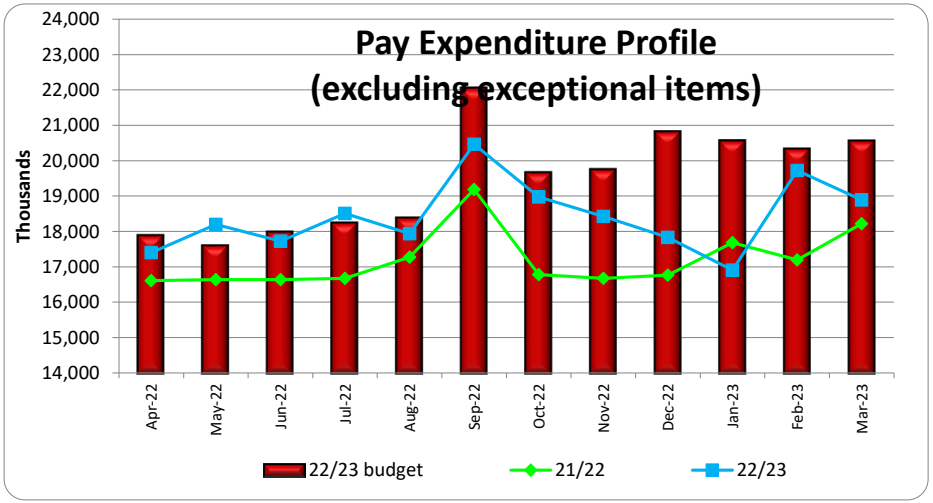
Our workforce is our greatest asset and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for in excess of 85% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities include a focus on the health and wellbeing of this workforce.

Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

Staff type	Apr-22 £k	May-22 £k	Jun-22 £k	Jul-22 £k	Aug-22 £k	Sep-22 £k	Oct-22 £k	Nov-22 £k	Dec-22 £k	Jan-23 £k	Feb-23 £k	Mar-23 £k	Total £k
Substantive	15,672	16,136	16,033	16,399	16,217	18,386	16,937	16,570	16,078	14,704	17,586	15,571	**196,289**
Bank & Locum	986	1,145	985	1,161	1,004	1,229	1,261	1,058	1,016	1,273	1,314	2,245	**14,675**
Agency	740	920	711	950	716	849	775	797	735	928	818	1,073	**10,013**
Exceptional : pay award												9,983	**9,983**
Exceptional : Notional pension contributions												8,798	**8,798**
Total	**17,397**	**18,201**	**17,728**	**18,510**	**17,937**	**20,464**	**18,972**	**18,425**	**17,828**	**16,905**	**19,719**	**37,670**	**239,757**
21/22	16,610	16,641	16,637	16,675	17,273	19,187	16,781	16,674	16,769	17,684	17,199	18,220	**206,351**

Bank as % (in month)	5.7%	6.3%	5.6%	6.3%	5.6%	6.0%	6.6%	5.7%	5.7%	7.5%	6.7%	11.9%	6.1%
Agency as % (in month)	4.3%	5.1%	4.0%	5.1%	4.0%	4.1%	4.1%	4.3%	4.1%	5.5%	4.2%	5.7%	4.2%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,130	4,109	4,129	4,148	4,162	4,153	4,222	4,223	4,228	4,235	4,274	4,306	**4,193**
Bank & Locum	251	294	252	307	259	272	313	264	272	329	297	309	**285**
Agency	148	141	149	142	137	175	158	149	170	160	156	169	**155**
Total	**4,530**	**4,545**	**4,530**	**4,597**	**4,559**	**4,600**	**4,693**	**4,636**	**4,670**	**4,724**	**4,727**	**4,784**	**4,633**
20/21	4,461	4,455	4,396	4,447	4,494	4,494	4,489	4,450	4,482	4,559	4,532	4,591	**4,488**



As in previous months pay expenditure has been impacted by a number of one off adjustments. Because of the significant financial values involved key adjustments have been separately identified in the table above.

In each case additional income has been received. National pension contributions is a notional adjustment with equal income and expenditure. Pay awards is an estimate of potential costs based upon the current offer. This is currently reported as a cost pressure in 2022 / 23 with nationally calculated income less than expected costs.

Neither of these have a WTE associated with them. Overall there has been another stepped increase reported in March. Substantive staff has increased, supported by continued international recruitment, but also for the timing of new recruitment into IAPT services Trustwide.

2.2 Agency Expenditure Focus

Agency spend is £1,073k in March.
Spend in 2022 / 23 is £10.0m.

Agency costs have a continued focus for the NHS nationally and for the Trust. As such separate analysis of agency trends is presented below. The Trust has also included an additional key performance indicator for 2022 / 23 linked to agency as a proportion of the overall workforce.

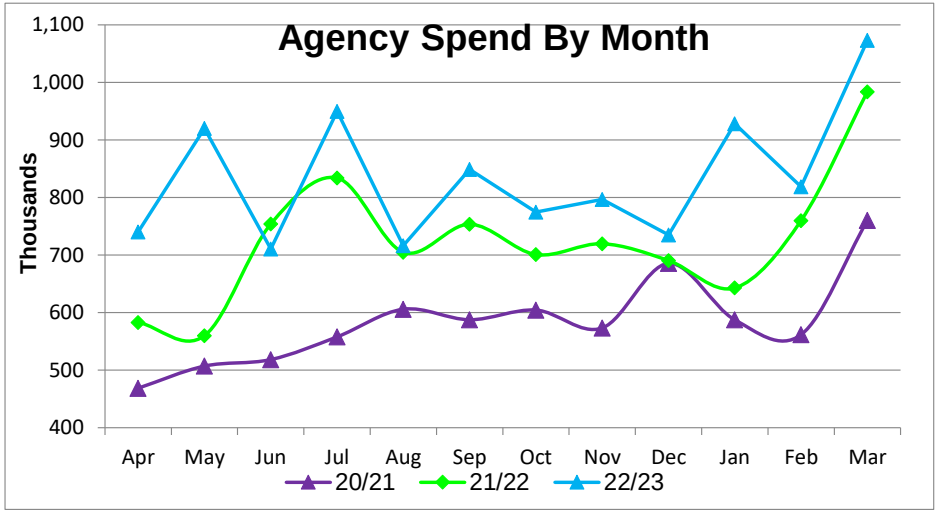
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

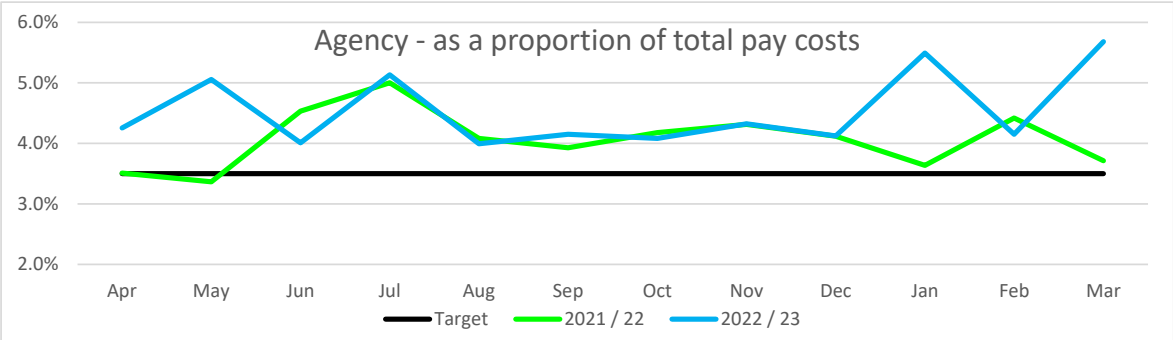
Under the NHS Single Oversight Framework, expected maximum agency levels have been set at an Integrated Care Board (ICB) level for 2022 / 23. Within this overall limit an allocation of £7.8m has been set for the Trust. This has been exceeded by £2.2m.

The Trust is already focussed on this as part of the wider workforce strategy as it's often seen as the last resort and the least cost effective but in some cases is the only viable option for ensuring continuity of safe services.

As experienced in previous years there is an increased level of agency expenditure reported in March. Although this increase is across most categories it is highest for unregistered nursing and other clinical staff.

In addition to the £7.8m target, focus has returned to non clinical agency usage. The Trust has spent £372k on admin and clerical staff in order to support service delivery.





From 1st April 2022 a new key performance indicator has been included within the Trust Integrated Performance Report that highlights the proportion of total Trust pay costs which are agency.

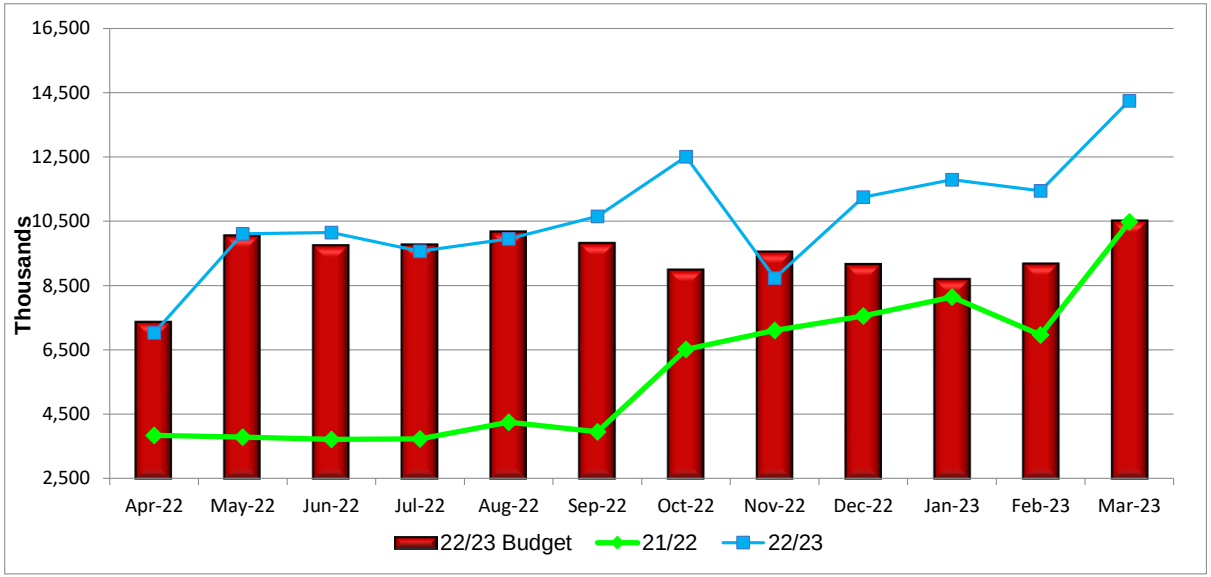
A revised cumulative target, based on the £7.8m target, of 3.5% has been set and monthly performance is shown on the left. Performance in March 2023, excluding exceptional pay items, was 5.5% with cumulative year position of 4.5%. The national target for 2023 / 24 is to be 3.7%.

2.3 Non Pay Expenditure

Whilst pay expenditure is the majority of all Trust expenditure, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the care groups and corporate services, and excludes capital charges (depreciation and PDC) which are shown separately in the Trust Income and Expenditure position.

Non pay spend	Apr-22 £k	May-22 £k	Jun-22 £k	Jul-22 £k	Aug-22 £k	Sep-22 £k	Oct-22 £k	Nov-22 £k	Dec-22 £k	Jan-23 £k	Feb-23 £k	Mar-23 £k	Total £k
2022/23	7,025	10,112	10,148	9,568	9,952	10,655	12,511	8,729	11,253	11,795	11,450	14,253	**127,452**
2021/22	3,834	3,783	3,712	3,729	4,246	3,949	6,512	7,107	7,556	8,140	6,961	10,478	**70,008**

	Budget Year to date	Actual Year to date	Variance
Non Pay Category	**£k**	**£k**	**£k**
Drugs	3,459	3,374	(84)
Establishment	7,365	10,237	2,872
Lease & Property Rental	7,383	7,557	174
Premises (inc. rates)	5,839	6,582	743
Utilities	2,233	2,382	150
Purchase of Healthcare	9,915	12,185	2,270
Lead Provider Collaborative	64,660	68,309	3,649
Travel & vehicles	4,371	4,278	(93)
Supplies & Services	6,982	7,416	434
Training & Education	2,529	2,137	(392)
Clinical Negligence & Insurance	1,031	1,026	(5)
Other non pay	(2,809)	1,969	4,778
Total	**112,956**	**127,452**	**14,496**
Total Excl OOA and Drugs	**99,582**	**111,893**	**12,311**



Key Messages

As per previous updates the major influence on Trust non-pay expenditure over the past year has been the implementation of the Adult Secure Collaboratives. For West Yorkshire this was in October 2021 and South Yorkshire went live from 1st May 2022. Budgets, and actual expenditure reflect this increase. This will be reported separately in 2023 / 24 for clarify on the impact of collaboratives and also highlight Trust specific non-pay pressures

Other headlines include continued underspends against budget on the travel and training lines. Budgetary requirements have been reassessed as part of the 2023 / 24 planning process.

Other non pay includes all other items not categorised into the above headings. As such this covers a wide range of items and budgets held centrally. Major areas of spend include audit fees, consultancy costs, Trusts costs as part of linked charities including Creative Minds and the Fieldhead Museum.

2.3 Out of Area Beds Expenditure Focus

The heading of purchase of healthcare within the non pay analysis includes a number of different services; both the purchase of services from other NHS trusts or organisations for services which we do not provide (mental health locked rehab, pathology tests) or to provide additional capacity for services which we do. From October 2021 this also includes the West Yorkshire Adult Secure Provider Collaborative and South Yorkshire Adult Secure Provider Collaborative from 1st May 2022.

Due to it's volatile, and potentially expensive nature, the non-pay focus has been on out of area bed expenditure. In this context this refers to spend incurred in order to provide clinical care to adult acute and PICU service users in non-Trust facilities. The reasons for taking this course of action can often be varied but some key reasons are highlighted below.

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

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

This analysis is for the out of area placements relating to adult acute beds including PICU in all areas. This excludes activity relating to locked rehab in Barnsley or the purchase of other healthcare services.

Out of Area Expenditure Trend (£)

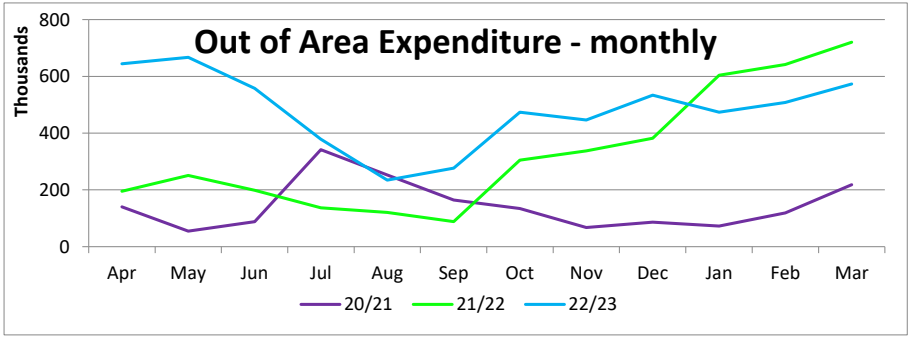
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
20/21	141	55	88	342	253	164	135	68	86	73	119	218	**1,741**
21/22	195	251	199	137	121	88	305	337	382	604	641	720	**3,981**
22/23	644	667	557	378	235	276	474	446	534	474	508	573	**5,767**

Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
20/21	110	54	120	305	147	76	111	105	148	124	100	126	**1,526**
21/22	221	313	316	223	261	409	422	460	555	653	498	690	**5,021**
22/23	484	512	587	479	355	292	523	606	521	568	548	552	**6,027**

Bed Day Information 2022 / 2023 (by category)

PICU	427	417	446	379	247	204	235	270	328	348	394	340	**4,035**
Acute	57	95	141	100	108	88	288	336	193	220	154	212	**1,992**
Total	484	512	587	479	355	292	523	606	521	568	548	552	**6,027**



Inpatient services have continued to experience sustained levels of demand and therefore out of area placements have continued at a high level.

Utilisation, in March, is in line with the average since October 2022 at 552 bed days.

Actions continue to minimise the impact, financially and operationally, from out of area placements. Repatriation (or discharge if appropriate) happens at the earliest possible opportunity.

3.0 Statement of Financial Position (SOFP) 2022 / 23

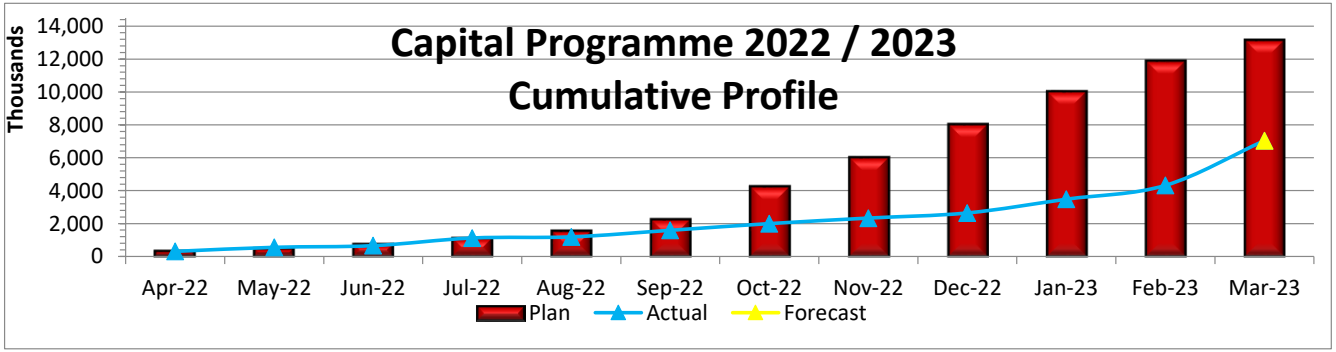
Balance Sheet / Statement of Financial Position (SOFP)	2021 / 2022 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	107,352	163,681	1
Current Assets			
Inventories & Work in Progress	189	231	
NHS Trade Receivables (Debtors)	973	1,664	4
Non NHS Trade Receivables (Debtors)	921	2,443	4
Prepayments	2,174	3,482	2
Accrued Income	816	9,305	3
Asset held of Sale	1,500	1,500	
Cash and Cash Equivalents	81,368	74,585	Pg 13
Total Current Assets	**87,941**	**93,209**	
Current Liabilities			
Trade Payables (Creditors)	(39,400)	(46,790)	5
Capital Payables (Creditors)	(1,790)	(739)	6
Deferred Income	(6,480)	(4,172)	
Other Liabilities (IFRS 16 / leases)		(51,979)	1
Total Current Liabilities	**(47,670)**	**(103,680)**	
Net Current Assets/Liabilities	**40,271**	**(10,470)**	
Total Assets less Current Liabilities	**147,623**	**153,210**	
Provisions for Liabilities	(7,716)	(4,319)	8
Total Net Assets/(Liabilities)	**139,907**	**148,891**	
Taxpayers' Equity			
Public Dividend Capital	45,624	45,657	
Revaluation Reserve	13,156	14,026	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	75,907	83,988	7
Total Taxpayers' Equity	**139,907**	**148,891**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2022.

1. There has been a stepped change in the value of Trust assets from 1st April 2022 with the value of Trust leases (as per IFRS 16) now included. This is offset, in part, by the other liabilities line now added to this presentation.
2. As per previous years, with payments made as contractually required for the new financial year such as rent and leases, prepayments is higher than previous months.
3. Accrued income is high month although the majority (£9.1m) relates to income to fund the 2022 / 23 proposed pay award. This value is as calculated, and communicated, by NHS England.
4. NHS debtors are higher than plan due to invoices relating to the Adult Secure collaboratives remaining unpaid.
5. Creditors continue to be managed and the Trust continue to pay 95% of valid invoices within 30 days.
6. Capital creditors remain low due to the profile of schemes currently underway in the capital programme.
7. This reserve represents year to date surplus plus reserves brought forward.
8. As planned the value of Trust provisions has reduced during 2022 / 23. This is through redundancy, VAT risk and legal provisions.

3.1 Capital Programme 2022 / 2023

Capital schemes	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k
Major Capital Schemes						
Bretton Centre	7,500	7,500	619	(6,881)	619	(6,881)
OPS transformation	500	500	593	93	593	93
Maintenance (Minor) Capital						
Clinical Improvement	745	745	544	(201)	544	(201)
Safety inc. ligature & IPC	1,065	1,065	490	(575)	490	(575)
Compliance	700	700	1,397	697	1,397	697
Backlog maintenance	350	350	426	76	426	76
Sustainability	350	350	19	(331)	19	(331)
Plant & Equipment	550	550	139	(411)	139	(411)
Other	0	0	681	681	681	681
IM & T						
Digital Infrastructure	450	450	1,503	1,053	1,503	1,053
Digital Care Records	40	40	31	(9)	31	(9)
Digitally Enabled Workforce	375	375	138	(237)	138	(237)
Digitally Enabling Service Users & Carers	65	65	107	42	107	42
IM&T Contingency	100	100	0	(100)	0	(100)
Lease Impact (IFRS 16) VAT Refunds	354	354	358	4	358	4
TOTALS	**13,144**	**13,144**	**7,042**	**(6,102)**	**7,042**	**(6,102)**



Capital Expenditure 2022 / 23

The Trust capital programme forms part of the overall West Yorkshire ICS capital plan. For 2022 / 23 the Trust component is £13.144m.

Forecasts have been updated over the course of the year, reflective of progress and decisions made, and as such a lower year end spend position has been expected for a number of months.

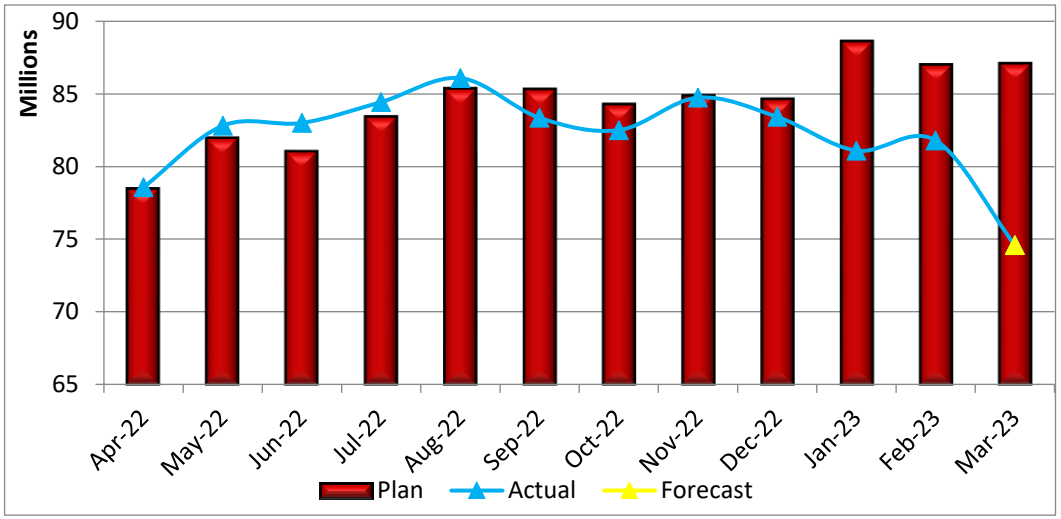
Although the Bretton Centre scheme was paused the Trust has utilised £7.0m of the capital allocation and in doing so delivered schemes, and benefits for:

* Ward enhancements and extra care area on an older peoples ward

* 56 minor capital schemes improving wards and environments, safety and compliance with legisation and best practice and a number of equipment purchases.

* Continued IM & T investment including infrastructure updates and moving forward digital modernisation

3.2 Cash Flow & Cash Flow Forecast 2022 / 2023

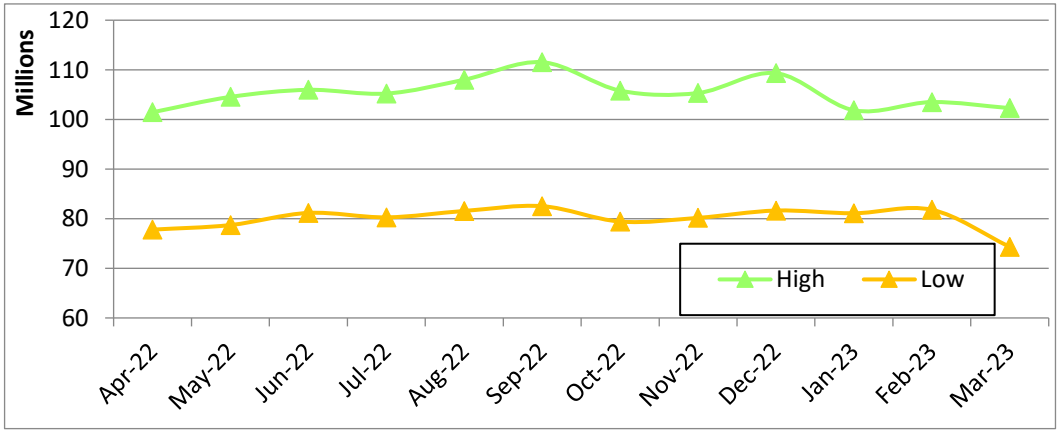


	Plan £k	Actual £k	Variance £k
Opening Balance	76,454	81,368	
Closing Balance	87,037	74,585	(12,452)

Cash has reduced in month

Cash has reduced in month as discussed on page 14. This includes the payment of Public Dividend Capital (PDC) which is paid bi-annually.

A large number of payments have been made in March as per the transparency information starting on page 17.



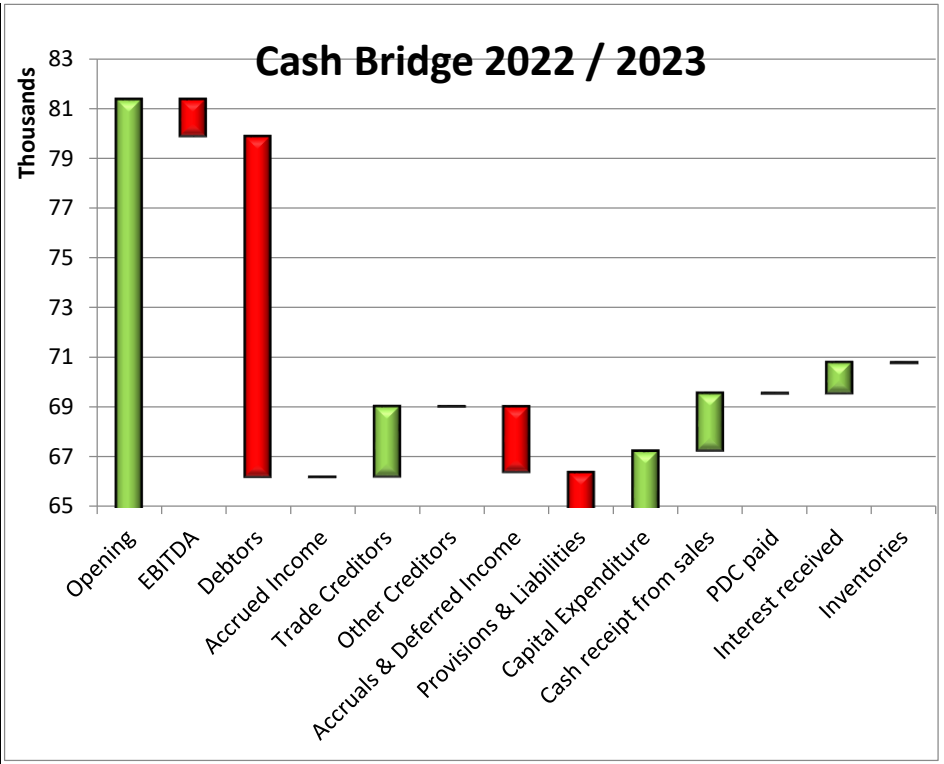
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £102.3m
The lowest balance is: £74.3m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**76,454**	**81,368**	4,914	
Surplus / Deficit (Exc. non-cash items & revaluation)	18,562	17,065	(1,497)	
Movement in working capital:				
Inventories & Work in Progress	0	(43)	(43)	
Receivables (Debtors)	1,725	(11,949)	(13,674)	
Trade Payables (Creditors)	3,781	6,618	2,836	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0	(2,641)	(2,641)	
Provisions & Liabilities	0	(3,397)	(3,397)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(11,290)	(7,042)	4,248	
Cash receipts from asset sales		2,319	2,319	
Leases	(498)	(7,257)	(6,759)	
PDC Dividends paid	(2,148)	(2,175)	(27)	
PDC Dividends received			0	
Interest (paid)/ received	450	1,718	1,268	
Closing Balances	**87,037**	**74,585**	**(12,452)**	



The table above summarises the reasons for the movement in the Trust cash position during 2022 / 2023. This is also presented graphically within the cash bridge.

Cash receipts include both overage on Castleford, Normanton & District Hospital and the sale of the Keresforth site.

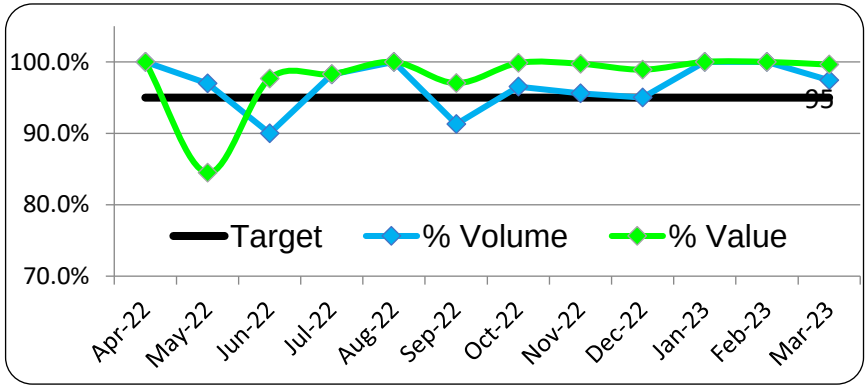
4.0 Better Payment Practice Code

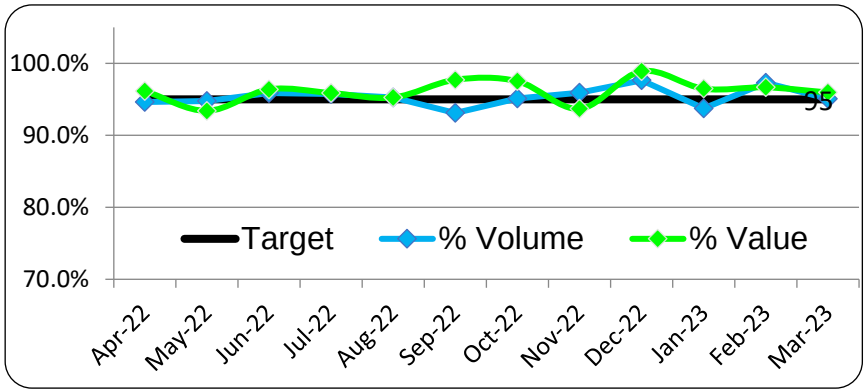
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently.

NHS	Number %	Value %
In Month	97%	100%
Cumulative Year to Date	97%	99%

Non NHS	Number %	Value %
In Month	95%	96%
Cumulative Year to Date	95%	96%





4.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000 (including VAT where applicable).

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

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

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

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
21-Mar-23	Purchase of Healthcare	AS Collaborative	Bradford District Care Nhs Foundation Trust	203116	998,695
14-Mar-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4890	793,567
20-Mar-23	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare Nhs Trust	1000056805	713,730
10-Mar-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	999024	571,562
13-Mar-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS31	544,330
29-Mar-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS32	544,330
21-Mar-23	Purchase of Healthcare	AS Collaborative	Bradford District Care Nhs Foundation Trust	203115	480,000
14-Mar-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	999047	393,000
02-Mar-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510007761	389,655
28-Mar-23	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber Mental He	0000093749	325,180
09-Mar-23	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 270	295,636
07-Mar-23	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care Nhs Foundation Tr	2100118948	293,365
23-Mar-23	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care Nhs Foundation Tr	2100119018	293,365
14-Mar-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	999046	288,000
14-Mar-23	Purchase of Healthcare	AS Collaborative	Sheffield Childrens Nhs Foundation Trust	2100224398	243,353
21-Mar-23	Rates	Barnsley	Barnsley Metropolitan Borough Council	CY56026530102023	203,520
02-Mar-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4886	194,656
23-Mar-23	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care Nhs Foundation Tr	2100119019	188,824
30-Mar-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4926	188,377
29-Mar-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS09	185,000
20-Mar-23	Computer Software	Trustwide	Softcat Plc	INVUK748582	170,371
28-Mar-23	Consultancy	Trustwide	James Harvard Ltd	1012856953	155,000
02-Mar-23	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber Mental He	0000093670	134,624
01-Mar-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510007756	125,604
01-Mar-23	Computer Hardware	Trustwide	Dell Corporation Ltd	7402891958	103,744
14-Mar-23	Staff Recharge	Trustwide	Sheffield Childrens Nhs Foundation Trust	2100224398	98,445
23-Mar-23	Rates	Kirklees	Kirklees Metropolitan Council	96916507327022392672	92,672
09-Mar-23	IT Services	Trustwide	Daisy Corporate Services	3I505404	90,250
23-Mar-23	Uniforms	Trustwide	Grahame Gardner Ltd	923851	82,602
14-Mar-23	Staff Recharge	Trustwide	Sheffield Childrens Nhs Foundation Trust	2100224398	73,557

11-Mar-23	Drugs	Trustwide	Bradford Teaching Hospitals Nhs Foundation Trus	323371	71,593
14-Mar-23	Staff Recharge	Trustwide	Sheffield Childrens Nhs Foundation Trust	2100224398	71,292
14-Mar-23	Staff Recharge	Trustwide	Sheffield Childrens Nhs Foundation Trust	2100224398	66,251
10-Mar-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	999023	63,771
21-Mar-23	Purchase of Healthcare	AS Collaborative	Humber Nhs Foundation Trust	59892455	62,643
14-Mar-23	Purchase of Healthcare	AS Collaborative	Humber Nhs Foundation Trust	59891831	61,701
20-Mar-23	Purchase of Healthcare	AS Collaborative	Humber Nhs Foundation Trust	59891828	58,515
21-Mar-23	Rates	Calderdale	Calderdale Metropolitan Borough Council	252023909989072023	56,832
24-Mar-23	Drugs	Trustwide	Lloyds Pharmacy Ltd	114483	56,569
22-Mar-23	Community Medical Packs	Trustwide	Corrmed Ltd	INV2847	55,380
31-Mar-23	Purchase of Healthcare	Trustwide	Northorpe Hall Child & Family Trust	INV0474	53,742
02-Mar-23	Computer Software	Trustwide	Softcat Plc	INVUK758513	48,778
26-Mar-23	Staff Recharge	Trustwide	Bradford District Care Nhs Foundation Trust	203163	47,385
06-Mar-23	Purchase of Healthcare	AS Collaborative	Mersey Care Nhs Foundation Trust	72484739	46,230
01-Mar-23	Furniture & Fittings	Trustwide	Pineapple Contracts	SI83678	45,486
23-Mar-23	Staff Recharge	Kirklees	Kirklees Council	8607791934	45,250
10-Mar-23	Purchase of Healthcare	Trustwide	Sheffield Health & Social Care Nhs Foundation Tr	2100118950	45,091
14-Mar-23	Purchase of Healthcare	Trustwide	Invictus Wellbeing Services Cic	2023022	45,000
24-Mar-23	Furniture & Fittings	Trustwide	Elysium Healthcare Ltd	12811203	45,000
11-Mar-23	Drugs	Trustwide	Nhs Business Services Authority	1000076207	44,752
16-Mar-23	Purchase of Healthcare	Trustwide	Elysium Healthcare Ltd	CHA02986	44,104
03-Mar-23	Mobile Phones	Trustwide	Vodafone Ltd	103359456	43,743
28-Mar-23	Furniture & Fittings	Trustwide	Pineapple Contracts	SI84425	43,632
11-Mar-23	Drugs	Trustwide	Nhs Business Services Authority	1000075883	43,559
21-Mar-23	Consultancy	Trustwide	James Harvard Ltd	1012855317	43,050
27-Mar-23	Data Lines	Trustwide	Vodafone Ltd	103528618	42,872
28-Mar-23	Furniture & Fittings	Trustwide	Pineapple Contracts	SI84423	41,928
28-Mar-23	Staff Recharge	Trustwide	Leeds & York Partnership Nhs Foundation Trust	999160	41,721
23-Mar-23	Purchase of Healthcare	Forensics	Sheffield Childrens Nhs Foundation Trust	2100224848	41,391
14-Mar-23	Staff Recharge	Trustwide	Sheffield Childrens Nhs Foundation Trust	2100224398	37,908

13-Mar-23	Rates	Kirklees	Kirklees Metropolitan Council	96921639X2023	37,632
22-Mar-23	Utilities	Trustwide	Edf Energy Customers Ltd	000014770783	36,527
22-Mar-23	Audit Fees	Trustwide	Deloitte Llp	8003347496	36,000
23-Mar-23	Staff Recharge	Trustwide	Bradford District Care Nhs Foundation Trust	203149	33,955
02-Mar-23	Computer Software	Trustwide	Mri Software Emea Ltd	MRIUK1014849	33,776
22-Mar-23	Protective Clothing	Trustwide	Bitepro Ltd	105675	33,190
28-Mar-23	Rates	Wakefield	Wakefield Metropolitan District Council	8885112606032023	33,024
10-Mar-23	Staff Recharge	Trustwide	Leeds & York Partnership Nhs Foundation Trust	999022	32,871
10-Mar-23	Service Charge	Barnsley	Chapelfield Medical Centre	316	32,630
23-Mar-23	Purchase of Healthcare	Trustwide	Elysium Healthcare Ltd	THO03698	32,267
21-Mar-23	Consultancy	Trustwide	Robertson Cooper Ltd	INV0809	32,173
20-Mar-23	Staff Recharge	Kirklees	Kirklees Council	8607815593	32,171
09-Mar-23	Advocacy	Trustwide	Cloverleaf Advocacy 2000 Ltd	11863	31,397
24-Mar-23	Rent	Kirklees	Sjm Developments Ltd	LINV51227	30,450
22-Mar-23	Security Maintenance	Trustwide	Pinpoint Ltd	67730	29,612
07-Mar-23	Purchase of Healthcare	AS Collaborative	Humber Nhs Foundation Trust	59892411	28,712
07-Mar-23	Purchase of Healthcare	Trustwide	Cygnet Surrey Ltd	WOK0278020	27,860
13-Mar-23	Rates	Kirklees	Kirklees Metropolitan Council	9689426262023	27,648
21-Mar-23	Rates	Barnsley	Barnsley Metropolitan Borough Council	CY56026542402023	27,536
21-Mar-23	Rates	Kirklees	Kirklees Metropolitan Council	96891289427022317136	27,136
07-Mar-23	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	MAS0278055	26,684
20-Mar-23	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	WKE0277781	26,684
13-Mar-23	Rates	Kirklees	Kirklees Metropolitan Council	9692164152023	26,368
17-Mar-23	Purchase of Healthcare	Trustwide	Humber Nhs Foundation Trust	59892383	26,000
09-Mar-23	Computer Hardware	Trustwide	Community Links Ltd	2255	25,670
23-Mar-23	Purchase of Healthcare	AS Collaborative	Sheffield Childrens Nhs Foundation Trust	2100224726	25,433
21-Mar-23	Consultancy	Trustwide	Liaison Financial Services Ltd	34073	25,000
21-Mar-23	Purchase of Healthcare	Trustwide	Barnsley Community And Voluntary Services	77	25,000
22-Mar-23	Purchase of Healthcare	Trustwide	Nova Wakefield District Ltd	1271	25,000
22-Mar-23	Purchase of Healthcare	Trustwide	Third Sector Leaders Kirklees	1217	25,000

4.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

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

* Forecast Surplus / Deficit - This is the surplus or deficit we expect to make for the financial year

* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known.

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

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

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

* CDEL - Capital Departmental Expenditure Limit. This refers to the amount of capital set by Her Majesty's Treasury each year which the whole of the NHS must remain within for capital expenditure.

* ICS - Integrated Care System.

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

Appendix 2 - Statistical Process Control (SPC) Charts Explained

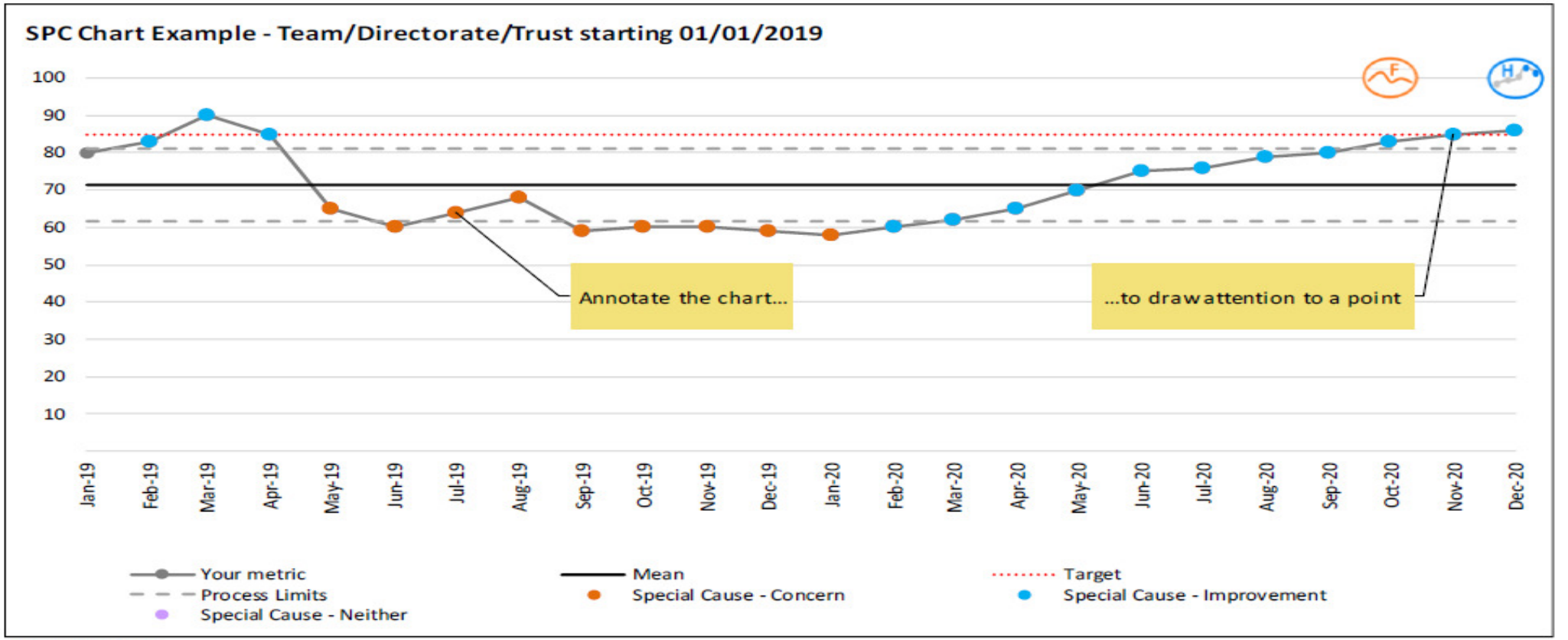
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data which are unlikely to have occurred due to chance and require investigation. They can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting the target without a change.

Special Cause Variation is statistically significant patterns in data which may require investigation, including:

- **Trend**: 6 or more consecutive points trending upwards or downwards
- **Shift**: 7 or more consecutive points above or below the mean
- **Outside control limits**: One or more data points are beyond the upper or lower control limits

	Variation Icons **The icon which represents the last data point on an SPC chart is displayed.**						**Assurance Icons** **If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.**		
ICON									
SIMPLE ICON	● ● ●	● ? H L ●	● H ●	● L ●	● H ●	● L ●	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2 - Statistical Process Control (SPC) Charts Explained



Observations

Based on the data from latest calculation date (data point 1 - 01/01/19).

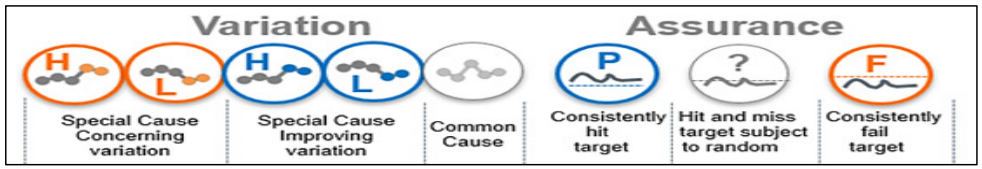
Single Point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There are 6 points above the UCL and 7 points below the LCL.
Trend	When there is a run of 6 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control.

Glossary

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

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

SPC Chart Icon Summary



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

NB: The year end forecast position for the dashboards was reviewed in October 2019 and revised to align with the NHSI rating system.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 10.2

Private/Public paper:	**Public**		
Title:	Financial and Operational Planning		
Paper presented by:	Adrian Snarr- Director of Finance, Estates and Resources Sean Rayner- Director of Provider Development		
Paper prepared by:	Rob Adamson- Deputy Director of Finance Louise King- Head of Financial Planning & Development Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	This paper primarily links to the effective use of resources but supports the Trust's wider strategic objectives, by ensuring we have the financial resources in place to deliver our plans both as a Trust and wider system partner. The Trust values are central to our approach to operational planning.		
Purpose:	The purpose of this paper is to update Trust Board on the final operating plan for 2023/24.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	• 1.1 The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place. • 1.2 The focus on integrated care models at place may result in unwarranted variation and differences in standards and could potentially impact the sustainability of smaller specialist services. • 3.1 Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. • 3.3 Capability and capacity gaps and/or capacity/resource not prioritised leading to failure to meet strategic objectives.		
Contribution to the objectives of the Integrated Care System/Integrated	The paper outlines our approach to planning to ensure that the Trust delivers effective, efficient, and high-quality services and contributes to the system plans at ICB level.		

Care Board/Place based partnerships	
Any background papers / previously considered by:	An update on the Planning Guidance and Trust operating plan was presented to, and discussed, at EMT on 12th January 2023, and further discussed at EMT Time Out on 19th January 2023. Regular updates on progress of development of the plan have been provided to EMT (23rd February 2023, 9th March 2023), and EMT Time Out on 16th March. An update on plan development was provided to the Finance, Investment & Performance Committee in January 2023 and Trust Board on 31st January 2023. The plan was approved by Finance Investment & Performance Committee on 20th March 2023. The full Trust Operational Plan for 2023/24 was shared in the private session of Trust Board on 28th March 2023.
Executive summary:	• On 23 December 2022, NHS England (NHSE) released its 2023/24 priorities and operational planning guidance NHS Operational Planning Guidance for 2023/24, outlining three priority areas for the service: o to recover core productivity; o progress the aspirations in the Long Term Plan; and o transform the health and care system for the future. • Work has been taking place since September both internally and with our places on development of plans. • There have been place based planning meetings taking place across our geography. • Draft plan submissions (activity, workforce and finance) were shared with the ICB in February 2023. • A draft plan was submitted by Integrated Care Boards (ICBs) on 23rd February 2023. The draft submissions comprised financial and workforce templates and system narrative. • Final plans were submitted by ICBs on 30th March 2023. • NHS England has confirmed it will continue to work with ICBs and providers over the next few weeks. All systems are expected to submit final plans by noon on 4th May. • The attached paper provides a summary of the Operational Plan. • A copy of the full Trust Operational Plan 2023/24 is attached as an appendix for reference. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.

Recommendation:	**Trust Board is asked to RECEIVE the summary of the final Trust Operational Plan 2023/24.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023

Agenda item – 10.2

Financial and Operational Planning

1. Introduction

The purpose of this paper is to provide Trust Board with the final operating plan for 2023/24, including finance plan, workforce assumptions, activity assumptions against planning guidance.

2. Background

On 23 December 2022, NHS England (NHSE) released its 2023/24 priorities and operational planning guidance NHS Operational Planning Guidance for 2023/24, outlining three priority areas:

- to recover core productivity;
- progress the aspirations in the Long Term Plan; and
- transform the health and care system for the future.

Work has taken place since September both internally and with our places on development of plans. Place-based planning meetings have been taking place across our geography.

The Trust shared draft submissions (activity, workforce and finance templates) with our places and the ICB in February 2023.

A draft plan was submitted by Integrated Care Boards (ICBs) on 23rd February 2023. The draft submissions comprised financial and workforce templates and system narrative.

Final plans were submitted by ICBs on 30th March 2023.

A final workforce, finance and plan narrative was prepared by the Trust. The plan was approved by the Finance Investment & Performance Committee on 20th March 2023, in advance of submission to the ICB. The full Trust Operational Plan for 2023/24 was shared in the private session of Trust Board on 28th March 2023.

NHS England has confirmed it will continue to work with ICBs and providers over the next few weeks. All systems are expected to submit final plans by noon on 4 May.

3. Care Group Plans

To support the system level requirements work has taken place to develop plans at Care Group Level covering the following areas:

- Care group strategy, quality and performance.
- National and local priorities.
- Inequalities approach.
- Workforce challenges and requirements.
- Estates and digital requirements.

Workshops with each service area were held to facilitate completion of plans and included representation from Operations, Finance, Workforce, Strategy and the People Directorate.

Final plans have been completed to ensure a consistent set of assumptions available for narrative, workforce and finance submissions.

4. Approach by Place

Meetings were established in each of our places in order to support plans which the Trust is fully engaged in. In addition, checkpoint meetings with NHSE were held for each place in February prior to the draft plan submission, and in March prior to final plan submission.

5. Compliance with national planning guidance

Our Trust Operational Plan assumes delivery against the following planning requirements working in partnership at place and system level:

Urgent and Emergency Care

- Reduce the number of medically fit to discharge patients in hospitals, addressing NHS causes and working in partnership with Local Authorities.

Community Health Services

- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard.
- Increase referrals into urgent community response (UCR) from all key routes, focus on maximising referrals from 111 and 999, creating a single point of access where not already in place.

Use of Resources

- Deliver a balanced net system financial position for 2023/24.
- Systems to review workforce growth by staff group and identify expected productivity increases in line with the growth seen.
- Reduce corporate running costs with a focus on consolidation, standardisation and automation to deliver services at scale across ICS footprints using the NHSE annual cost data benchmarking and a corporate service improvement toolkit.
- Reduce procurement and supply chain costs by realising the opportunities for specific products and services.
- Purchase medicines at the most effective price point by realising the opportunities for price efficiency identified by the Commercial Medicines Unit, and ensure the best value from the NHS medicines bill.
- Reduce agency spending across the NHS.

Mental health

- Improve access to mental health support for children and young people.
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.
- Work towards eliminating inappropriate adult acute out of area placements.
- Recover the dementia diagnosis rate to 66.7%.
- Improve access to perinatal mental health services.
- Continue to achieve the Mental Health Investment Standard.

- Develop a workforce plan that supports delivery of the system's mental health delivery ambition, working closely with ICS partners including provider collaboratives and the voluntary, community and social enterprise (VCSE) sectors.
- Improve mental health data to evidence the expansion and transformation of mental health services, and the impact on population health, with a focus on activity, timeliness of access, equality, quality and outcomes data.

People with a Learning Disability or Autism

- Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024.
- Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit.

Embedding measures to address health inequalities

- Continue to address health inequalities and deliver on the Core20PLUS5 approach.

Workforce

- Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise.
- Workforce plans support improved staff experience and retention through systematic focus on all elements of the NHS People Promise and implementation of the Growing Occupational Health Strategy, improving attendance toolkit and Stay and Thrive Programme.
- Increased productivity by fully using existing skills, adapting skills mix and accelerating the introduction of new roles (e.g. anaesthesia associates, AHP support workers, pharmacy technicians and assistants, first contact practitioners, and advanced clinical practitioners).
- Flexible working practices and flexible deployment of staff across organisational boundaries using digital solutions (e-rostering, e-job planning, Digital Staff Passport).
- Regional multi professional education and training investment plans (METIP) and ensure sufficient clinical placement capacity, including educator/trainer capacity, to enable all NHS England- funded trainees and students to maintain education and training pipelines.
- Implementation of the Kark recommendations and Fit and Proper Persons (FPP) test.

Digital

- Use forthcoming digital maturity assessments to measure progress towards the core capabilities set out in What Good Looks Like (WGLL) and identify the areas that need to be prioritised in the development of plans. Specific expectations will be set out in the refreshed WGLL in early 2023.
- Put the right data architecture in place for population health management (PHM).
- Put digital tools in place so patients can be supported with high quality information that equips them to take greater control over their health and care.

System working

- Developing ICP integrated care strategies and ICB joint forward plans.
- Maturing ways of working across the system including provider collaboratives and place-based partnership arrangements.

Our plans do not currently meet the following areas of guidance and plans are in place to address this.

- By September 2023, self-referral routes to falls response services, musculo-skeletal physiotherapy services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services. This affects Barnsley services and will require a significant discussion at place which has not yet taken place. Internal discussions are in place to progress this work.
- Increase the number of adults and older adults accessing IAPT treatment- due to recent communications from NHS England regarding reduced targets/aspirations for 2023/24 for IAPT access due to national issues of recruitment and retention, our plans forecast access will remain at 2022/23 rates.

6. Finance plan

6.1 National Guidance and assumptions

The overall NHS funding settlement includes an additional £3.3bn in both 2023/24 and 2024/25 (compared to the previous settlement) to address pay and non-pay inflationary pressures. The overall view from NHS England is that this settlement would require £12bn of savings over the current year and the next two years, plus significant improvements in productivity.

NHS England is issuing two-year revenue allocations for 2023/24 and 2024/25. ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners.

Provider contracts are expected to increase by a net tariff uplift of 1.09%. This is based on a tariff Cost Uplift Factor (CUF) of 2.9%, less a national efficiency ask of 1.1% and less convergence adjustment of 0.71%.

Cost	Estimate	Cost weight	Weighted estimate
Pay	2.1%	68.9%	1.5%
Drugs	1.3%	2.4%	0.0%
Capital	4.0%	7.1%	0.3%
Unallocated CNST	1.5%	2.2%	0.0%
Other	5.5%	19.3%	1.1%
Total			2.9%

It should be noted that the 2022/23 pay award resulted in a cost pressure due to the differential rates for Agenda for Change staff and that we have a higher proportion of non pay than the cost weighting above. It is not yet known if the 2023/24 Pay recommendation will have differential rates.

Although the national efficiency built into the tariff calculation is 1.1%, the NHS England message is that there is an overall efficiency expectation of 2.2% (the reality within NHS Trusts is that this will be higher including for SWYFPT).

To generate the required level of efficiency savings, systems:

- Must reduce agency spending across the NHS to 3.7% of the total pay bill in 2023/24. (Our first draft assumptions for agency exceed this target).
- Reduce corporate running costs with a focus on consolidation, standardisation and automation.
- Reduce procurement and supply chain costs by realising the opportunities for specific products and services.

6.2 Financial plan- headline figures

The financial plan for the Trust has been prepared and shows a balanced position as set out below.

	2021/22	2022/23 FOT	2023/24 Plan
	£k	£k	£k
Total Revenue	**301,783**	**355,814**	**360,483**
Pay Costs	(212,882)	(221,225)	(229,802)
Non Pay Costs	(71,833)	(125,116)	(125,314)
Gain / (loss) on disposal	1,154	820	
Impairment of Assets	0	(787)	0
Total Operating Expenses	**(283,561)**	**(346,308)**	**(355,116)**
EBITDA	**18,222**	**9,506**	**5,367**
Depreciation	(7,125)	(5,869)	(5,948)
PDC Paid	(2,070)	(2,129)	(2,489)
Interest Received	39	1,670	3,070
Surplus / (Deficit)	**9,066**	**3,178**	**0**
Depn Peppercorn Leases (IFRS16)		(229)	0
Revaluation of Assets	1,212	2,225	0
Surplus / (Deficit)	**10,278**	**5,173**	**0**

Key movements from 2022/23 Forecast Outturn (FOT) to 2023/24 Budget

Excluding the impact of new investment requests, the impact of pay award and inflationary pressures reduce Trust surplus to a breakeven position.

	£000's
2022/23 FOT Surplus/(Deficit)	**3,178**
Tariff Uplift	2,949
FYE Income	4,500
2% Pay Award	-4,967
Workforce Growth	-5,500
Non Pay Inflation	-2500
NR Spend	1,800
Reduction in OOA Placements	600
Other	-60
2023/24 Budget Surplus/(Deficit)	**0**

6.3 Plan including Investments/CIP Target

	21/22 £000s	22/23 FOT £000s	23/24 Base Budget £000s	CIP's	Cost Pressures New	Cost Pressures Existing	23/24 Proposed Budget £000s
Total Block Income	**274,176**	**269,423**	**277,479**	**0**	**0**	**0**	**277,479**
Total Operating Expenses	**251,125**	**256,116**	**272,009**	**(8,651)**	**5,628**	**3,023**	**272,009**
Covid-19 costs	5,984	3,850	0				0
EBITDA	**17,068**	**9,457**	**5,470**	**8,651**	**(5,628)**	**(3,023)**	**5,470**
Depreciation	7,125	5,876	6,051				6,051
PDC	2,070	2,032	2,489				2,489
Interest	(39)	(1,629)	(3,070)				(3,070)
Total Costs	**266,265**	**266,244**	**277,478**	**(8,651)**	**5,628**	**3,023**	**277,478**
Surplus/(Deficit)	**7,912**	**3,178**	**0**	**8,651**	**(5,628)**	**(3,023)**	**0**
Depn Peppercorn Leases (IFRS16)	0	(229)					
Impairment of Assets	0	1,438					
Revaluation of Assets	(1,212)	0	0				0
Profit/Loss on Disposal	(1,154)	0	0				0
Surplus / (Deficit) pre true up & covid	**10,278**	**4,387**	**0**	**8,651**	**(5,628)**	**(3,023)**	**0**

To note, this excludes the Provider Collaboratives. Cost pressures includes a contingency of £1.7m.

6.4 Income assumptions

The plan assumes tariff uplift as per national guidance 1.09% (2.9% cost uplift factor less 1.1% efficiency and 0.71% convergence adjustment)

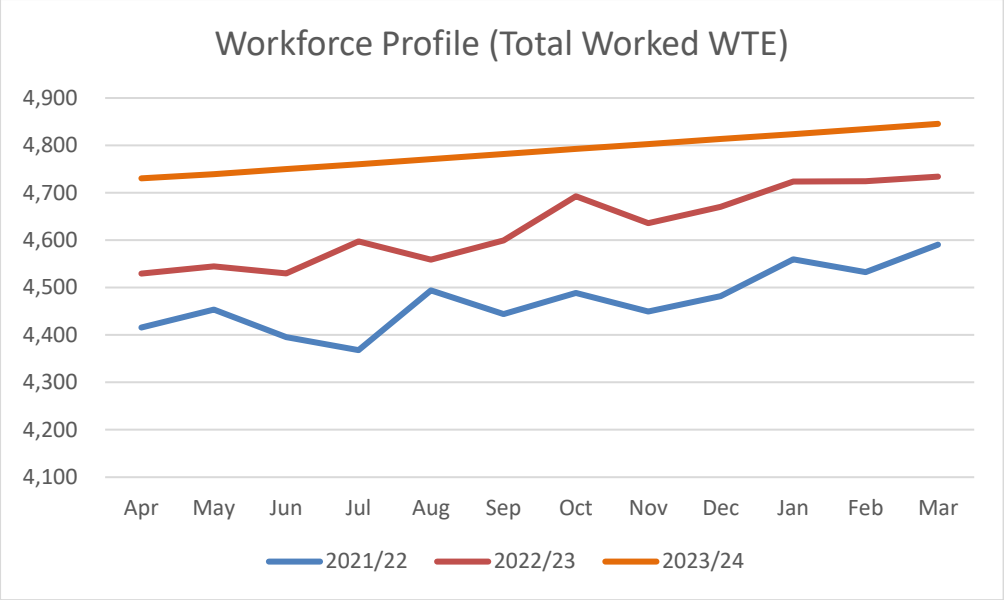
The plan does not currently assume any new investment income for 2023/24 bids. The assumption is that full year effect growth will contribute to the MHIS target for the system.

6.5 Workforce Profile and Vacancy Factor

To predict our anticipated workforce throughout 2023/24 the Trust has assumed the growth in substantive WTE seen this year (3%) will continue.

The plan also assumes a reduction in agency to meet the national target of 3.7% which will reduce our agency staffing from 145 WTE in April to 120 WTE in March 2024. This will be offset by a corresponding uplift in substantive staffing as a result of ongoing retention and recruitment activity.

Overall this would require substantive recruitment of 800 WTE next year (140 growth and 660 to cover turnover).



6.6 Pay assumptions

Pay budgets have been calculated based on staff in post and adjusted for the impact of incremental drift. Where posts are currently vacant the budget has been calculated at the mid point of the band.

The reduction in national insurance (back to 13.8%) has been factored into budgets (£1.7)m reduction in 2023/24 budgets. The reduction in tariff for this change has also been factored in.

Pay award as per the national guidance of 2% results in an increase of £5.0m.

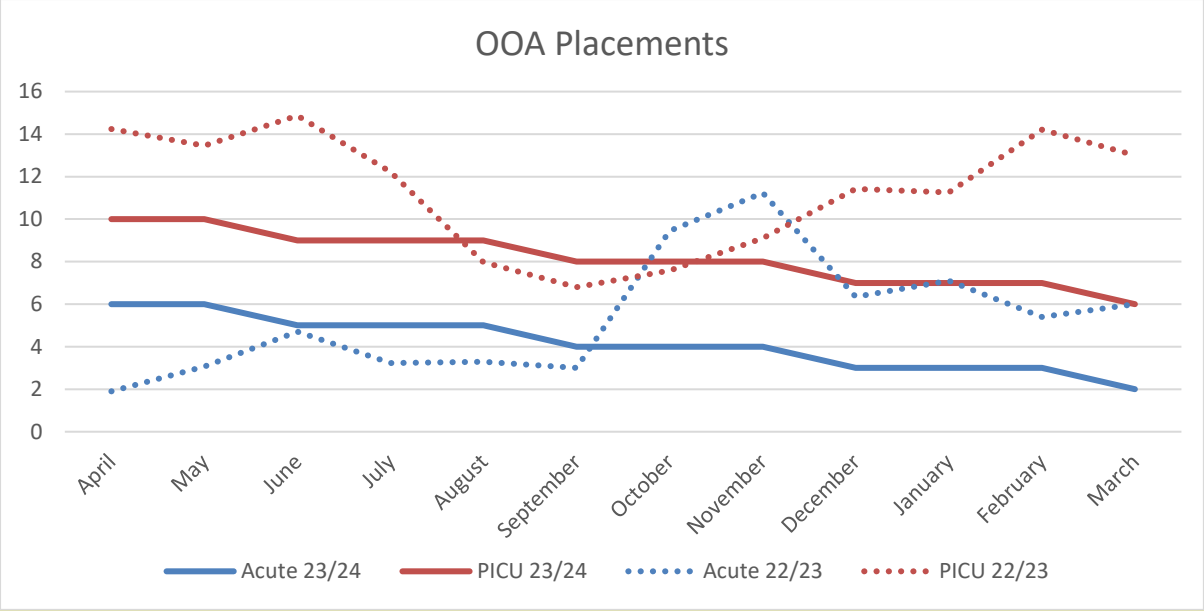
Individual departments reflect the agreed funded establishment with a vacancy factor held at Care Group Level.

Based on the workforce profile proposed for 2023/24 the calculated vacancy factor is a net (£16.3m) reduction to pay budgets. This is made up of a £(40.5)m reduction to substantive budgets offset by the Bank £15.5m and agency £8.7m.

As this calculation assumes current staffing levels, it has resulted in a non recurrent increase in the budgets for Forensic, Inpatient and OPS Care Groups whilst a review of the establishment is undertaken.

6.7 Out of area

The 2023/24 plan has a target for reducing inappropriate out of area placements by March 2024. The plan assumes an average of 4 Acute and 8 PICU patients across the year profiled as follows;



With an inflation assumption of 10% on bed day prices this results in an OOA budget of £4.8m for 2023/24 a reduction of £0.6 on this years FOT of £5.4m. There does remain some risk with this plan with current patient numbers 3 higher than that assumed in April 2023.

6.8 Non pay assumptions

Non pay has been realigned based on this year's forecast outturn, adjusted for non-recurrent spend and contract changes where notified.

Non pay inflation assumptions assumed in plan are as follows:

- Drugs 5%
- Food 10%
- Energy 10%
- Other 5%

6.9 New Investment and CIP's

Overall the Trust financial plan reflects a CIP target of:

£11.9m CIP of which;
£8.7m core plan as per table in 6.3. which is largely unidentified or requires EQIA assessments to be undertaken focus is on agency reduction, pay premiums, stretch target on OOA placements, focus on non pay
£2.2m is from OOA planned reduction (current run rate vs 23/24 assumption) does not currently feature in table 6.3 but is netted off within the overall position.
£1.1m provider collaboratives, this is an application of national planning assumptions and efficiency will be taken from 23/24 contract offers. Does not feature in table 6.3 as that excludes collaboratives.

In order to ensure the Trust delivered a balanced position for next year the following action will be taken:

- All recurrent and non-recurrent new investment is held until we have a credible CIP plan with the exception of;
- Hold the £1.0m non recurrent investment contingency and further non pay inflation needs to be managed in existing budgets.

6.10 Capital

The overall West Yorkshire ICB capital allocation for 2023 / 24 is £159.5m. Of this the SWYPFT allocation, as calculated by the ICB, is £8.3m. This is mathematical calculation rather than a risk-based prioritisation of funding and schemes. This creates risk within the whole system. This excludes the impact of IFRS 16 / Leases.

The current internal plan is below with a detailed paper to follow.

Programme Area	2023/24 (£k)	2024/25 (£k)
Estates Minor Cap	3,310	2,070
IT Cap	2,765	2,910
Major schemes	2,225	3,078
Total	**8,300**	**8,058**

Recommendation

The Trust Board is asked to:

- **RECEIVE** the update on the final Trust Operational Plan 2023/24.

South West Yorkshire Partnership NHS Foundation Trust

Operational Plan

2023/2024

16th March 2023

FINAL

Version 17.0

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1. Context

On 23rd December 2022, NHS England (NHSE) released its 2023/24 priorities and operational planning guidance 'NHS Operational Planning Guidance for 2023/24', outlining three priority areas:

- to recover core productivity.
- to progress the aspirations in the Long Term Plan.
- to transform the health and care system for the future.

Integrated Care Boards (ICBs) were asked to work with their system partners to develop plans to meet the national objectives set out in the guidance and the local priorities set by systems. Requirements outlined the need for plans to be triangulated across activity, workforce and finance, and signed off by ICB and partner trust and foundation trust boards before the end of March 2023.

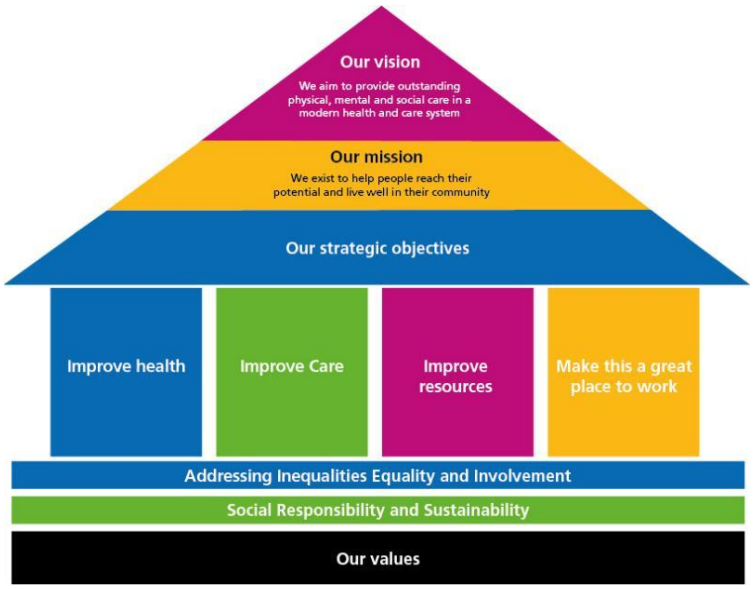
To support these system level requirements, work has taken place internally to prepare the Trust's operational plan. Plans have been developed by Care Groups and Corporate Service areas as follows:

- Forensics.
- Learning Disabilities and Adult ADHD/ASD.
- Barnsley Community (including Barnsley Mental Health Community).
- Mental Health Adults and Older Adults.
- CAMHS.
- Finance.
- Quality and professions.
- People.
- Provider collaboratives.
- Estates and facilities.
- IM&T.
- Medical Directorate.

The Trust Operational Plan has been built up from the detailed Operational Plans developed by individual Care Groups and support functions.

2. SWYPFT strategic context

The Trust has strong values, and a clearly defined vision and strategy, which is refreshed on a regular basis to take account of any changes in the operating environment. Our strategy is closely aligned to the NHS Long Term Plan. The Trust place considerable emphasis on our values, and input from our service users, patients, staff, members, and carers as we develop our plans.



The Trust has four strategic objectives, these are to:

1. Improve health.
2. Improve care.
3. Improve the use of resources.
4. Be a great place to work.

In addition, the Trust has five clearly identified strategic ambitions which the Board has agreed:

- A compassionate and innovative organisation with equality, co-production, recovery, and creativity at its heart.
- A regional centre of excellence for learning disability, specialist, and forensic mental health services.
- A trusted provider of general community and wellbeing services delivering integrated care.
- A strong partner in mental health and learning disability service provision across South Yorkshire and West Yorkshire.
- A trusted host or partner in our four local integrated care partnerships.

Trust priorities have been reviewed and updated for 2023/24. The review has considered:

- Trust mission, vision, values, objectives and ambitions.
- Review of the priorities for 2022/23 to consider whether they need to continue.
- A full analysis of business and associated risks and PESTLE (Political, Economic, Social, Technological, Legal and Environment) and SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses.
- Consideration of the Operational Planning Guidance.
- A review of the Trust's role in local place-based integrated care partnerships in Barnsley, Wakefield, Calderdale and Kirklees, South Yorkshire ICS and West Yorkshire ICS.
- Each Place's Health and Wellbeing Strategy (and emerging Health and Care Plans).

- Use of the Trust's Integrated Change Framework principles of risk/cost/complexity to assign work to different levels and clarify those which are the top-level priorities.

Priorities for 2023/24 (subject to Board approval) are as follows:

- Ensure that equality, diversity and inclusion is central to everything we do to reduce inequalities, tackle stigma and eliminate discrimination.
- Transform our older people inpatient services.
- Improve our mental health services so they are more responsive, inclusive and timely.
- Improve safety and quality.
- Spend money wisely and increase value.
- Make digital improvements.
- Inclusive recruitment, retention and wellbeing.
- Live our values.

3. Addressing inequalities

Our Trust belongs to us all. It considers the voices of service users, carers, families and friends, our staff, Board members and people who live in the local communities we serve. We take this responsibility very seriously, and it is fundamental to how we communicate with and work alongside everyone. Addressing inequalities in health such as barriers to accessing services, alongside systemic and institutionalised racism and discrimination continue to be a key focus.

Whilst we know there is still much more that we need to do, in 2022/23 the Trust has made significant progress in delivering on our equality and public sector equality duty, and work is progressing at pace to ensure we continue to build on our progress in the forthcoming year and beyond. To ensure we 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, we must consider equality and involvement at each stage of service delivery including as part of any decision-making process.

The Trust believes that an integrated approach to equality, involvement, communication, and membership helps us to deliver on our inclusion agenda. We know that each of these areas has its own drivers and legal obligations which we need to adhere to and deliver on. Our approach to equality will be driven by involving people and will ensure our methods and approaches are reflective of the audience we are aiming to reach. This means that a one size fits all or single approach will not provide the right conditions. Our commitment will be to always understand our audience before we start any activity.

The Trust has an Equality, Involvement, Communication and Membership Strategy and supporting annual action plans to ensure an integrated approach to delivering on our strategic objectives. The approach is insight driven and offers a joined-up approach to delivering equality and involvement in its broadest sense. The strategy identifies the processes already in place to support equality and inclusion, and the breadth of insight and intelligence that already exists.

Using the principle of involvement to underpin everything we do, we will drive the equality and inclusion agenda and ensure that equality inclusion and equity is central to everything we do to reduce inequalities, tackle stigma and eliminate discrimination.

3.1 Our equality objectives

Our objectives for equality and involvement are set out below, and each are supported by annual actions for 2023/2024.

Objective 1: Ensure we gather good quality data which can be used to support performance monitoring of service use and improve outcomes among those from the most deprived

neighbourhoods including Black, Asian and Minority Ethnic communities, people with a Learning Disability, Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) and people who identify as LGBTQ+, young people and carers.

Actions 2023/2024:

- Refresh all equality data in line with population census 2021.
- Continue to promote the 'All of You' campaign, to improve data quality and collection for all protected groups.
- Ensure we record carers, capture digital and communication preferences.
- Support staff to identify the right approach to capturing equality data which is trauma-informed through development sessions.
- Continue to improve the Equality Inclusion and Involvement Committee dashboard and metrics, identifying any specific areas of concern for improvement work.
- Continue to improve the Trust's insight, to ensure the data we collect can be intelligently analysed.
- Develop a 'health inequalities' tool for staff, using the Kings Fund approach to help identify and address health inequalities.

Objective 2: Ensure we provide person centred care which promotes inclusive, culturally and gender sensitive services, delivered by a diverse and representative workforce who seek to understand and pro-actively address inequalities and challenge discrimination.

Actions 2023/2024:

- Ensure every service has an up-to-date equality impact assessment (EIA) and accompanying action plan to address impacts.
- Ensure staff are compliant with equality, diversity and inclusion (EDI) mandatory training.
- Ensure managers and leaders received the enhanced EDI training.
- Offer staff development sessions.
- Embed the transgender policies with a quick guide.
- Develop a readers panel.
- Continue to collect reflective images for use in all information/ social media and publications.
- Embed the accessible information /disability policies and develop a short how to guide/development.
- Using a change approach and quality improvement (QI) methodology in service improvement areas.
- Ensure our estates reflect the needs of our staff and communities.

Objective 3: Ensure we work in partnership with partners and communities including the voluntary, community and faith sector to improve access to services, and ensure those from our most deprived neighbourhoods have equal access to pathways of care.

Actions 2023/2024:

- Reach out to a range of community faith networks to improve the Trust offer of 'Spirit in Mind'.
- Continue to develop awareness of different religions and beliefs through information and communication channels.
- Refresh and continue to celebrate the faith calendar, giving visible parity to all religion and beliefs.
- Increase the befriender offer.
- Continue to increase our Creative Minds offer using creative interventions in partnership with the voluntary and community sector (VCS).
- Continue to work with, and co-design our service offer in partnership with, the VCS.
- Continue to build on our commitment to carers.

Objective 4: Develop and sustain an equality competent organisation that demonstrates an inclusive and diverse leadership and workforce, addressing the balance of power and ownership at all levels, and improve equality of opportunity for staff and volunteers.

Action 2023/2024:

- Focus on inclusive recruitment and retention at all levels in the Trust.
- Commence a co-produced approach to leadership and talent management.
- Deliver the 'Flair' survey to understand racial bias and deliver an action plan on improvement.
- Appoint a dedicated lead for equality, diversity and inclusion in the People Directorate, with a focus on workforce.
- Deliver on Race Forward and align to 'All of You'.
- Increase the recruitment of diverse peer support workers.
- Continue to support staff networks.
- Develop a Trust approach to the emerging Women's Strategy.
- Assess against the national LGBT Framework.

We aim to ensure we involve and encourage the active participation of all our stakeholders to ensure our services are designed to meet the needs of our communities and support our workforce.

3.2 Involvement objectives

Objective 1: To ensure people who access health and social care services, families, carers and the public are involved in shaping health and care proposals and plans. To use what we already know as a starting point, so we do not repeat conversations or create involvement fatigue.

Actions 2023/2024:

- Develop a Trust wide understanding of involvement.
- Ensure that all priority programmes use insight data and involvement to drive activity.
- Continue to transfer the offer of a central survey monkey account to ensure management of surveys including use of equality monitoring.
- Finalise a Trust-wide survey toolkit.
- Develop a Trust-wide insight bank using survey findings.
- Embed a framework for consultation using the older people' services transformation approach.

Objective 2: To use equality and demographic data to ensure we inclusively involve the right people at the very beginning of a process in order to influence the development and design of services.

Actions 2023/2024:

- Ensure involvement approaches include a clear stakeholder map to help ensure we reach the right target audience as part of a planned approach to involvement.
- Ensure Joint Strategic Needs Assessment (JSNA) and EIA demographic data is used and analysed, to ensure we use the right methods and approaches for involvement.
- Ensure public membership database is used to ensure we reach people in each of our communities.

- Ensure Annual recruitment to the Members' Council is shared through our community networks, to increase representation and ensure the council is reflective and representative.
- Assess involvement in decision making to ensure we are reflective and representative.
- Increase the diverse representation of volunteers in the Trust.
- Evidence our approach using Equality Delivery System (EDS2) to demonstrate compliance with our equality duties.

Objective 3: To use the assets in our communities and create the right conditions to involve local people, going to where people and ensuring they remain involved.

Actions 2023/2024:

- Deliver a programme of training four times a year to increase our asset database.
- Maintain the asset-based approach administration offer through our core volunteer service.
- Continue to recruit a diverse pool of assets, to ensure reach into all our geographical locations, groups and settings.
- Utilise our assets to deliver programmes of work, ensuring they use the resources available.
- Continue to support our governors to involve people in our local communities.
- Work with the voluntary and community sector organisations in each of our places to deliver programmes of work.

Objective 4: To ensure we are an exemplar in co-production - through equal and reciprocal relationships with communities and professionals; recognising that both partners have vital contributions to make and ensuring we have a clear reward and recognition approach.

Actions 2023/2024:

- To develop a number of tools which can support co-production.
- To develop and deliver development sessions on co-production approaches to managers.
- To gather case studies which demonstrate our approach to co-production.
- To roll out our reward and recognition approach across the Trust.
- Increase our peer support worker approach to ensure we have lived experience represented in all service settings.
- Deliver a volunteer to career approach in targeted areas of deprivation.

Objective 5: To record, report and publish insight, so people can see the information driving our service decisions and actively demonstrating how we are using the intelligence we capture to deliver service improvement and patient centred outcomes.

Actions 2023/2024

- To use what we already know as a starting point by developing a framework to capture insight.
- To continue to ensure we record and report involvement activity using templates and recording equality data.

- To publish timely involvement reports on the website and provide updates.
- To align our approach with our service improvement, change and quality improvement approach.
- To ensure involvement and insight reports inform all strategies.
- To continue to consolidate insight through a quarterly insight report and update using 'you told us, we listened'.
- To develop a patient stories approach that is trauma informed.

The Trust's Equality Inclusion and Involvement Committee and sub-committee has been established to act on behalf of the Board and to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does. The Committee oversees the implementation of the Equality, Involvement, Communication and Membership Strategy to improve access, experience, and outcomes for people from all backgrounds and communities. This includes people who use, work and volunteer for our Trust services and those who work in partnership with the Trust with the strategic aim of improving health, care, resources and making our Trust a great place to work.

The Trust works with a range of partners across the system including West Yorkshire and South Yorkshire ICBs to ensure a partnership approach to system transformation. In addition, senior leaders work at a place-based level, led by local authorities and commissioners to ensure the Trust is part of local decisions and can respond in partnership to protect and support the most vulnerable. The Trust uses the JNA intelligence to understand the local population and the Equality Impact Assessment (EIA) as a tool to inform service impacts, identify actions and ensure service improvement.

The Trust aim to have access to commissioner equality impact assessments, engagement findings and ethnicity data to build on work taken place to inform service development and delivery and make best use of shared insight. This approach will ensure the Trust develop services based on existing intelligence as a baseline. We ensure that at a service level a robust Equality Impact Assessment is completed as a key part of any service development, delivery or change and we have established strong relationships with communities through our creative approaches through linked charities Creative Minds and Spirit in Mind and recovery colleges. The Trust has a translation and interpreter service which is used to support access to services. Information is available in easy read formats. We have a co-design approach to communications to ensure literature and images are reflective of the intended audience.

The Trust has developed an experience and engagement tool which includes a mandatory equality monitoring form so data can be disaggregated and interrogated by diversity and ethnicity. All services have an EIA in place, completion and updates are monitored and reported to the Equality Inclusion and Involvement Committee to provide assurance. The Trust have created a Trust-wide Mental Health EIA and an evidence and research toolkit to support staff to update and completed existing EIAs. There continues to be a focus on gathering equality data to ensure the quality of data is improved, so that data can be used to support insight which can inform our approach to identify and address health inequalities.

4. Activity Planning

4.1 Approach to activity planning

Our approach to activity planning is based on a practical understanding of service pathways and the journey taken by service users. We deliver across a broad portfolio of services and communities. In each, we seek to optimise the experience of care, ensure that resources are deployed effectively by matching capacity to demand, and where necessary highlighting development requirements arising from our partnerships with commissioners and providers.

4.2 Achieving key operational standards

We are a Trust that provides prevention, wellbeing, and community healthcare services as well as learning disability and mental health services. As such there are many operational standards that are important to us in addition to those that are reported on nationally. These are reviewed locally in our Care Groups and by our senior operational management group.

Activity plans will continue to support achievement of the key operational standards we are required to meet both nationally and locally. Typically, the Trust has a strong record in achieving both national and local targets and where there are issues plans are rapidly deployed to address. For example, for Early Intervention in Psychosis (EIP) services, we have continued to achieve the 60% target for the two-week access standard for completed pathways (84.8% December 2022). During 2022/23 the Trust has made positive progress with IAPT access standards. In December 2022 98.5% of people accessed IAPT within 6 weeks (target 75%) and 99.5% people accessed IAPT within 18 weeks (target 95%). We continue to achieve IAPT recovery rates (52.6% versus 50% target in December 2022) and extend the reach of IAPT services to help more people. The Trust has exceeded targets for number of people accessing Individual Placement Support in 2022/23.

We know that there are a number of key areas where improvements need to be made. For example, the percentage of patients on the Care Programme Approach (CPA) offered a copy of their care plan remains below target at 44% in December 2022. Work continues in clinical services to adopt collaborative approaches to care planning and new metric has been identified and work is being undertaken to implement this in the coming months.

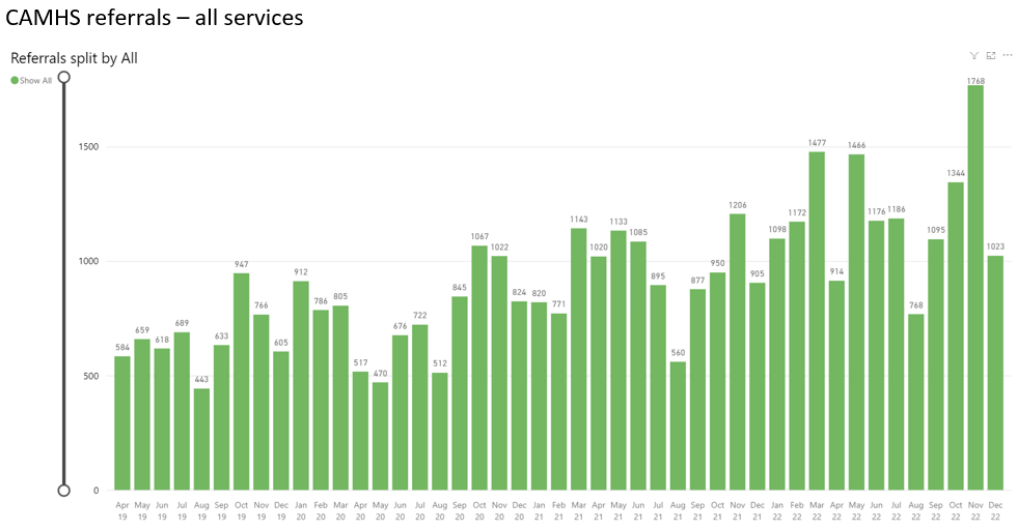
The percentage of patients with an up-to-date risk assessment continues to remain below target for both mental health community (71.2%) and mental health inpatient teams (76.4%). We have set up a trajectory of improvement to full performance by the end of Quarter 3 2022/23, but this will remain a focus for 23/24.

4.3 Pressures associated with increase in demand and acuity

The Trust continue to experience demand-led growth in activity and acuity in areas such as CAMHS, mental health intensive home-based treatment, speech and language therapy, neighbourhood rehabilitation and neighbourhood nursing.

Increase in demand in CAMHS services can be seen in the below chart which shows the total number of referrals received to all Trust CAMHS services since April 19. This shows a spike in November 22 where number of referrals received was the highest in the period since April 19.

CAMHS referrals all services



There are some services where the waiting times to access assessment and treatment remain too long. These are systemic problems, and we continue to work with our commissioners to ensure that additional investments are accompanied by improvements in pathways and service delivery. Due to Covid-19, waits for some services such as CAMHS neurodevelopmental assessment increased, and this continues to be a cause for concern.

Key areas of focus outlined in Care Group plans include:

- Improving waiting times (referral to treatment) for CAMHS, particularly waits for CAMHS neurodevelopmental (ADHD/ASD) diagnostic assessment.
- Improving waiting times for psychological therapies e.g. cognitive behavioural therapy and counselling services in Barnsley.
- Managing demand for children's services in Barnsley.
- Managing demand for adult neurodevelopmental (ASD/ADHD) services.

4.4 Key activity planning assumptions

4.4.1 LD and Autism

Our plan supports the following system target:

- Ensuring 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024.

To support delivery, ongoing work has taken place with GP practices to align the register of learning disability (LD) patients, and to facilitate annual health checks (AHCs), in line with planning guidance to ensure delivery of annual health checks for people with a learning disability. SWYPFT's locality community nursing teams support this activity for anyone that is open to the team. In addition to this, GP Practice LD awareness raising training has been rolled out to the majority of practices across our places to support completion of AHCs for people with a learning disability. Nurses in community teams provide regular reasonable adjustment advice to practices and will attend AHCs to support where needed (for service users that are open to SWYPFT). Strategic Health Facilitators are in place to support this work.

4.4.2 Community Health Services (general)

The Trust will contribute to system targets in Barnsley to:

- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard.
- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

The Trust have a well-established Urgent Community response pathway in Barnsley, and are able to meet the 2-hour crisis response standard to prevent hospital attendance, and support patients more effectively at home. We are currently achieving 84% against the 70% target of seeing patients within 2 hours. Patients have direct access to MSK First Contact Practitioners (FCP) via our FCP Model implemented in Barnsley.

4.4.3 Urgent and Emergency Care

Our plan ensures alignment with the NHS England Delivery Plan for Recovering Urgent and Emergency Care Services, January 2023.

As described above, the Trust have a well-established Urgent Community response pathway in Barnsley and are able to meet the new 2-hour crisis response standard. Further refinement and development are underway with the GP out of hours service and our social care response service. During the night, co-location and shared resource enables an improved service offer to stabilise and support patients offering an alternative to transport to accident and emergency. We have worked with Yorkshire Ambulance Service to develop direct booking from 111 into this service offer rather than a referral to the service. As a result of work with Yorkshire Ambulance Service and RightCare, we have been able to support category 3 and 4 patients, which will support a reduction in the number of ambulance calls outs, improved waiting times for patients.

In terms of our broader contribution to planned and proactive care (which supports more care at home and less flow to secondary care, accident and emergency etc) on average on a daily basis across neighbourhood nursing, neighbourhood rehab our Barnsley services are visiting upwards of 900 patients in their own homes and on average only 0.4% are admitted to hospital, significantly reducing pressure on emergency care.

In response to guidance issued by Government in March 2020, the Trust and its partners developed a hospital discharge service in Barnsley. This requirement was put into place to free up inpatient bed provision to deal with the COVID-19 pandemic. Community health providers were asked to set up a co-ordination team to ensure that patients were discharged on time and provided with follow up support as needed. This is now fully embedded delivering to Discharge to Assess guidance and has received national recognition (June 2021).

Our recovery and support provided post-discharge (including rehabilitation and reablement services) aims to help people return to the quality of life they had prior to their most recent admission. For some people this may require support for these additional needs for a period of approximately 6 weeks, although for the majority it will be suitable for them to return to usual packages of care (if applicable) in less time. Progress of this has been excellent and Barnsley recognised nationally for its model of delivery and collaborative working.

The NHS Delivery Plan makes several references to urgent mental health support and the Trust Plan aligns with these requirements. The Trust will keep under close review the NHSE evaluation of mental health crisis assessment suites.

4.4.4 Access to mental health support for children and young people

As described above, waiting times and waiting numbers for CAMHS and neurodevelopmental services within CAMHS remain high. Waiting list initiatives are in place to work towards stabilising this position from March 2023.

The percentage of CAMHS patients waiting less than 18 weeks from referral to treatment was 70% in December 2022. This has increased over the last few months, but this is not necessarily positive as it is linked to increase in referrals/demand - as new referrals have a shorter waiting time. CAMHS continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service will provide additional support.

We continue to have challenges accessing tier 4 beds for children/young people and increasing demand/acuity regarding children/young people eating disorders.

4.4.5 Adult mental health

The Trust will contribute to system targets to:

- Increase the number of adults and older adults accessing IAPT treatment.
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.
- Improve access to perinatal mental health services.

Due to recent communications from NHS England regarding reduced targets/aspirations for 2023/24 for IAPT access due to national issues of recruitment and retention, our plans forecast access will remain at 2022/23 rates.

The Trust have forecast in our plans to achieve the 5% year on year increase in the number of adults and older adults supported by mental health services. This will be supported by the continued work to develop the transformed services in each system, and the fulfilment of the Mental Health Investment Standard.

For Perinatal Mental Health, we have forecast to reach the access target of 10% of the eligible population by the end of March 2024. The Perinatal Team has faced the same recruitment challenges as those nationally which does impact on the ability to manage capacity and hit access targets. However, we are in a strong position approaching the end of this financial year in terms of recruitment. Therefore, moving into the new financial year should ensure the capacity to meet the increased targets. Currently our referral rate is good, therefore focus in 2023/24 will be on improving waiting times to improve women's engagement in their assessment and treatment appointments. We will continue to work closely with our partner agencies, running Perinatal Network meetings and delivering training to ensure services are aware of our referral pathway and service specification. In 2023/24 data from the Maternal Mental Health Services (MMHS) flow will be reflected in our data set which we anticipate will have a positive impact on performance.

4.4.6 Out of area adult acute inpatient mental health placements

The Trust will continue to work towards eliminating inappropriate adult acute mental health out of area placements.

In the past few years, the Trust has experienced an increase in demand for inpatient care that has exceeded our capacity. People therefore have had to be placed outside the Trust bed base and this impacts on them and their family/friends. The factors which are contributing to this situation are many and complex.

Significant work has been undertaken to understand and manage the bed pressures. Through recent years, an improvement programme has been established to focus on areas which will have the biggest impact on reducing demand pressures and enabling a strategic longer-term approach to implementing a lower admission model. The work has been focused on providing all care as close to home as possible.

The Trust has continued to support improvement activity via the out of area programme including:

- Implementing criteria-led discharge across the inpatient service, which helps ensure appropriate stays in our wards by identifying and addressing barriers to discharge in a timely manner.
- Extending our Trust-wide patient flow service to 7 days a week and until 7pm on weekdays, which helps ensure the most appropriate use of inpatient beds / optimise bed usage, with systems to make sure that all viable options are tested before people go out of area.
- Establishing strong trauma-informed pathways in every place that better enable us to support people in the community.
- Ensuring effective gatekeeping for people in crisis.

The Trust had achieved zero acute out of Trust placements by March 2021, although there remained a need for a small number of gender specific PICU placements (not commissioned for). However, since April 2021 and through 2022, there has been an increase in demand for out of area beds, which has been exacerbated by pressures across acute inpatient wards.

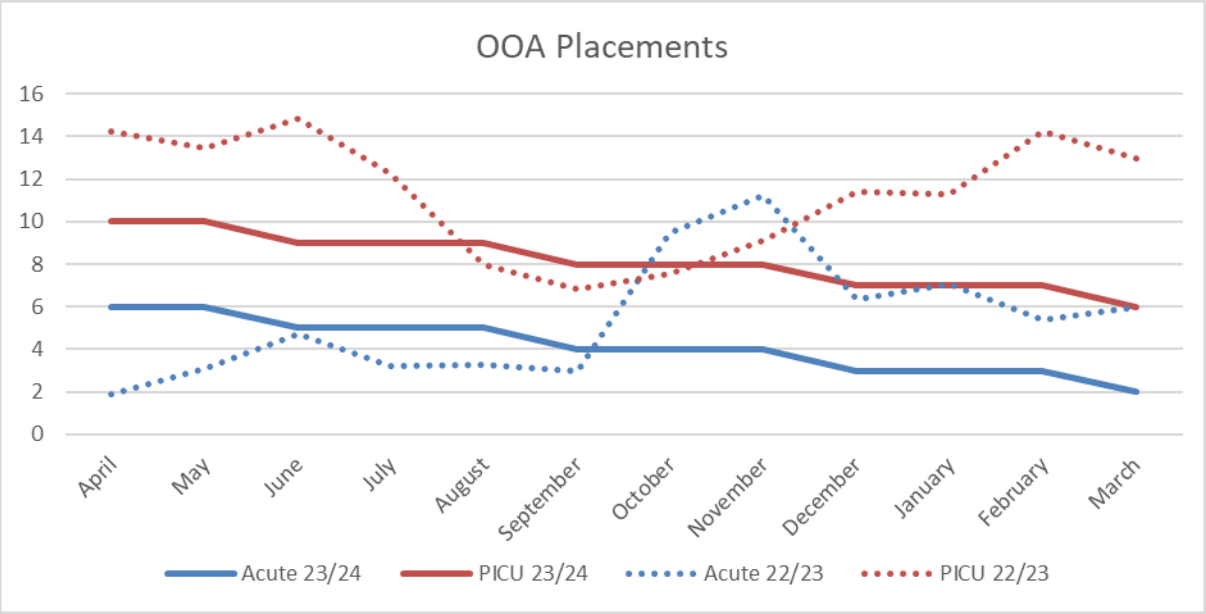
There remain challenges in the system, as evidenced by the ongoing use of PICU beds, especially for gender specific requirements, and challenges with increases in demand across the whole system. This is in the context of the Trust acute service operating under considerable and ongoing pressures.

Work continues in front line services to adopt collaborative approaches to care planning, to build community resilience, and to explore all possible alternatives to hospital admission for people who need acute care. This has included continued developments in the trauma-informed personality disorder pathway. Work continues in the intensive home-based treatment teams (IHBT) to look at building up early discharge, alternatives to admission and to ensure robust gatekeeping.

Going forward, we are continuing with our change programme in a partnership approach with commissioners until we have confidence that we have established a sustainable lower admission and bed use model.

Due to the increased pressures, the Trust further revised trajectory for out of area placements. Our 2023/24 plan has a target of reducing inappropriate out of area placements by the end of March 2024. It assumes an average of 4 Acute and 8 PICU OOA beds across the year profiled as follows:

Out of area placements



This revised trajectory underpins our plan assumptions.

Whilst work will continue to focus on crisis alternatives to admissions, a key priority in 2022 has been to refocus on ensuring timely discharge from the wards and more proactive care management of the people that are placed out of area to ensure they can be discharged or repatriated as soon as appropriate. A range of activities has been taken forward in 2022 to put systems in place, both internally and with partners, to facilitate timely discharge. This work is helping to ensure that the Trust is being more systematic at identifying and overcoming barriers for discharge and is now being aligned to the NHSE/I discharge initiative.

The proactive approach to care management of people out of area has meant that the Trust can quickly repatriate people when there is capacity in system and keep a focus on timely discharge for people who remain out of area.

A separate programme board is now established and oversees activity to ease some of the current challenges across the inpatient wards. This has led the establishment of enhanced leadership models across the wards and the governance for this programme from 2023 will oversee the inpatient activity to improve flow across the wards.

5. Quality Planning

5.1 Our approach to quality improvement, leadership, and governance

Our executive lead for quality improvement is the Chief Nurse, Director of Quality and Professions. Our Trust-wide improvement approach is clearly reflected in our Quality Strategy. The strategy starts with our mission and values and describes how we utilise these to deliver and inform quality and identify quality improvement.

Our Quality Strategy aims to:

- Deliver our quality priorities
- Support our journey to becoming outstanding

- Measure and understand where we have made improvements and where we can do better, against our quality priorities

Our current quality priorities are:

- Equality, inclusion and equity
- Safe and responsive care
- Health, wellbeing and experience of staff

These will be reviewed through the life of the quality strategy (2023-2026).

Within our strategy we describe an integrated approach to the delivery of change based on recognised best practice. Through this we aim to ensure that quality improvement occurs as near to people who use our services as possible, and we support the delivery of change initiatives to ensure quality improvements are successfully implemented.

Improvement and innovation for quality is about making healthcare safe, effective, service user centred, timely and efficient. Our key driver is to ensure that we should systematically improve quality throughout our services, strive to support our service users to achieve positive outcomes and live life to the full whilst reducing unnecessary clinical variation.

Quality improvement is a priority at Board level and throughout the Trust. The Clinical Governance and Clinical Safety Committee (CGCSC) reports directly to the Trust Board and the lead is a Non-Executive Director supported by the Deputy Chair, the Chief Nurse, Director of Quality and Professions. A number of standing sub-groups which cover quality and safety areas are chaired by the Medical Director, Director of Nursing, Quality and Professions or their deputies and report directly into the Clinical Governance and Clinical Safety Committee. Quality improvement is routinely reported to our Trust board through our Integrated Performance Report.

We have aligned our strategic objectives, priorities and programmes and quality initiatives and we will use these as a framework to focus on continuous improvement, innovation, and monitor assurance. In addition, we will ensure all our improvement efforts will make the best use of expertise and resources.

To guide our development, we report on a range of different quality indicators in our Integrated Performance Report (IPR), including friends and family test results, infection prevention, serious incidents, safer staffing, reducing restrictive physical intervention, safeguarding, pressure ulcers, CQUIN performance, restrictive interventions, and complaints. Each of these has a specific ‘stretch’ target that reflects improvement in quality, and can be viewed by team, service and Trust-wide. The report is considered at the Executive Management Team (EMT), the Board and its committees. This enables us to evidence the return on our investment in quality.

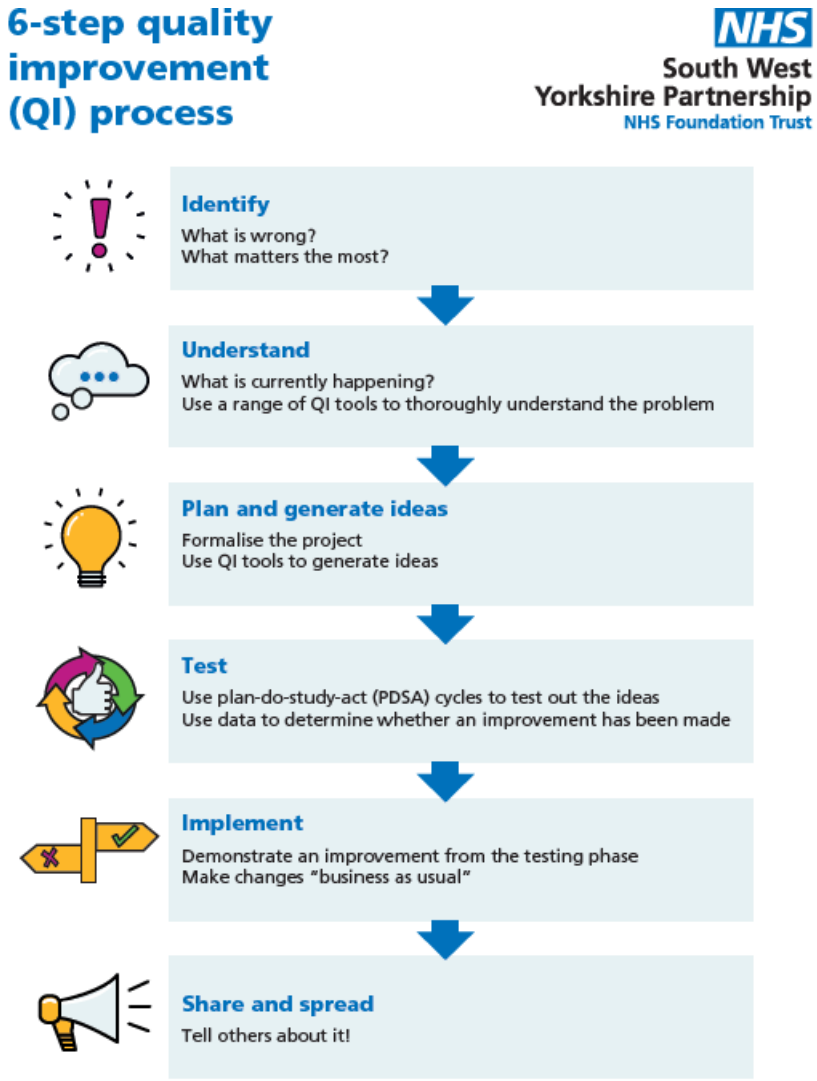
We learn through a robust clinical audit programme, and we participate in research and development with links to universities and Academic Health Science Network (AHSN). We also contribute to, and learn from, external benchmarking and reporting initiatives, including the national confidential enquiry into homicide and suicide, mental health benchmarking and workforce capacity and demand. There is also an active programme of quality monitoring visits to our operational areas, from which we derive significant learning and quality assurance.

In line with the vision, we set out in our Quality Strategy we will use the Model for Improvement to address themes identified in the Care Quality Commission (CQC) inspection report (2019) which not only impacts on our requires improvement rating for safety but in serious incident reports fitness to practice cases and CQC Mental Health Inspections. These areas are:

- Risk assessment.
- Care planning.
- Record keeping.

- Safe medicines.
- Reducing violence against staff.
- Always Events: Dignity and respect.

SWYPFT Quality Improvement (QI) project process



The **benefits** of using quality improvement methods also mitigate the risks. Benefits include:

- Staff engagement.
- Ownership of problems and solutions at all levels in the Trust.
- Sustainable outcomes.
- QI approach aligns with the Trust's vision and values.
- Approach builds empowerment of the workforce.
- Approach builds a culture of continuous quality improvement.
- Improved outcomes for service user.
- Improved working conditions for staff.

The **risks** for the Trust in terms of using the quality improvement approach

- Adopting a quality improvement approach involves significant and sustained cultural change and requires time and resource.

- We need to accept that quality improvement is not a ‘quick fix’.
- This will need changes in mindset at all levels including senior leaders so there is a need to commit to a shift from ‘problem-solving’ to being enablers of change.
- Quality improvement methods require a fundamental change to how we work, our leaders need to ensure that staff are engaged with and actively involved in developing a shared vision of the quality improvement strategy.
- For the approach to be successful it is vital that there is board level commitment to the principles of quality improvement and support for the shift in emphasis from assurance to improvement.

In mitigation to these risks, the Trust has endorsed the quality improvement approach as detailed in our quality strategy and in the training they are supporting, i.e. NHSI Quality Improvement Board Development and the Institute of Health Improvement modules for quality improvement.

5.2 Summary of Quality Improvement Plan (including compliance with national quality priorities)

Our quality priorities use the CQC five key domains as our framework for developing quality approaches in the Trust. Our quality priorities reflect the needs of our service users and learning from our quality improvement systems. Priorities are aligned to national drivers and the Integrated Care System plans for West Yorkshire and Harrogate (WYH) and South Yorkshire and Bassetlaw (SYB).

5.3 Key priorities for 23/24

Our Quality Strategy identifies the following key actions for 2022/23 in line with our quality priorities. These will be continually reviewed throughout the life of the current strategy.

Safe and Responsive Care

- Implementation of Patient Safety Incident Response Framework
- Introduction of volunteer support roles to support waiting well and post discharge service users
- Use technology to support improvements to risk assessment and care planning.
- Continue with the rollout of SafeCare
- Improving clinical record keeping across all service areas
- Revising the Care Programme Approach process
- Run Trust wide learning events in response to emerging themes from serious incidents

Equality, Inclusion and Equity

- Monitor and understand health inequality data across our geography
- Increase co-production of care plans, problem solving and improvement
- Development of patient experience representatives across the Trust.
- Introduce the Triangle of Care to support better involvement of carers and families in care planning
- Develop processes for collecting equality data within quality initiatives
- Embed staff training and supported related to equality and diversity into all aspects of quality improvement
- Develop a practical way to collate actions as a result of feedback received.
- Ensure feedback mechanisms are accessible to users, carers, and families

Health, wellbeing, and experience of staff

- Improving accessibility and communication of our health and wellbeing offer.
- Continued focus on psychological and physical health and the prevention of illness
- Roll out menopause support programmes
- Recruitment of staff dietician

- Become a Trauma Informed Organisation
- Further embed the wellbeing champions, equity guardians, civility and respect champions
- Continuing focus on developing a sustainable workforce.
- Embed a robust CPD programme

6. Workforce Planning

6.1 Approach to workforce planning

The Trust implemented our 3-year Workforce Strategy in July 2021 (2021-2024), which was agreed at Board and is governed by the People and Remuneration Committee (PRC). The Workforce Strategy recognises that a key requirement of delivering safe and sustainable services within agreed resources is a fit for purpose workforce. The Workforce Strategy is consistent with the workforce issues identified in the NHS Long Term Plan and has 5 key strands, underpinned by equality and diversity and values-based human resources management with the key theme being SWYPFT as a 'Great Place to Work'.

The strands are all built on a foundation of the Trust Values:

- We put people first and, in the centre, and know that families and carers matter.
- We're respectful, honest, open and transparent.
- We constantly improve and aim to be outstanding so that we're relevant today and ready for tomorrow.

The Workforce Strategy is also designed to ensure we have the people to:

- Support the delivery of NHS Long Term Plan and the greater emphasis on mental health particularly for children and young people.
- Implement the Mental Health Framework.
- Support the Integrated Care Systems.
- Support place-based health and wellbeing plans.

6.2 The SWYFPT Workforce

Over the next 12 months, we are projecting that our workforce staff in post will grow by a projected 3% overall. Our 12-month workforce plan establishment is projected to rise as a result of expansion to mental health investments and continued delivery of our successful recruitment via international avenues, particularly for mental health nursing, but also expanding to other professions. Utilisation of agency remains a challenge, but we are working on several recruitment and retention strategies to address this position. The Trust have implemented an agency scrutiny group whose aim is to identify reductions in long term agency expenditure. The use of agency is primarily due to hard-to-fill vacancies and increases in inpatient acuity and short-term requirements that cannot be covered by the Trust's internal bank. We continue to review all vacant posts and consider an alternative workforce solution to those that are more difficult to recruit to positions. The trust will soon be publishing its revised recruitment and retention plan, which focuses on widening participation and engagement across the widest potential labour market, building upon our current social media engagement, the roll out of reduced time to hire initiatives with the implementation of new application tracking and onboarding IT, and full roll out of the Trusts first micro-site for career engagement.

Currently we have 4,211 Whole Time Equivalent (WTE) substantive staff in post (March 23) with an overall vacancy position of 17%.

Turnover (for the last 12 months) is at 16% (March 23) and is projected to continue at these levels. This is due to several pressure factors in the system, including expansion of our establishment following mental health investment (MHIS). The NHS is facing unprecedented challenge in the labour market and competition for staff both with other healthcare providers and employers in other sectors for non-clinical roles will continue into the mid-term. The number of posts lying vacant across the NHS in England has reached a record high of 132,139 – 9.7% of the planned workforce and a vacancy rate of 11.8% for nurses

(NHS Employers, September 2022) specifically in clinical professional roles within mental health nursing, psychology, CAMHS and learning disability services, although recruitment pressures are not solely held within just these roles. We currently adopt best practice retention and recruitment across all occupations however the labour market will remain a challenge due to competition for available staff. We know that where turnover is high it can lead to difficulties recruiting staff, particularly if skills or expertise is in short supply and have negative effects on staff wellbeing and stress and anxiety related absence.

Our main workforce increase will be within our band 5 nursing roles across in-patient services as this is where our most urgent need remains, along with expansion of key clinical support workforce roles (nursing associates, associate clinical practitioner delivery and psychotherapy roles). Our plans to increase our band 5 nurse workforce will come from two key recruitment streams. We are building upon our successful year 1 international nurse recruitment programme which delivered an extra 35 wte nurse placements in 2022. We are planning to deliver a further 56-60 between January to December 2023, and further to this have identified targeted overseas events aimed at increasing this number significantly as one-off recruitment events. In addition to this we have planned values-based assessment centres on a rolling monthly basis aimed at recruitment of both nurse band 5 roles and HCSW roles both substantive and bank. These workstreams have been factored into our recruitment plan which should see recruitment activity double from that achieved in 2022-23.

We continue to experience demand-led growth in activity and acuity in some areas. Due to Covid-19, waits for some services such as CAMHS neurodevelopmental assessment have increased. We have reviewed our activity, workforce, and financial data to ensure that we have appropriate resources in place to deliver effective services. Pressure regarding staffing levels and the recruitment/retention challenge in is a barrier to post-Covid stabilisation and recovery. This creates specific challenges around achieving safer staffing levels on wards and for example in ensuring sustainable access to Section 136 suites. A key issue moving forward is to strengthen 24/7 crisis provision (all ages) improving triage support of police/Yorkshire Ambulance Service and developing helpline and safe space options.

We have several key programmes of work we are involved in with each ICB which will have an impact on Trust workforce:

- Optimisation and best use of the mental health bed base across West Yorkshire.
- Implementation of plans to improve how learning disability services are best provided across West Yorkshire.
- Leading the Provider Collaborative for adult secure services across West Yorkshire.
- Mental Health & Learning Disability collaborative work across South Yorkshire and West Yorkshire.
- Implementing the Community Mental Health Transformation across both ICB footprints.
- Lead provider of Forensic CAMHS.
- Partner in the West Yorkshire Learning Disability Assessment & Treatment Unit.

6.3 Key workforce challenges

As staff leave posts, we are generally successfully filling them. Our recruitment activity is up 30% on normal activity over the last 6-12 months. We see the greatest challenge to recruitment from an available newly qualified demand, particularly within nursing, psychology and allied health profession roles. To maximise our potential to meet these challenges we have identified the following as key workstreams:

- A proactive international recruitment strategy building upon year implementation. Widening this further than mental health (MH) nurse recruitment to registered general nursing (RGN), allied health professional (AHP) professional roles and potentially psychology.
- Further recruitment through the Trust's International Fellowship programme. This 2-year placement programme has already seen the Trust employ 14 international fellows across the Trust who have gone on to secure full time roles, specifically in our specialty doctor vacancies.

- Attendance at recruitment events both locally, national and internationally. We will be moving back to more physical attendance events post Covid as well as diversifying our reach into LBGTQ+ and protected characteristic groups for staff.
- Bespoke boosted adverts on social media. Identification of targeted marketed campaigns for hard to fill role and areas of service (e.g. Secure CAHMS, Forensics, General Community roles)
- Enhanced links with Job Centre Plus, New to Care and other Employability schemes to promote entry level roles across estates, ancillary roles and admin.
- Work closely with Touchstone to promote improved access and support to application into vacancies from disadvantaged groups.
- Continual rolling adverts for band 5 nursing, international direct hire nursing, healthcare support worker roles both substantively and bank.
- Work ongoing to embed a collaborative bank across the NHS Mental Health Trusts. This has been delayed due to provider acquisition but remains a focus for delivery.
- Continuing to seek to streamlined recruitment process including the introduction of an Applicant Tracking system and onboarding system to enhance the applicant experience, improve ongoing communication and engagement and reduce time to hire.
- A standalone SWYPFT careers microsite improving engagement.
- The re-branding and re-communication of the Trust-wide internal transfer scheme matching staff to alternative roles for staff who are looking to leave the Trust. The Trusts 'Above-the-bar' scheme will also be improved to see greater placement of staff appointable but unsuccessful matched to vacancies elsewhere in the Trust.
- A range of wellbeing initiatives for current and prospective staff

Retirement numbers have been lower than might have been expected in the past 12 months, but the trend for retirements is now starting to rise. The prolonged impact of Covid and the Trusts efforts to encourage staff to support the staffing issues resulted in staff postponing their intentions to retire. Now the pandemic is easing those staff are now choosing to take their retirements (and similarly some staff who had not intended to retire have now decided to do so) due to the impact of work from the past 18-24 months.

Retirement risks % of staff aged over 50 years of age

	%
Add Prof Scientific and Technical	25.83
Additional Clinical Services	31.05
Administrative and Clerical	47.01
Allied Health Professionals	23.19
Estates and Ancillary	63.30
Medical and Dental	39.20
Nursing (Registered)	33.20

We would expect to see higher numbers, particularly from more skilled specialist roles in all professions over the next 2-3 years with 23.6% of staff aged 55 and over. It is projected that circa 100 staff will retire annually and therefore strong succession planning and talent identification will be required.

Our biggest workforce gaps are being seen in several areas. Nursing primarily will continue to see significant vacancies in the mid-term due to the increased need for establishment growth to meet both inpatient and community nurse led services, including all areas of inpatient services across forensics, working aged adults and older people's services. Our International Nurse Recruitment (INR) programme currently supplies almost 20% of our total new nurse intake due to a shortfall in newly qualified demand (NQD) from universities, but we do not want this to remain our only support to effective recruitment of

nurses in the mid-term. We need to see less reliance on this through the next 3-5 years and so front loading and expansion of nurse placements is needed now given lead in times to qualify.

Whilst the Trust does not see immediate issues regarding Health Care Support Worker recruitment due to our successful apprenticeship programme and recruitment initiatives, competition for staff at entry level is becoming more challenging and entry level requirements need to be widened.

Work has continued to strengthen crisis and Intensive Home-Based Treatment pathways for all CAMHS, and the 7-day working is now in place with extended hours in Wakefield, Kirklees and Calderdale. All Age Liaison is in place in all areas. In West Yorkshire ICS, relationships with the new CAMHS inpatient building have been established and we are working well with regional colleagues to seek and offer support and share best practice. CAMHS staff recruitment, retention and development has been a key focus the main priority to move towards trauma-informed care and treatment that is responsive to risks and risk management. We are however seeing significant recruitment challenges within CAMHS services, notably for psychology roles and specialist CAMHS nurse roles and ACP level nursing.

Wakefield, Kirklees and Calderdale have established Mental Health Support Teams (MHSTs) and are working within their localities to connect the work we do with the third sector and other partners to ensure good outcomes for children and young people.

We are working to develop a robust utilisation of the ARRS posts hosted within secondary care services. This funding extends the offer directly into Primary Care bases with clear access into mental health (MH) services which will working alongside other 3rd Sector MH providers and the Recovery College Community Connectors in each Neighbourhood. The implementation of the ARRS roles within Primary Care is a major workforce investment. Due to the development of these roles, we will doubtless see competition to keep our skilled staff, particularly in nursing, social workers, AHPs and pharmacy.

Through our Community Mental Health Transformation programme, we will fundamentally transform the care offer for adults and older adults with a range of severe mental health problems and co-existing needs. This will be achieved through new integrated models of care that enable timely access to high quality, evidence-based, joined-up care.

Shortfalls in other professional roles domestically including AHPs (Occupational therapy and physiotherapy) will see us widen our international recruitment to supply existing vacancies in these roles.

Recruitment continues to be the focus within our neighbourhood nursing teams and our community mental health teams with key challenges recruiting to some higher-level nursing posts (e.g., nurse prescriber). The Trust is leading on a South Yorkshire and Bassetlaw collaborative virtual recruitment programme, with its aim to target those hard to recruit to roles and diversify employment potential.

Whilst we have Associate Clinical Practitioner (ACP) roles embedded into the Trust already, we continue to develop role availability and widen its placement. We have several ACP's graduating this year who await placement into the Trust. Clinical placement for existing Trainee Associate Clinical Practitioner (TACPs) continues to be a risk to the Trust as well as being an outlier to some Trusts regarding post-qualification agenda for change banding.

Building on the foundation of the Wakefield Connecting Care Hubs and a history of partnership working through the Wakefield Mental Health Alliance, Wakefield continues to develop multidisciplinary teams with leads from across the system, including Voluntary and Community Sector champions to ensure that people receive the best care to meet their individual needs in the community.

Working closely with the Wakefield Primary Care Networks (PCNs), the Wakefield model will ensure that the ambition for the Primary Care Mental Health Practitioners through ARRS will be aligned to the Wakefield vision and that service users and their carers experience a seamless transition of care.

Kirklees is testing a new approach to providing support, care and treatment within 4 Primary Care Networks with the intention to expand the offer across Kirklees in the future. As Pathways are developed (Including physical health) these will be implemented consistently across Kirklees. In 2023/24 the programme will ensure that each Primary Care Network will benefit from a co-located, mini-mental health team, working together to provide a seamless service with interventions of varying intensity, appropriate to the individual level of need – with integrated pathways to the core specialist hub.

We will implement and evaluate the effectiveness of redesigned, new, physical, or virtual Neighbourhood Mental Health (MH) Hubs. These will be integrated multidisciplinary, partnership-based (MDT) teams and Community Health & Wellbeing (CHWB) Workers, aligned to the specific, identified population health needs of each PCN, delivered initially in 3 Calderdale PCNs last year and this. This model will be rolled out across the remaining 2 PCNs over the three-year transformation. Over the three years, the Calderdale system will move away from concepts of 'primary' and 'secondary' services, of discharge and referral, towards providing flexible, place based mental health and wellbeing support from the system as a whole.

6.4 The Longer-Term Workforce (New roles and Digital)

There are several alternative roles which are currently being mapped and planned for to meet alternative skill mix opportunities including expansion of Peer Support workers, Trainee Associate Psychological Practitioners (TAPPs), Physicians Associates, Trainee Nurse Associate (TNAs) into Nurse Associates, Associate Clinical Practitioner (ACPs), and assistant level clinical support roles within Allied Health Professions, pharmacy and psychology. These need to be linked to effective and feasible operational workforce plans within service. We are also developing our volunteer to career offer.

The Trust sees embracing new and existing its digital strategy a key driver in meeting some of our workforce challenges technology. We revised our digital strategy through to 2024, and this strategy with close alignment to national regional (WY & SY ICS digital strategies) and place-based digital priorities. This places a strong emphasis on championing digital inclusion for all and developing a digitally capable workforce.

6.5 Place-based Workforce Development

This section describes the place-based workforce programmes as they have been developed to support the Trusts workforce plans aimed at supporting integrated, local approaches to delivering care to service users. Across place there are several initiatives and workstreams which will inform and influence the workforce skill mix of the Trust, which include but are not restricted to:

<u>Kirklees</u>

- Further development of the CAMHS neurodevelopmental pathway to support addressing backlog and waiting times.
- Lead provider role for the Mental Health Support Teams in Kirklees, and further development of the model.
- Delivery of a Kirklees Learning Disability ASD Pilot.
- Increased capacity in eating disorder (ED) and crisis services to address waiting lists, enhanced support for transition for 18 to 25 year-olds, and pre and post diagnostic support and discharge support.

<u>Calderdale</u>

- Further development of the CAMHS neurodevelopmental pathway to support addressing backlog and waiting times.
- Enhanced capacity for ED and crisis.

Wakefield

- Development of a new pathway to meet the needs of more children with learning disabilities and neurodevelopmental issues and their families, in turn supporting achievement of LTP Children and Young People's access rates.
- Expansion of the Enhanced Outreach Team (EOT), in turn supporting access rates.
- Enhanced crisis support.
- Mental Health Support Teams.
- Workforce Hub Website in development. Will be integral to Wakefield H&C Partnership website/information.
- Mental Health First Aid: Looking to take place-based approach to this
- Systems leadership: creating a strategy for mentoring and coaching, creating a network of system leaders, preparing leadership development offering.
- Growing our workforce: mapping H&SC courses which are in place across place. Will be using to understand current/future needs

Barnsley

- Agreement of additional funding to the core service offer.
- Enhanced crisis, eating disorders. ADHD support and support for children in care.

6.6 Staff retention and wellbeing

Our retention work includes a continued focus on workplace wellbeing which includes:

- Enhanced occupational health service: including in-house staff counselling.
- A range of physical, mental and financial wellbeing initiatives are taking place which include smoking cessation, support for the menopause, specialist mental health input, and cost of living support package.
- Regular staff survey work (Pulse Survey, NHS Staff Survey) to understand hotspots and target resources, including wellbeing and diversity services.
- Improvements to our leavers questionnaire process to understand reasons for leaving and these are shared across our services.
- Better use of our resources with Trustwide roll out of both Healthroster for improved staff management and utlisation and the roll out of SafeCare in all our wards to improve staff resourcing and fill rates.
- Partnership with the MHLDA workforce group to pilot the Legacy Mentor roles.
- The newly appointed Diversity. Inclusion and Belonging lead which is working with our staff networks to improve staff experience, including work within WDES & WRES action plans.
- Redesign of our People Directorate around the Great Place to Work Strategy.

7. Financial Planning

7.1 National guidance and assumptions

The overall NHS funding settlement includes an additional £3.3bn in both 2023/24 and 2024/25 (compared to the previous settlement) to address pay and non-pay inflationary pressures. The overall view from NHS

England is that this settlement would require £12bn of savings over the current year and the next two years, plus significant improvements in productivity.

NHS England is issuing two-year revenue allocations for 2023/24 and 2024/25. ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners.

Provider contracts are expected to increase by a net tariff uplift of 1.09%. This is based on a tariff Cost Uplift Factor (CUF) of 2.9%, less a national efficiency ask of 1.1% and less convergence adjustment of 0.71%.

Cost	Estimate	Cost weight	Weighted estimate
Pay	2.1%	68.9%	1.5%
Drugs	1.3%	2.4%	0.0%
Capital	4.0%	7.1%	0.3%
Unallocated CNST	1.5%	2.2%	0.0%
Other	5.5%	19.3%	1.1%
Total			2.9%

It should be noted that the 2022/23 pay award resulted in a cost pressure due to the differential rates for Agenda for Change staff and that we have a higher proportion of non pay than the cost weighting above. It is not yet known if the 2023/24 Pay recommendation will have differential rates.

Although the national efficiency built into the tariff calculation is 1.1%, the NHS England message is that there is an overall efficiency expectation of 2.2% (the reality within NHS Trusts is that this will be higher including for SWYFPT).

To generate the required level of efficiency savings, systems;

- must reduce agency spending across the NHS to 3.7% of the total pay bill in 2023/24. (Our first draft assumptions for agency exceed this target)
- Reduce corporate running costs with a focus on consolidation, standardisation and automation
- Reduce procurement and supply chain costs by realising the opportunities for specific products and services

7.2 Financial plan- headline figures

The financial plan for the Trust has been prepared and shows a balanced position as set out below.

	2021/22	2022/23 FOT	2023/24 Plan
	£k	£k	£k
Total Revenue	**301,783**	**355,814**	**360,483**
Pay Costs	(212,882)	(221,225)	(229,802)
Non Pay Costs	(71,833)	(125,116)	(125,314)
Gain / (loss) on disposal	1,154	820	
Impairment of Assets	0	(787)	0
Total Operating Expenses	**(283,561)**	**(346,308)**	**(355,116)**
EBITDA	**18,222**	**9,506**	**5,367**

Depreciation	(7,125)	(5,869)	(5,948)
PDC Paid	(2,070)	(2,129)	(2,489)
Interest Received	39	1,670	3,070
Surplus / (Deficit)	**9,066**	**3,178**	**0**
Depn Peppercorn Leases (IFRS16)		(229)	0
Revaluation of Assets	1,212	2,225	0
Surplus / (Deficit)	**10,278**	**5,173**	**0**

Key movements from 2022/23 Forecast Outturn (FOT) to 2023/24 Budget

Excluding the impact of new investment requests, the impact of pay award and inflationary pressures reduce Trust surplus to a break even position.

	£000's
2022/23 FOT Surplus/(Deficit)	**3,178**
Tariff Uplift	2,949
FYE Income	4,500
2% Pay Award	-4,967
Workforce Growth	-5,500
Non Pay Inflation	-2500
NR Spend	1,800
Reduction in OOA Placements	600
Other	-60
2023/24 Budget Surplus/(Deficit)	**0**

7.3 Plan including Investments/CIP Target

	21/22 £000s	22/23 FOT £000s	23/24 Base Budget £000s	CIP's	Cost Pressures New	Cost Pressures Existing	23/24 Proposed Budget £000s
Total Block Income	**274,176**	**269,423**	**277,479**	**0**	**0**	**0**	**277,479**
Total Operating Expenses	**251,125**	**256,116**	**272,009**	**(8,651)**	**5,628**	**3,023**	**272,009**
Covid-19 costs	5,984	3,850	0				0
EBITDA	**17,068**	**9,457**	**5,470**	**8,651**	**(5,628)**	**(3,023)**	**5,470**
Depreciation	7,125	5,876	6,051				6,051
PDC	2,070	2,032	2,489				2,489
Interest	(39)	(1,629)	(3,070)				(3,070)
Total Costs	**266,265**	**266,244**	**277,478**	**(8,651)**	**5,628**	**3,023**	**277,478**
Surplus/(Deficit)	**7,912**	**3,178**	**0**	**8,651**	**(5,628)**	**(3,023)**	**0**
Depn Peppercorn Leases (IFRS16)	0	(229)					
Impairment of Assets	0	1,438					
Revaluation of Assets	(1,212)	0	0				0
Profit/Loss on Disposal	(1,154)	0	0				0
Surplus / (Deficit) pre true up & covid	**10,278**	**4,387**	**0**	**8,651**	**(5,628)**	**(3,023)**	**0**

7.4 Income assumptions

The plan assumes tariff uplift as per national guidance 1.09% (2.9% cost uplift factor less 1.1% efficiency and 0.71% convergence adjustment)

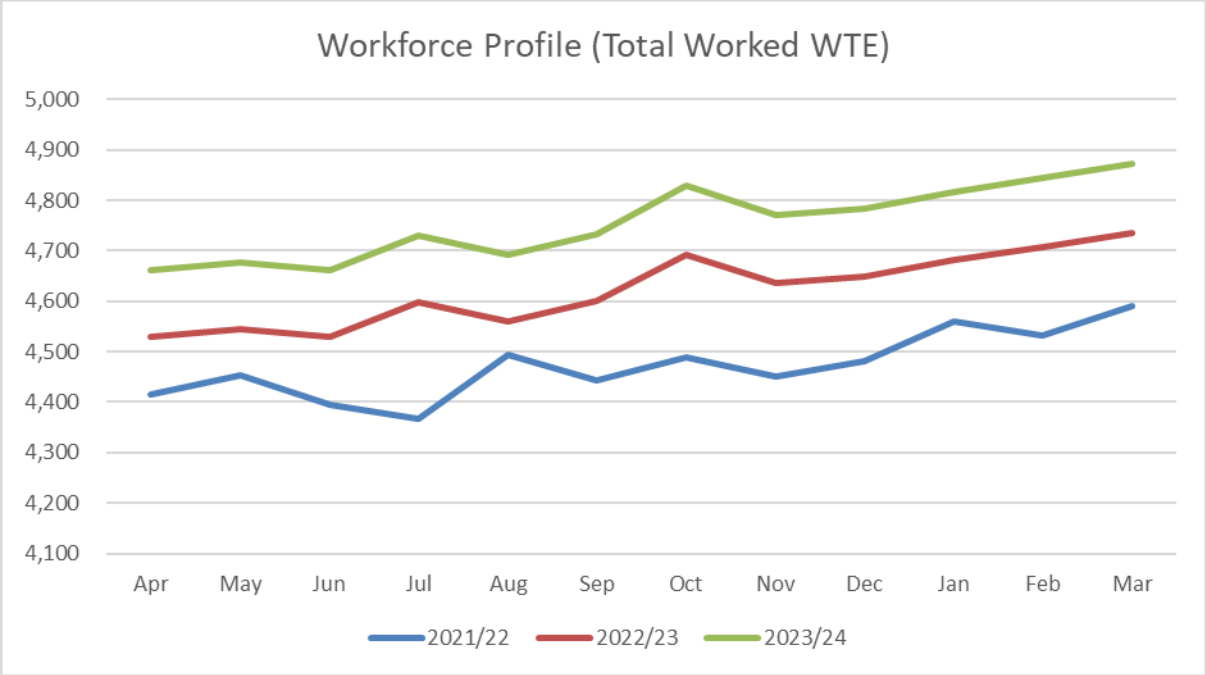
The plan does not currently assume any new investment income for 2023/24 bids. The assumption is that full year effect growth will contribute to the MHIS target for the system.

7.5 Workforce Profile and Vacancy Factor

To predict our anticipated workforce throughout 2023/24 the Trust has assumed the growth in substantive WTE seen this year (3%) will continue.

The plan also assumes a reduction in agency to meet the national target of 3.7% which will reduce our agency staffing from 145 WTE in April to 120 WTE in March 2024. This will be offset by a corresponding uplift in substantive staffing as a result of ongoing retention and recruitment activity.

Overall this would require recruitment of 800 WTE next year (140 growth and 660 to cover turnover).



7.6 Pay assumptions

Pay budgets have been calculated based on staff in post and adjusted for the impact of incremental drift. Where posts are currently vacant the budget has been calculated at the mid point of the band.

The reduction in national insurance (back to 13.8%) has been factored into budgets (£1.7)m reduction in 2023/24 budgets. The reduction in tariff for this change has also been factored in.

Pay award as per the national guidance of 2% results in an increase of £5.0m.

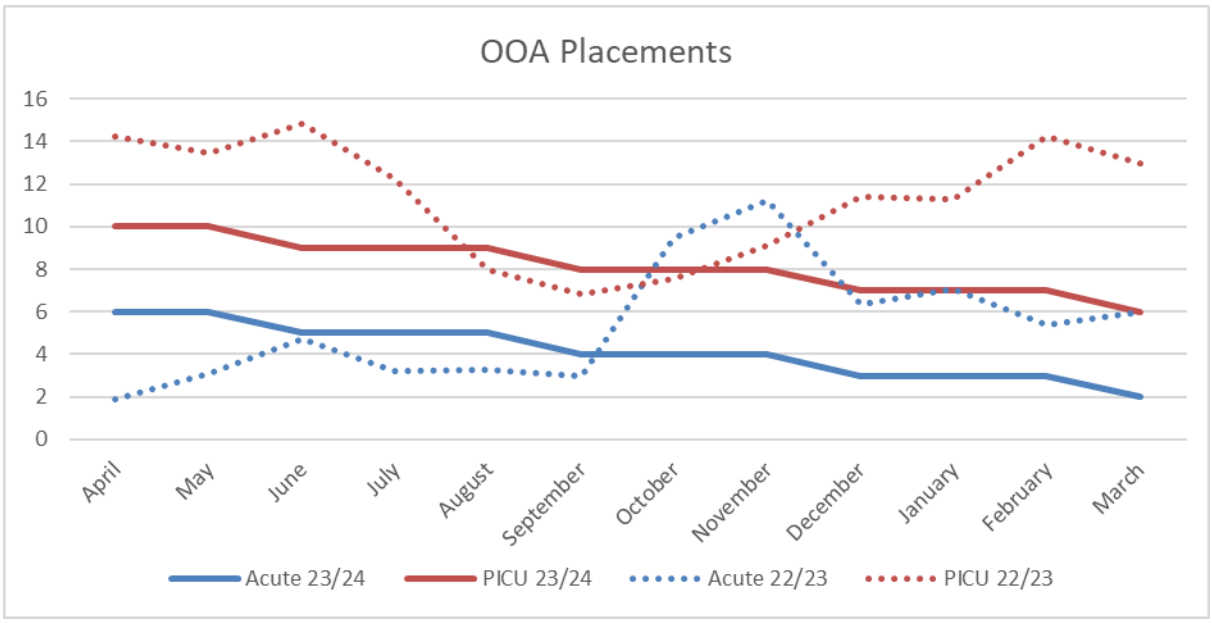
Individual departments reflect the agreed funded establishment with a vacancy factor held at Care Group Level.

Based on the workforce profile proposed for 2023/24 the calculated vacancy factor is a net (£16.3m) reduction to pay budgets. This is made up of a £(42.0)m reduction to substantive budgets offset by the Bank £15.5m and agency £8.7m.

As this calculation assumes current staffing levels, it has resulted in a non recurrent increase in the budgets for Forensic, Inpatient and OPS Care Groups.

7.7 Out of area

The 2023/24 plan has a target for reducing inappropriate out of area placements by March 2024. The plan assumes an average of 4 Acute and 8 PICU patients across the year profiled as follows;



With an inflation assumption of 10% on bed day prices this results in an OOA budget of £4.8m for 2023/24 a reduction of £0.6 on this years FOT of £5.4m. There does remain some risk with this plan with current patient numbers 3 higher than that assumed in April 2023.

7.8 Non pay assumptions

Non pay has been realigned based on this year's forecast outturn, adjusted for non-recurrent spend and contract changes where notified.

Non pay inflation assumptions assumed in plan are as follows:

- Drugs 5%
- Food 10%
- Energy 10%
- Other 5%

7.9 New Investment and CIPs

Overall the Trust financial plan reflects a CIP target of:

£11.9m CIP of which;
£8.7m core plan as per table in 6.3. which is largely unidentified or requires EQIA assessments to be undertaken focus is on agency reduction, pay premiums, stretch target on OOA placements, focus on non pay
£2.2m is from OOA planned reduction (current run rate vs 23/24 assumption) does not currently feature in table 6.3 but is netted off within the overall position.

£1.1m provider collaboratives, this is an application of national planning assumptions and efficiency will be taken from 23/24 contract offers. Does not feature in table 6.3 as that excludes collaboratives

In order to ensure the Trust delivered a balanced position for next year the following action will be taken;

- All recurrent and non recurrent new investment is held until we have a credible CIP plan with the exception of;
- Hold the £1.0m non recurrent investment contingency and further non pay inflation needs to be managed in existing budgets

7.10 Capital

The overall West Yorkshire ICB capital allocation for 2023 / 24 is £159.5m. Of this the SWYPFT allocation, as calculated by the ICB, is £8.3m. This is mathematical calculation rather than a risk based prioritisation of funding and schemes. This creates risk within the whole system. This excludes the impact of IFRS 16 / Leases.

The current internal plan is below with a detailed paper to follow

Programme Area	2023/24 (£k)	2024/25 (£k)
Estates Minor Cap	3,310	2,070
IT Cap	2,765	2,910
Major schemes	2,225	3,078
Total	**8,300**	**8,058**

8 Digital approaches

8.1 Pandemic response and new sustainable ways of working

Following on from the Trust's continued response to COVID-19, services and care professionals persist in embracing digital solutions to support and help keep safe all who are receiving care or who are within our care. These combined approaches are maintained through face-to-face and virtual remote care delivered safely based on service user's needs, preferences, risk, and choice. Blended approaches to working practices continue to evolve as services/teams develop more hybrid (agile) ways of working that are operationally effective and sustainable, accounting for learning and experience insight provided from the Trust's digital pandemic response.

As Trust services continue on their respective service recovery activities, and in responding to increasing demand for access to services which is placing greater pressures on existing operational frontline service delivery, the potential to explore and exploit appropriate and fit for purpose digital technologies that serve to incorporate new ways of working, which enable service efficiencies through reducing bottlenecks in process workflow that contribute to service improvement. To this end, we are witnessing an increased interest and need internally to consider the potential for exploiting digital solutions/apps that incorporate artificial intelligence capabilities to help with addressing the current pressures and increased demand, that

support the workforce and also serve to improve our digital service offers to our service users and carers and their overall experiences.

8.2 Support for information sharing & integrated models of care

The Trust's main electronic clinical record system, SystmOne, continues to enable record sharing capabilities providing our wider SystmOne partners with access to the Trust's service user record information, where there is a legitimate relationship established, adhering to robust governance and consent models. The deployment of SystmOne Electronic Prescribing and Administration of Medications (EPMA) functionality within the Trust's Inpatient Services is progressing well and plans are being developed to oversee the introduction of EPMA into community services also, which is designed to improve patient safety and reduce risk. In addition, a well-established SystmOne continuous development programme of work which focuses on ensuring that the Trust uses SystmOne to an optimal level and fully exploits the current and emerging functionality available. This work spans both Mental Health Services and Physical Health Services, as well as Trust-wide SystmOne initiatives, that help in forging stronger links with primary care and partners. All of which has data quality requirements and clinical standardisation at its core.

The Trust is currently remains committed to onboarding to the Yorkshire & Humber Care Record (YHCR), which is focused on connecting the Trust's clinical portal solution "PORTIA" to consume available YHCR data. The richness of the YHCR datasets will increase as more partner organisations from across West Yorkshire and South Yorkshire onboard to the YHCR. This places the Trust is a good position from which to further develop integration capabilities with the YHCR during 2022/23, providing the basis and foundations from which to facilitate and realise development of local/regional shared care record opportunities that improve information sharing across the health and care workforce.

8.3 Digital infrastructure, cyber security, and sustainability

The Trust has a reputable and proven digital infrastructure which encompasses a robust programme of constant modernisation and enhancements that provide the bedrock for the advancement of digital innovation and digital transformation opportunities. The Trust is constantly enhancing its cyber security controls and measures, has a track-record of trialing/piloting and adopting NHS Digital centralised services. Cyber security and the sustainability agenda play a prominent role in all aspects of the Trust's digital environment and future digital development roadmap. In relation to cyber security, the Trust has a relative high-level of maturity, fully complies with the national standards and adheres to NHS Digital CareCert notifications, taking the necessary actions to mitigate against potential risks and threats. In support of sustainability, specific requirements are being incorporated into procurement approaches and tendering activities and reasonable adjustments are incorporated into hardware replacement programmes in collaboration with Estates & Facilities.

8.4 Digital strategy alignment and relevance

During 2020/21, the Trust revised its digital strategy spanning the next three years through to 2024, and this strategy remains consistent and valid today, with close alignment to national (NHS Long Term Plan, What Good Looks Like framework and Digital Priorities for Mental Health), regional (WY & SY ICS digital strategies) and place-based digital priorities, placing a strong emphasis on championing digital inclusion for all and developing a digitally capable workforce, enabling the overriding need for embedding digital as part of service redesign and within service offerings to ensure equality and accessibility is fully recognised, understood, and remains central to our approach to recovery and sustainability. During 2023/24, the Trust's Digital Strategy will be reviewed and revised, as the current strategy expires at the end of the 2023/24 financial year.

In Q4 2023/24, NHS England will be releasing a digital maturity assessment toolkit for NHS organisations to complete. This is a revamp of work last conducted in 2017 and aims to establish a baseline from which to identify key themes, areas for prioritization and development locally, regionally and nationally.

8.5 Digital inclusion

The Trust is actively engaged in wider system digital inclusion discussions at ICS and constituent place levels, recognising the need for a systems-wide approach to addressing digital inclusion constraints. The Trust is also developing mechanisms from which to gain a better understanding of the digital needs, preferences, and aspirations of all who access Trust services, which will help in providing further insight when designing services and embedding digital offerings, enabling 'digital by choice' in line with the Trust's values. Several opportunities are being explored, that aim to donate redundant IT equipment being decommissioned by the Trust for re-usage within our communities, subject to legal and regulatory dimensions.

The redesign of service incorporating a sustainable digital consultation offer will be predicated on ensuring the virtual service interventions are to be an equal level of service intervention to that offered by a face-to-face appointment and that are safe (including cyber safe). Central to this approach will be the active consultation, involvement, and participation of all stakeholders in the redesigning and testing out of new service models and ways of interaction and working. We will actively work together with service users, carers, support networks and our wider partners in addressing any barriers that may adversely impact health inequalities and further widen perceived digital division. Feedback will be actively sourced in collaboration with all accessing services and experiencing care to inform, shape and revise service models as necessary providing equity for all.

8.6 Developing a digitally enabled workforce

The Trust's workforce is our greatest asset and to be truly digitally excellent, our staff need to have access to the necessary IT equipment and information systems, as well as being armed with the requisite digital skills, to be fully conversant, competent, capable, and confident in their use of digital solutions. This will in turn promote high-quality care provision and help to meet the expectations of our service users and carers. However, exhibiting good digital knowledge, skills and capabilities is not about developing technical proficiency but in recognising that when coupled with an assured outlook, it is how digital solutions can be applied during effective care delivery. Therefore, improving care and helping to create positive health outcomes. The Topol Review predicts that within 20 years, 90% of all jobs in the NHS will require some element of digital skills, meaning that all staff will require digital literacy. To enable this, it is understood that opportunities to develop digital skills must be easily accessible to staff and allow the individual to self-assess their own training needs based on their own perceived levels of digital capabilities. The Trust is committed to empowering staff through nurturing and developing digital capabilities for all, as it is inevitable that digital will play an ever-increasing role in all aspects of job functions.

Guidance and support materials have been made available for educators, trainers, and facilitators in delivering sessions virtually. Learning & Development have reviewed all existing training materials that were previously delivered in classrooms and have converted those appropriate to delivery using Microsoft Teams and other digital solutions. New education and training programmes developed on an emergent basis are assessed against risk and best impact measures to inform using digital solutions over classroom-based training methods. The Education and Training Governance Group provides assurance for all training delivery and oversees changes in Mandatory Training provision.

Work is ongoing in collaboration between Learning & Development, Estates & Facilities, and IM&T with regards to reviewing and improving digital training delivery capabilities across the Trust. This work will take learning from our recent experiences and across our networks, to improve the digital training offer, where applicable and appropriate. Developing plans for converting a selection of training rooms into digital training suites to reduce the need for large groups in one place, support the Trust's sustainability agenda, and reduce associated costs for travel, etc.

Work is also underway nationally, supported by the constituent regions with regards to developing a national digital workforce plan which will also highlight key themes, define responsibilities and actions for prioritization locally, regionally and nationally.

9 Social responsibility and sustainability

Underpinning our plans are our social responsibility and sustainability ambitions, outlined in our Social Responsibility and Sustainability Strategy.

The Trust Social Responsibility and Sustainability Strategy will use the levers we have to maximise the benefits SWYPFT delivers to local people, communities and places, especially those facing challenge and disadvantage. We will build on the Trust's core and current activities and role as an 'anchor organisation' rooted in the areas we serve, and strengthening the positive impact that comes from our:

- Partnerships, culture and civic role.
- Role as an employer.
- Procurement of goods and services.
- Management of environmental impacts, our estate and assets.
- Engagement with less advantaged and diverse communities to maximise the responsiveness, value, inclusiveness and uptake or our services.

Doing so will deliver social, economic and environmental benefits and reduce health inequalities. SWYPFT already has policies and approaches in place that support these goals, including through our Green Plan; our Equality and Inclusion Action Plan; and our Equality, Involvement, Communication and Membership Strategy. This strategy builds on and integrates with these and adds value where opportunity arises but avoids duplication.

The way in which it was produced and is being delivered – with wide input from internal stakeholders and external partners – aligns with our principles and values. This engagement, together with an assessment of our baseline position, assets and challenges has informed the five main opportunity areas for action we will focus on.

10 Estates and facilities

The Trust has a large and diverse estate both in geography and ownership with considerable resources and finance used to maintain the estate in a safe and welcoming manner.

Current key issues include:

- Maintaining the estate to the correct level for both safety and clinical effectiveness.
- Helping occupants to best utilise space through the use of booking tools and utilisation information to improve availability.
- Analysing any gaps in estate provision to include in annual plans and the longer-term estate strategy.

- Improving the estate through minor capital investment with a two-year detailed plan supported by a five-year outline plan.
- Developing an estate strategy to cover the period 2023-33,
- Developing a net zero carbon roadmap for Board consideration.

Estates priorities for 2023/24 are as follows:

- Movement of meal service to hostess arrangement to meet new food guidance starting at Kendray site.
- Deliver Estates Strategy 2023- 33.
- Deliver carbon reduction road map.
- Renew power and water infrastructure at Kendray.
- Deliver minor capital programme.
- Review energy costs.
- Review food costs.
- Review RRP for trades staff.

Priorities beyond this include:

- Rollout of hostess service to Fieldhead.
- Delivery of capital plan including major schemes.
- Increase pace on carbon reduction delivery.
- Review the estates and facilities vehicle fleet.

The Trust is in the process of adopting a multi-year approach to capital management. This plan will need to work within the ICB capital envelope, therefore the Trust will have an externally driven target each year which will purely be driven by depreciation. This approach sets a relatively low cap which will influence the ability of the Trust to undertake larger schemes. This can be overcome by looking at priorities at an ICB level but will require work at a system level. Capital expenditure also covers IM&T developments and the need to work within limits does have the same restrictions as for Estate. On this basis estates, finance and IM&T liaise closely on the capital plan, both in year and in the longer term strategic planning.

11 Partnerships

The communities we serve are largely located in South Yorkshire (Barnsley) and in West Yorkshire (Calderdale, Kirklees and Wakefield) with additional services in Wetherby, Sheffield, Rotherham and Doncaster. In addition, we serve the wider Yorkshire and Humber population in respect of our forensic service provision as well as place-based work across a range of geographies in Yorkshire. We are actively engaged in the West Yorkshire Health and Care Partnership Integrated Care System (ICS) and the South Yorkshire Integrated Care System.

We are also fully engaged in the development of local place-based plans in both ICSs which are the building blocks of our partnerships. We achieve this through our relationships with Health and Wellbeing Boards, Place-based Committees to the ICB and a variety of developing integrated care partnership and delivery forums. We are increasingly involved in a range of provider collaboratives and alliances across all our places.

During 2022/23 we have undertaken a significant amount of work in integrated care partnerships in each of our four local areas including supporting the move to more formal place-based arrangements to reflect the development of Integrated Care Boards as statutory bodies.

In terms of key programmes of work we are involved in with each ICS, and which have an impact on the Trust, these are summarised as follows:

- Optimisation and best use of the mental health bed base across West Yorkshire.
- An active partner in the adult eating disorders and Children and Young People's Mental Health Services (CYPMHS) Lead Provider Collaboratives in West Yorkshire.
- 'Co-ordinating Provider' of the Lead Provider Collaborative for adult secure services across West Yorkshire.
- 'Co-ordinating Provider' of the Lead Provider Collaborative for adult secure services across South Yorkshire.
- Mental Health, Learning Disability and Autism collaborative work across South Yorkshire and West Yorkshire.
- Implementing the Community Mental Health Transformation across both ICS footprints.
- Partner in the West Yorkshire Learning Disability Assessment & Treatment Unit Provider Collaborative, led by Bradford District Care Trust.
- Partner in the West Yorkshire Liaison and Diversion service and Lead Provider in South Yorkshire.
- An active partner in work to support the children's and adults neurodevelopment pathways in South Yorkshire.

The Trust operates principally in four places and our role in each one is similarly summarised below.

Barnsley- as a provider of mental health, learning disability and community health services, SWYPFT are a key partner within the Barnsley Integrated Care Partnership which brings partners together from across the system to develop new models of care and integrated clinical pathways and monitor system performance.

We have contributed to a place-based plan which focuses on addressing health inequalities in the Barnsley population. Collectively we have further developed a three-tier model for addressing inequalities which is supported by a collective plan to address inequalities in Barnsley.

A formal Barnsley Health and Care Alliance is well established, with an advisory Committee in place, and an alliance agreement with the Barnsley Healthcare Federation is in place with joint leadership arrangements to enable closer alignment between primary and community care for the people of Barnsley. We are seeing impact and benefits from these closer working relationships including the development of integrated roles such as ARRs role to support mental health and wellbeing and first contact physios. We have also developed a joint operational plan that prioritises LD and SMI annual health checks to address inequalities. Frailty and dementia are also a shared priority and we have adopt design thinking as an approach to support improvements in service user and carer experience, strengthen the assessment process and integrated ways of working.

Over the year we have worked as part of the bronze/silver/gold command structures to deliver a robust and coordinated response to the pandemic. We have provided data and insight into the intelligence cell and have provided significant support into the public vaccination programme. Our community services have worked consistently and seamlessly with those of the acute hospital to ensure that people have been discharged quickly and efficiently with the right level of support. We have received external recognition for our integrated discharge to assess processes.

We have worked with the whole system to deliver the Mental Health strategy under the leadership of the Mental Health Partnership Board. We are working with system partners to deliver the community mental health transformation in Barnsley

Calderdale- a single plan for Calderdale that sets out a vision to improve health, social and economic outcomes has been developed. The focus of the "Calderdale Cares" proposal is to develop and deliver integrated care through localities including the development of primary care networks and primary care home. We are a key partner on the Calderdale Cares Partnership Board and have a signed partnership agreement with our partners.

The Trust continue to work with the system leadership to implement Calderdale Cares. This includes working with partners to accelerate the arts, health, and wellbeing agenda. We have helped lead the collaborative work within community and primary care services for the people of Calderdale. This has included work with care homes and the community mental health transformation. We have joined a provider collaborative in Calderdale with a focus on tackling climate.

The Trust have worked as part of the bronze/silver/gold command structures to deliver the response to the pandemic. We have contributed to a place-based plan which focuses on addressing health inequalities in the Calderdale population. change, increasing social value and supporting new ways of integrated working in the Upper Calder Valley.

The Trust has continued to support the implementation of CHOICE in Calderdale, specifically within Calderdale Children and Adults Neurodevelopmental services.

Kirklees – the Trust play a key role in the Kirklees Health and Care Partnership, and Mental Health Alliance, using our learning from a similar approach in Wakefield. A Kirklees Health and Care Partnership Forum is established, as well as a Kirklees Delivery Collaborative reporting into the Forum. A Community Services review of those services which make up the Care Closer to Home Contract continues, with short term options agreed, whilst longer term plans are developed.

Wakefield – –the Trust are a key member of the Wakefield District Health and Care Partnership, and overarching Provider Collaborative which reports into the Partnership. This builds on the strong partnership arrangements already existing in Wakefield which includes the Wakefield Mental Health Alliance, which the Trust 'hosts', and other alliances and partnerships such as the Connecting Care Hubs; the End of Life Care Alliance; Unplanned Care Alliance etc.

12. Specialised Provider Collaboratives

The Trust is Coordinating Provider of two NHS-Led Specialised Provider Collaboratives:

- West Yorkshire Adult Secure Provider Collaborative.
- South Yorkshire and Bassetlaw Adult Secure Provider Collaborative.

Delineated commissioning arrangements have been established for both collaboratives, and commissioning intentions prepared for 2023/24 in order to inform plans.

In West Yorkshire, the Trust is also a partner in the Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) Provider Collaborative- co-ordinated by Leeds and York Partnership NHS Foundation Trust (LYPFT) and Adult Eating Disorder Services Provider Collaborative - co-ordinated by LYPFT.

The National Specialised Commissioning Team has engaged Lead Providers and regional colleagues to discuss recommendations for regional Forensic CAMHS (FCAMHS). Support has been gained from partners for SWYPFT to be 'co-ordinating provider' for FCAMHS across Yorkshire and Humber due to the fact SWYPFT currently provides the full pathway of care and across the appropriate geography.

An implementation plan has been prepared by the Trust which aims for a 'go live' of 1st April 2023. This was supported by the February 2023 Collaborative Committee and Trust Board meeting, subject to a support from NHSE during the transitional phase. This is factored into our plans.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 10.3

Private/Public paper:	**Public**		
Title:	**Bi-Annual Safer Staffing Report**		
Paper presented by:	Darryl Thompson, Chief Nurse / Director of Quality and Professions		
Paper prepared by:	Colin Hill, Specialist Advisor for Safer Staffing Carmain Gibson-Holmes, Deputy Director of Nursing, Quality and Professions		
Mission/values:	We put the person first and in the centre We aim to improve and be outstanding We are relevant for today and ready for tomorrow		
Purpose:	The purpose of this report is to update Trust Board on the safer staffing agenda including right staff, right skills, right place; establishment reviews, workforce planning, new and developing roles and recruitment and retention in line with NHS Improvement (NHSI) Developing Workforce Safeguards policy 2018. It provides an outline of the work in progress and plans in place for the future to ensure our clinical areas are appropriately staffed and can deliver safe and effective services.		
Strategic objectives:	Improve Health		
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	2.3 Increased demand for services and acuity of service users exceeds supply and resources available leaving to a negative impact on quality of care 4.1 Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience and sustainability of safer staffing levels		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Safer staffing is a priority for all health and social care providers. The challenges experienced by our Trust are not in isolation, they are being noted at a national level. This has an impact on the delivery of care at individual, place based and regional levels. It is the responsibility of each provider to maintain safer staffing, reduce the impact of their services pressures on others and ensure positive experience and early help is delivered to all who require intervention. There are times when safer staffing solutions are best achieved through partnership working or shared posts and recruitment drives. Seeing each other as partners rather than competitors can support reduction in unwanted staff movement, support staff supervision and development and enable skill building. The Trust works in close partnership with both West Yorkshire and South Yorkshire Integrated Care Systems to deliver a sustainable and high quality workforce for now and the future.		

Any background papers / previously considered by:	This report was provided to members of the Executive Management Team and Clinical Governance and Clinical Safety Committee in April 2023.
Executive summary:	Safer staffing remains a priority within the Trust, this report provides an outline of the work in progress and plans in place for the future to ensure our clinical services are appropriately staffed and can deliver safe and effective services. Making decisions about staffing follows a triangulated approach which includes three key expectations: Right Staff; Right Skills; Right Place and Time. Our approach to these is detailed within the report, highlighting our commitment to deliver safe care which promotes good outcomes for our services and a positive experience for our workforce. Safer staffing remains a challenge, and this report highlights the work underway to mitigate and manage this risk as well as to improve the situation sustainably. Key areas to note include: • Local, regional and national challenges with recruitment of health and care staff continues. • A number of actions have been implemented to support recruitment and retention of staff, including the development of new roles to support career progression, international recruitment, flexible working, and recruitment of bank and agency staff. • 21 band 5 nurses have been offered roles since October • Recruitment activity is 35% higher in the past 6 months than in the previous 6 months and the Trust has seen more starters than leavers in all four of the last quarters preceding this report. • Through our international nursing recruitment programme we have successfully recruited 53 nurses • The Trust continues its current recruitment activity which is already widening entry level opportunity for new starters and expanding our reach for advertising all roles. • There continues to be a high reliance on bank and agency shifts to reach / maintain safe staffing. • There are occasions when registered nurse shifts are replaced with health care assistants to meet safer staffing numbers, leaving a deficit in skill mix. • There are situations where service user and staff experience is impacted by available staffing numbers, such as Section 17 leave and access to training. • There are robust escalation processes in place. • We continue to utilise the Mental health Optimal Staffing Tool (MHOST) to support staff modelling and template review processes. • Reporting mechanisms are good but could be strengthened further to understand the full quality impact on care and experience. • Staff continue to report staffing concerns on Datix and these are reviewed at clinical risk panel. It is not expected that the staffing pressures will ease significantly within the next reporting period and therefore plans are in place to manage the quality and experience impact. There are clear actions identified for the next reporting period, progress will continue with actions already in place and the Trust will continue to monitor safer staffing and take action to ensure service user, staff and service safety.
Recommendation:	**Trust Board are asked to NOTE and COMMENT on the content of this report and consider the actions identified for the next reporting period.**

Trust Board
Bi-Annual Safer Staffing Report
25 April 2023

1. Purpose of report

The purpose of this report is to update Trust Board on the safer staffing agenda including right staff, right skills, right place; establishment reviews, workforce planning, new and developing roles and recruitment and retention in line with NHS Improvement (NHSI) Developing Workforce Safeguards policy 2018. It will provide an outline of the work in progress and plans in place for the future to ensure our care groups are appropriately staffed and can deliver safe and effective services.

The report will cover the points within the Trust Board safer staffing checklist (Appendix 1) to enable Trust Board members to feel assured they have the information required.

2. Background

All NHS trusts are required to deploy sufficient, suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively. They should also have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times. The approach used must reflect current legislation and guidance where it is available. (National Quality Board (NQB), Safe sustainable and productive staffing 2016).

To demonstrate how the Trust approaches this, regular papers on safer staffing have been presented to Trust Board and the Trust report monthly on safer staffing through the Integrated Performance Report (IPR) and other reporting mechanisms related to quality of care, and service user and staff experience.

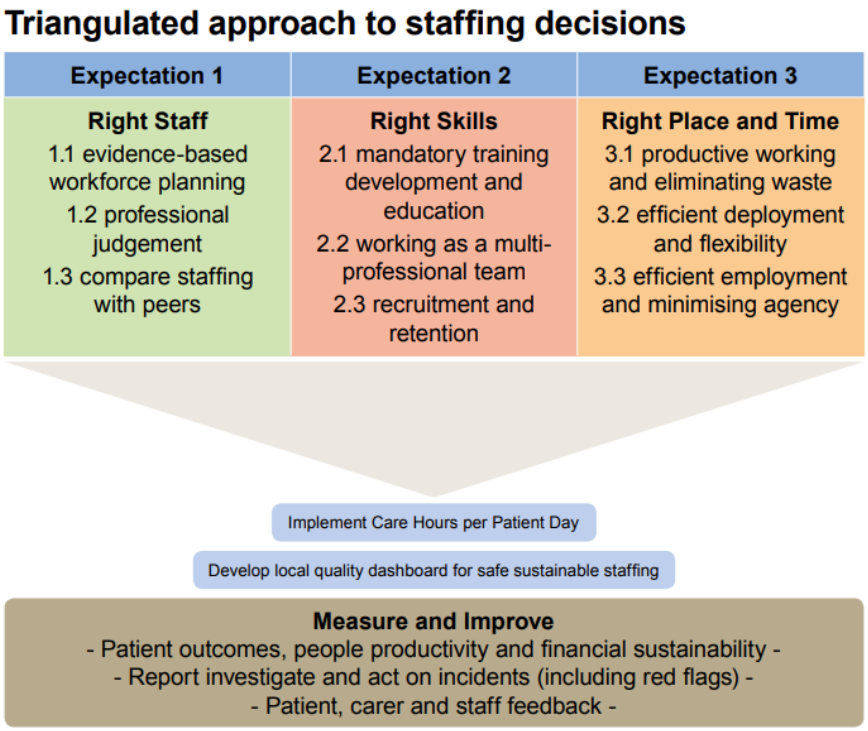
This report builds upon the safer staffing paper presented at Trust Board in November 2022.

3. Introduction

Safer staffing is a priority of the Trust, as well as regionally and nationally. There are significant challenges with workforce across all health and social settings, meaning services are working hard to manage and mitigate risks to ensure safe and effective care is delivered. This requires complex decision making on a regular basis by registered clinical and operational colleagues as well as at specialist advisor and executive management level.

The responsibilities from a professional nursing perspective are clear as outlined below:
"It is the responsibility of every registered nurse in the UK to ensure they are working in environments that have safe staffing and to report to senior management when safe staffing levels are not achieved" (Nursing and Midwifery Council, 2014).

Making decisions about staffing should follow a triangulated approach. The flow chart below supports providers of NHS services with the delivery of the right staff, with the right skills, in the right place at the right time (National Quality Board 2016):



Below are some examples of how the three expectations are demonstrated within our Trust.

Right staff

- Our Trust participated in the development and testing of the Mental Health Optimal Staffing Tool (MHOST).
- As a Trust we have embarked on a thorough review of staffing across our older people's, working aged adults and forensic services, which will inform us whether we have our establishment templates correct or where we may need to increase our resource in line with sustained demand and evolving pressures. This will include looking at a suite of composite figures as well as using the Mental Health Optimal Staffing Tool (MHOST).
- The staffing judgement tool within community teams is currently paused. We are due to relaunch this in May 2023.
- Managers are empowered to use a range of interventions (e.g., use of bank/agency etc.) to ensure safer staffing where unexpected demand is encountered.
- Whilst we currently compare data with similar wards or teams, further benchmarking is planned in the near future when better comparable data is available.

Right skills

- Mandatory training continues to be an area of focus within the Trust. A series of deep dives have been undertaken to understand challenges with meeting compliance in key areas and action plans are in place to ensure recovery.
- The Trust have appointed a Chief Allied Health Professional to support the development of the multidisciplinary teams and to strengthen the opportunity to consider new roles and new ways of working.
- Our international recruitment programme has proven to be a great success to date and the work programme to grow our own workforce alongside attracting highly skilled and trained individuals is proving to be positive. This will take some time to realise the benefits in wards and teams as well in care groups of staff in post.
- A continued effort to focus on staff wellbeing and development will support the retention strategy.

Right time and place

- Demand and capacity modelling undertaken with our community teams to understand the expected input and output.
- The use of 'Safecare' to review the impact of staffing on quality indicators.
- The commitment to be sustainable and eliminate unwanted variation and waste.
- The flexible approaches to working hours, flexible working and peripatetic teams will support vacancy recruitment.
- The collaborative bank proposals with Bradford District Care and Leeds & York Partnership Trusts.

4. Current position

Whilst our total workforce continues to grow, there are continued staffing pressures across the Trust. Ensuring there are sufficient staff available for our clinical wards and teams most in need is a continued challenge, which impacts on staff experience, staff retention, staff wellbeing and ultimately service user experience as staffing pressures have an impact on the quality of care and the skill mix available to deliver care and treatment.

There continues to be an indication through staff networks, staff side and staff surveys that our staff remain under pressure and feel stressed at times. Continued monitoring of the data and intelligence will help us to understand where we have pressure points, and where things are working well to share learning.

Our current recruitment focus is on Registered Nurses (RN) to meet the skill mix needs of our inpatient teams. We know that there are examples of experienced staff leaving inpatient settings and moving into primary care posts, community posts and managerial positions which are non-clinical, and this is leaving a deficit in teams in terms of both numbers and skills. We are starting to experience a trend of newly qualified registered nurses being offered developmental roles within community services which increases the pressure on recruiting from this valuable resource.

Although the work to date has predominantly focused on ensuring safer staffing levels on inpatient wards, we continue to engage with our community teams providing mental health, learning disability and physical health care to scope what safer staffing means to them and what support can be provided following transformation processes. Additional meetings are being arranged with Barnsley community services to increase the understanding of their needs and ensure they have the right opportunities and support to engagement in safer staffing discussions.

5. Reporting and data analysis

The Trust produces a monthly Integrated Performance Report (IPR) which includes a position on safer staffing and the fill rate for wards. The fill rate is the number of shifts that have been filled in comparison to the ward establishment.

The Trust also maintains accurate and up-to-date information of 'composite indicators' on the Electronic Staff Record System (ESR) in relation to the proposed safer staffing indicators as follows:

- Staff sickness rate
- The proportion of mandatory training completed

The most recent Trust figures:

Indicator	Trust overall	Inpatient Wards
Staff sickness rate taken from the ESR at the end of February 2023	5.3%	7.2%
The proportion of mandatory training completed at the end of February 2023	89.6%	88.8%

As of February 2023, Reducing Restrictive Physical Intervention (RRPI) and resuscitation training are two areas where compliance with mandatory training remained challenged, with RRPI rates at 71.9% (average) with a target rate of 80% and Resuscitation training at 73% (average) with a target rate of 80%. Action plans for improvement have been developed and implemented. Despite this, the mandatory training offer remains consistent to support the delivery of safe care across our services.

These areas are also reported within the IPR and indicate whether safer staffing levels are being met in relation to quality and experience. Analysis of the data is provided monthly by the specialist adviser for safer staffing.

5.1. Shift fill rates

The fill rate is the number of shifts that have been filled in comparison to the ward establishment. The ward establishment is the number of staff that were identified as accurate in 2019 when the previous establishment review was undertaken. At that time there was no definitive staff modelling tool, unlike today where we have the evidence based Mental Health Optimal Staffing Tool (MHOST). Previously we used a combination of the available resource and developed an adaptive tool. Staffing requirement (demand), by its nature fluctuates dependent on the acuity of the service users and therefore often exceeds the establishment template (capacity).

There is an ongoing establishment review for Older People's, Acute Adults and Forensic Care Groups. Further details will be provided in future reports.

The analysis of shift fill rates between September 2022 and February 2023 indicates:

- The Trust continues to reach over and above the fill rate of 100%. However, some shifts are replaced with Health Care Assistants (HCAs) when RNs are unavailable, therefore impacting on the effectiveness of skill mixing.
- The 100% or above fill rates should be read with caution as it does not necessarily demonstrate that we are meeting the demand within inpatient services which includes the quality indicators of safer staffing, such as ensuring timely interventions, delivery of an individual's full care planned needs, staff release for supervision, training and development.
- The fill rate is only achievable by utilising over 5,000 bank and agency shifts per month. These shifts will include additional numbers over and above the ward establishment, in response to acuity.
- Overall fill rates have continued to fluctuate in all areas. This is influenced by the demand on services and how many requests can be filled (see table below).

Fill Rate	Month					
BDU	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Barnsley	115%	114%	116%	114%	118%	119%
C & K	104%	104%	101%	105%	111%	108%
Forensic	119%	117%	121%	118%	120%	117%
Wakefield	142%	142%	146%	143%	146%	152%
Grand Total	**118%**	**117%**	**119%**	**118%**	**122%**	**121%**

Within the reporting period:

Day fill rates overall

- There have been four occasions where wards have fallen below the threshold of 80%. This is a decrease of 14 occasions within the previous six months.
- There were 53 instances, a decrease of 22, where wards were filled to 120% and beyond, which is indicative of acuity.

Day fill rates Registered Nurses

- There were 189 incidents, a decrease of 31 on the previous six months, where a ward fell below the 80% threshold for registered staff leaving them less registered staff than they were budgeted for.
- This figure has improved overall since December, and we would expect this to stabilise moving forward.

Night fill rates overall

- Over the last six months there have been no instances where a ward as fallen below 90% for night shift fill rates.
- There were no wards, consistent now for a period of 12 months, which fell below 90%
- There were 15 occasions where a ward fell below 100%.
- There were 101 occasions, a decrease of 12 on the previous report, where a ward exceeded 120%, again indicative of acuity.

Night fill rates Registered Nurses

- Despite prioritising Registered Nurse coverage for nights and at the weekend as there is less support staff available (managers/multidisciplinary team members etc.), there continues to be significant challenges in covering nights for RNs.
- There were 87, a decrease of 33, occasions when wards fell below the 100% fill rate for registered staff.
- Of those, 30, a decrease of 17 on the previous six months, fell below 80% and were supported by local escalation plans and/or with HCA coverage.
- In the same period wards exceeded 120% coverage on 29 occasions which was an increase of 11 on the previous period.

Unfilled shifts Registered Nurses

- There has been an overall improvement in numbers for most Care Groups.
- There may be occasions when shifts for Registered Nurses have been converted into HCA shifts to ensure safe staffing numbers of the ward.
- Overall night shift fill rates are good, with bank and agency staff preferring to cover night shifts. This means that day shift fill is a challenge, with Mondays being a particularly difficult shift to fill.
- There is a shortfall in shift fill, and this is often due to an increase in requests for shifts. This is also reflected in the fluctuation seen within the RN figures. Again, this shows an improving trend.

- Overall fill rates per ward have been maintained at a safe level (see table below). Some wards that are supporting other wards, following a clinical risk assessment and decision, have dropped below the 90% fill rate. At the same time other neighbouring wards have breached 120% fill rate.

Overall Fill Rate	Month-Year					
Unit	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Appleton	95%	88%	92%	119%	116%	117%
Ashdale	97%	101%	93%	99%	112%	106%
Beamshaw	122%	118%	118%	119%	122%	120%
Beechdale	125%	130%	132%	163%	189%	170%
Bronte	116%	106%	110%	128%	125%	110%
Chippendale	131%	134%	124%	117%	113%	111%
Clark	106%	106%	106%	109%	102%	111%
Elmdale	93%	102%	94%	101%	115%	111%
Enfield Down	93%	87%	87%	87%	91%	88%
Hepworth	114%	110%	107%	99%	101%	97%
Johnson	118%	114%	134%	145%	160%	158%
Lyndhurst	95%	93%	90%	86%	90%	91%
Melton Suite PICU	122%	124%	131%	125%	136%	147%
Neuro Rehab Unit	118%	113%	109%	113%	120%	122%
Newhaven	146%	152%	159%	131%	123%	115%
Poplars	176%	181%	199%	184%	166%	182%
Priestley	85%	87%	95%	85%	96%	116%
Ryburn	138%	111%	100%	95%	102%	103%
Sandal	93%	95%	98%	95%	100%	96%
Stanley	117%	126%	125%	124%	132%	127%
Stroke Rehab Unit	97%	99%	104%	100%	104%	103%
Thornhill	94%	102%	103%	101%	104%	92%
Ward 18	134%	125%	118%	113%	97%	104%
Waterton	124%	114%	125%	118%	112%	111%
Willow Ward	128%	126%	133%	119%	129%	106%
Ward 19 - Female	89%	90%	90%	91%	102%	93%
Ward 19 - Male	106%	103%	105%	109%	115%	115%
Nostell	109%	98%	105%	109%	130%	150%
Crofton	164%	159%	190%	186%	193%	184%
Walton PICU	157%	161%	145%	140%	135%	140%
Horizon	161%	157%	160%	151%	154%	153%
Overall Shift Fill Rate	**118%**	**117%**	**119%**	**118%**	**122%**	**121%**

Fill Rate Key for RNs and All Staff:	RNs - Less than 80% fill rate; All staff - Less than 90% fill rate
	Greater than or equal to 120% fill rate

Community data has not been centrally available to understand this further. Time has been spent with teams to explore the current position and ensure data can be collected and reported upon going forward. Some of the reasons data has not been available centrally is due to teams not utilising electronic reporting systems which can generate reports e.g health roster. Future reports will identify where community data is available and timescales for future team reporting given the time it takes to move teams onto these electronic reporting systems.

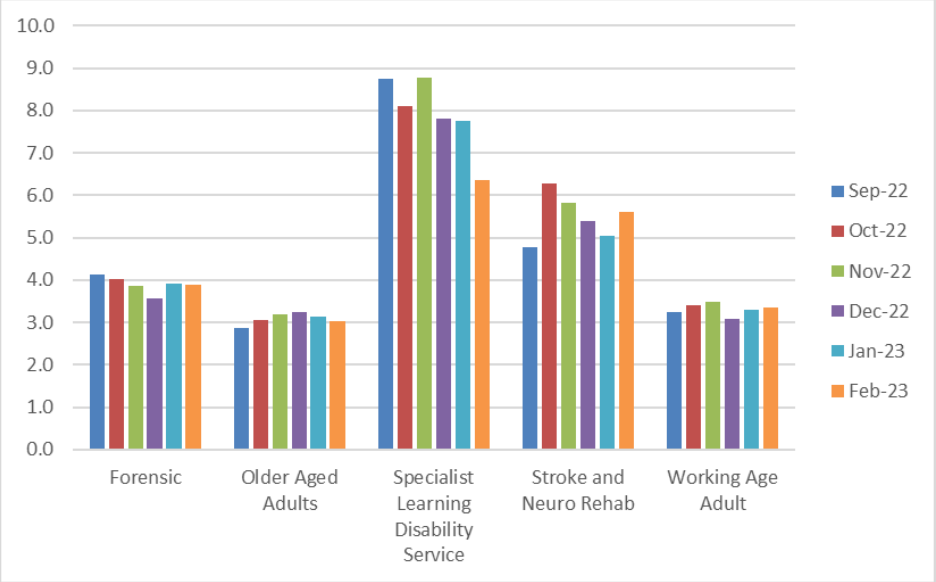
5.2. Care Hours Per Patient Day

The Trust is required, through NHS Improvement (NHSI), to publicly declare staffing fill rates for inpatient settings as well as the Care Hours Per Patient Day (CHPPD) for each inpatient area. CHPPD is the amount of care hours delivered to our service users by our inpatient workforce. It is split into Registered Nurses (RNs and Health Care Assistants (HCAs). We continue to compare our trends within the data to influence the overall narrative of demand on the ward's vs capacity of resources.

The chart below shows that during December there was a decrease in some of the Care Groups' RN CHPPD. This was expected in December due to a reduction of available staffing from both the substantive and flexible staffing pool.

This is predicted to continue improving with the number of newly qualified band 5 RNs as well as the increasing number of international nurse recruits being made available to the wards and achieving their registration onto the Nursing and Midwifery Council (NMC) register.

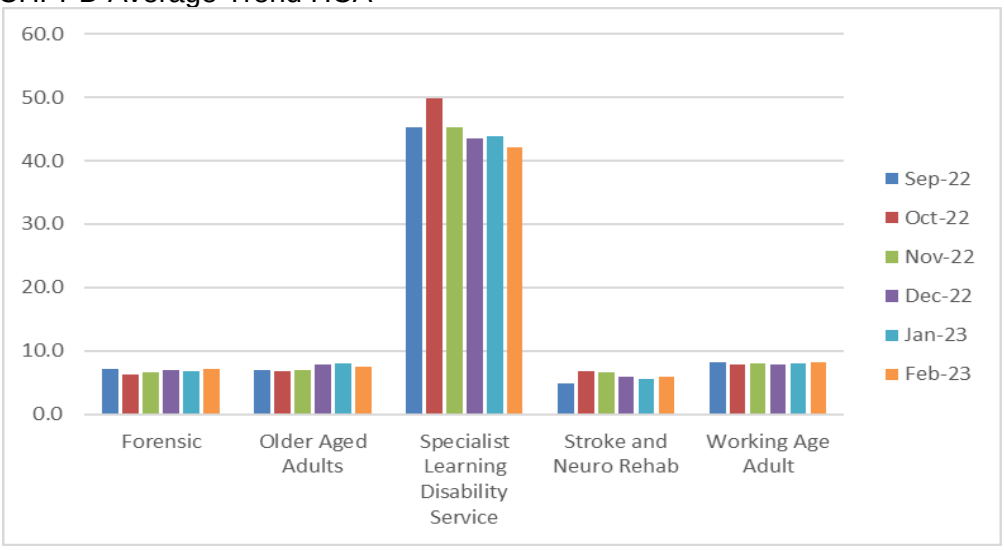
CHPPD Average Trend RN



The chart below shows a more consistent pattern to the delivery of CHPPD within the HCA workforce albeit with a greater fluctuation within Learning Disabilities due to the nature of the bespoke care packages being delivered.

With the ongoing recruitment and retention work, as well as the continued establishment reviews, it would be anticipated that these averages will stabilise or increase over the coming months.

CHPPD Average Trend HCA



At the current time there is no consistent comparable data regionally or nationally, which we expect will be rectified soon. As more data becomes available, further analysis will follow. The data below compares our CHPPD with the regional average for wards that have the same classification, i.e., older people's wards.

Ward Name	Area	Care Hours Per Patient Day (CHPPD)			
		Trust		Regional Average	
		Registered Nurses	HCA	Registered Nurses	HCA
Beamshaw	Barnsley	3.6	5.9	3.4	7.5
Clark	Barnsley	2.9	7.1	3.4	7.5
Melton Suite PICU	Barnsley	7.0	22.2	5.9	18.3
Neuro Rehab Unit	Barnsley	5.6	5.5	5.0	5.4
Stroke Rehab Unit	Barnsley	5.6	6.2	5.0	5.4
Willow Ward	Barnsley	3.6	6.0	3.0	9.2
Ashdale	C & K	1.9	4.6	3.4	7.5
Beechdale	C & K	2.3	8.2	3.0	9.2
Elmdale	C & K	1.8	5.6	3.4	7.5
Enfield Down	C & K	2.9	5.4	4.3	7.3
Lyndhurst	C & K	4.6	6.6	4.3	7.3
Ward 18	C & K	2.3	5.5	3.4	7.5
Ward 19 - Female	C & K	2.7	3.4	3.0	9.2
Ward 19 - Male	C & K	1.9	5.4	3.0	9.2
Appleton	Forensic	5.5	12.2	3.4	7.1
Bronte	Forensic	8.2	14.5	3.4	7.1
Chippendale	Forensic	3.6	6.1	3.4	7.1
Hepworth	Forensic	4.3	4.0	3.4	7.1
Johnson	Forensic	2.8	10.7	3.4	7.1
Newhaven	Forensic	3.1	7.2	3.4	7.1
Priestley	Forensic	3.0	4.7	3.4	7.1
Ryburn	Forensic	3.7	3.4	3.4	7.1
Sandal	Forensic	2.9	6.5	3.4	7.1
Thornhill	Forensic	3.3	3.9	3.4	7.1
Waterton	Forensic	2.0	4.6	3.4	7.1
Crofton	Wakefield	3.5	9.5	3.0	9.2
Horizon	Wakefield	6.3	42.1	7.3	20.0
Nostell	Wakefield	2.7	7.8	3.4	7.5
Poplars	Wakefield	4.1	12.7	3.0	9.2
Stanley	Wakefield	2.6	4.5	3.4	7.5
Walton PICU	Wakefield	4.6	14.2	5.9	18.3

*N.B. The colours are to differentiate the data, not to infer a level of performance.

6. Actions taken to manage and mitigate risks

Safer staffing is a high priority; therefore action is required to be taken when there is a shortfall in the required staffing numbers or where there may be an impact on the quality of care delivered due to staff availability, skill mix, skills or experience. Team managers and leaders plan care delivery through rotas, annual leave management, sickness management and recruitment and retention strategies. Where this is not sufficient staff to cover the care needs adequately, there are support mechanisms and services which can be implemented, such as bank and agency, support from corporate services, and Care Group level governance and support processes.

There are times when despite planning and good management or leadership, that last minute challenges or sustained periods of staffing challenges due to sickness, acuity or vacancies occur and this may require immediate action at team level. Staff are encouraged to complete a Datix where staffing challenges impact on them, service users or the safety of care delivery. When we do not meet the staffing threshold, we ensure the safety of our service users and staff by following the local escalation plans, to ensure that staff are deployed for maximum benefit to the service, shortfalls are shared out and support is mutually offered. All teams and Care Groups have business continuity plans and localised escalation plans which feed into the Trust's wider governance and risk management processes.

Safer staffing is discussed though Clinical Governance Group, Operational Management Group, Executive Management Team, Committees and Trust Board. This provides multiple escalation points each week and month whereby any risk issues can be identified, plans to mitigate and support can be implemented and provides an opportunity to review the impact of the situation and any actions taken. There are a number of staffing related risks held on the local and corporate risk registers to capture the risks and plans in place to reduce impact. Decision making about risk follows the tool on page 2 and considers the right staff, right skills, right time and place. An example risk management tool is embedded in Appendix 2.

As a Trust we have embarked on a thorough review of staffing across our older people's, working aged adults and forensic services, which will inform us whether we have our establishment templates correct or where we may need to increase our resource in line with sustained demand and evolving pressures. This will include looking at a suite of composite figures as well as using the Mental Health Optimal Staffing Tool (MHOST). Dates for task and finish groups have been established and the data is being collected and analysed to ensure a timely and robust plan is developed.

Some of the actions taken to reduce or mitigate risk in the last reporting period include:

- Enhanced payments.
- Increasing bank and substantive recruitment to increase the flow of staff coming into the Trust.
- Vacancies and sickness were mitigated through local escalation plans, where staff (such as ward managers, senior professionals) were identified to cover.
- We have enhanced the Trainee Nurse Associate (TNA) programme, which will increase our registered staffing resource as the cohorts complete their training.
- The Trust has also supported a clinical career pathway for nurses that include lead nurses, nurse practitioners, non-medical prescribers, and advanced clinical practitioners.
- New roles have been considered where sustained challenges with recruitment are identified. The new roles group review any proposed changes to skill mix to ensure care can be delivered safely and effectively without unintended consequences.

Additional steps have been taken to ensure there is always a RN present on all wards. These steps include the following:

- Reallocations of staff.
- Ward manger cover.
- Basing supernumerary team leaders on the wards.

Initiatives to support the HCA shortfall include:

- HCA recruitment onto the bank.
- Increasing the number of experienced staff being taken onto and working with Leeds York Partnership (LYPFT) and Bradford District Care (BDCT) on the collaborative bank project.
- Recruiting onto the peripatetic workforce across the Trust which will increase the flexible staffing available to us.

7. Datix and incidents

Since October 2022 there have been 133 Datix incidents completed that highlighted staffing related issues. This was a decrease of 43 reports from the previous six months. Forensic and LD (learning disability) services account for a substantial proportion of these, and we use the data to focus on hotspot wards and teams.

- Four incidences of one RN covering more than one ward
- Seven incidences of a preceptorship nurse being in charge
- Nine incidences of cancelled Section 17 leave

Whilst we continue to encourage staff to raise a Datix regarding staffing, this likely remains under reported when triangulated with staff surveys and wellbeing questionnaires as well as soft intelligence. We will continue to support staff in reporting incidents and are looking at how we can improve the feedback in a timely manner so that staff can see and feel that they are being listened to.

Reported staffing incidents, irrespective of how they have been graded, are monitored through the Trust's weekly risk panel and through the safer staffing meeting, with a focus on the impact on patient safety and quality of care. Where Section 17 leave is cancelled or tasks have not been able to be fulfilled a conversation takes place between the safer staffing lead and the clinical area (practice governance coach, ward manager or the service manager for the relevant team). Trends and themes will continue to be considered as part of this ongoing work.

8. Recruitment and retention

Staff wellbeing remains a key area of focus within the Trust and workstreams have been established to ensure we continue to provide support where and when it is required. These include a focus on staff wellbeing to support a reduction in sickness rates and ensuring staff have a good working experience. This will support retention as we continue to look at creative options to fill staffing vacancies. The Trust continues to proactively support staff groups to ensure that our resources are directed to where they are needed.

We continue to recruit band 5 nurses (21 have been offered roles since October to date).

Through our international nursing recruitment programme, we have successfully recruited 53 nurses since inception into the Trust from Zimbabwe, India, Botswana, Nigeria, Eswatini,

Mauritius and Kenya. The recruitment programme continues at a pace, and we are ensuring that the transition and integration plans are appropriate and achievable.

We have also completed our first international face to face recruitment in Eswatini and Botswana, with 102 offers being made of which 13 were Registered General Nurses, four specific Learning Disability Nurses and 85 Registered Mental Health Nurses. It is known that there will be an attrition rate of around 20 – 30 % and this has been factored into planning with operational colleagues.

There are plans in place to introduce an Allied Health Professional (AHP) international recruitment approach with a pilot scheme having been developed for three Occupational Therapists (OTs), with plans in progress through agency engagement.

The Trust's values-based assessment approach is increasing its throughput of staff, due to increased interest and applications, April will see four separate assessment centre events (normally one per month) and applicant numbers continue to increase for both HCA and RN substantive and bank posts. Further assessment centre events have been planned for every month of 2023-24.

Recruitment activity is 35% higher in the past 6 months than in the previous 6 months and the Trust has seen more starters than leavers in all four of the last quarters preceding this report. We are forecasting that this will continue with the increased numbers of candidates identified above and recruitment activity already in progress.

The Trust continues its current recruitment activity which is already widening entry level opportunity for new starters and expanding our reach for advertising all roles. Alongside this we will:

- Continue to engage with recruitment fairs, we have set out a 12-month plan of engagement across a wide number of recruitment opportunities which include international, national, University and further education, and diverse/local engagement opportunity, hard to reach/LGBQT+ focused recruitment and engagement events.
- Widen our recruitment reach outside of the NHS Jobs website, which risks restricting applicants from some populations. This includes widening reach into national online job boards (Indeed, Monster, LinkedIn, eCruit, JobFair, TotalJobs, Reed and others)
- Link with Job Centre Plus (JCP) to promote entry level roles across estates, ancillary roles, and admin which have already been successful avenues to employability.
- Utilise a series of rolling adverts on NHS Jobs for band 5 nursing, international nursing, HCA roles and bank availability.
- Enhance the social media presence of our advertising, communications and marketing.
- Make improved use of the internal transfer scheme and above the bar process; matching staff who are looking to leave the Trust to alternative roles.
- Move to both a new application tracking system (ATS) and onboarding system to ensure effective and efficient end to end recruitment (Genius). Our implementation of ATS will result in a review of our end-to-end recruitment process to identify a reduction in time to hire. The new ATS solution will enhance every stage of the candidate journey and provide much more candidate focused communication and potential.
- Further development and enhancement to our career's website and our Trust recruitment micro site.
- Continue to offer the 'Refer a friend' scheme for existing staff.

Other actions to support retention:

- Implementation of Trust-wide Recruitment & Retention Group, which will continue the work of the Inpatient Recruitment Taskforce Group.
- Strengthening our action plans and outcomes to intelligence gathered from our exit feedback procedure. We have increased our response rates from 5% up to over 50% in the past 18 months and now have the highest response rate in this area. Our quarterly reporting schedule to operational leads is set up.
- Action plan from the 2022-staff survey results
- Appointment to the role of Retention and Engagement Lead in the People Directorate which will focus on pro-active engagement across the Trust to improve all elements of our retention and engagement portfolio.

9. Bank and agency use

We continue to recruit onto bank as well as ensuring only active and appropriate colleagues remain registered on the bank.

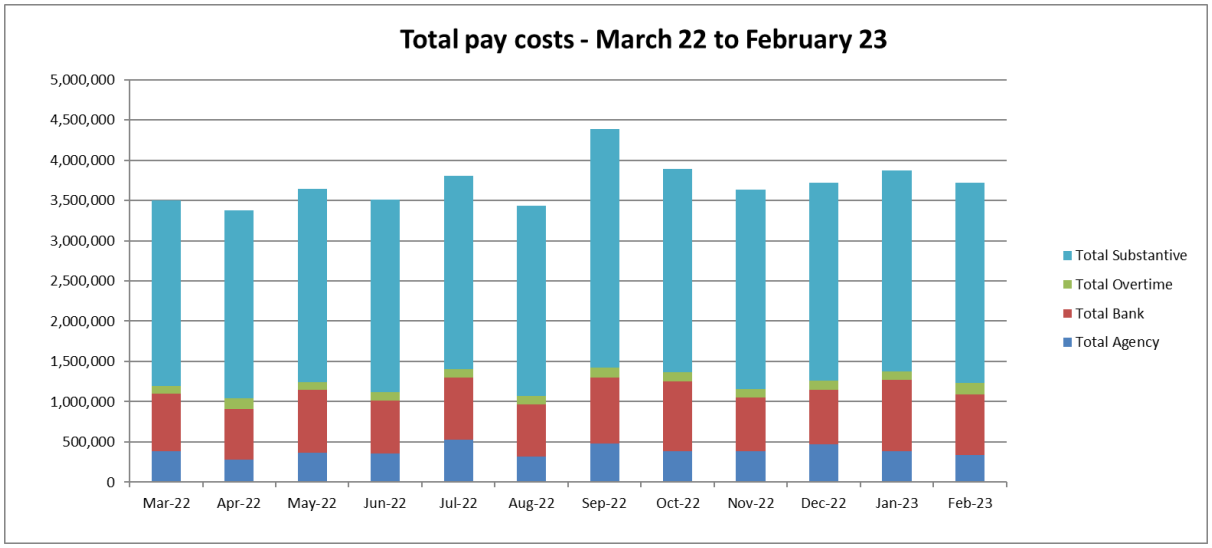
During February 2023, our last reference point, bank, and agency staff worked 702 RN shifts and 3,891 HCA shifts on inpatient wards.

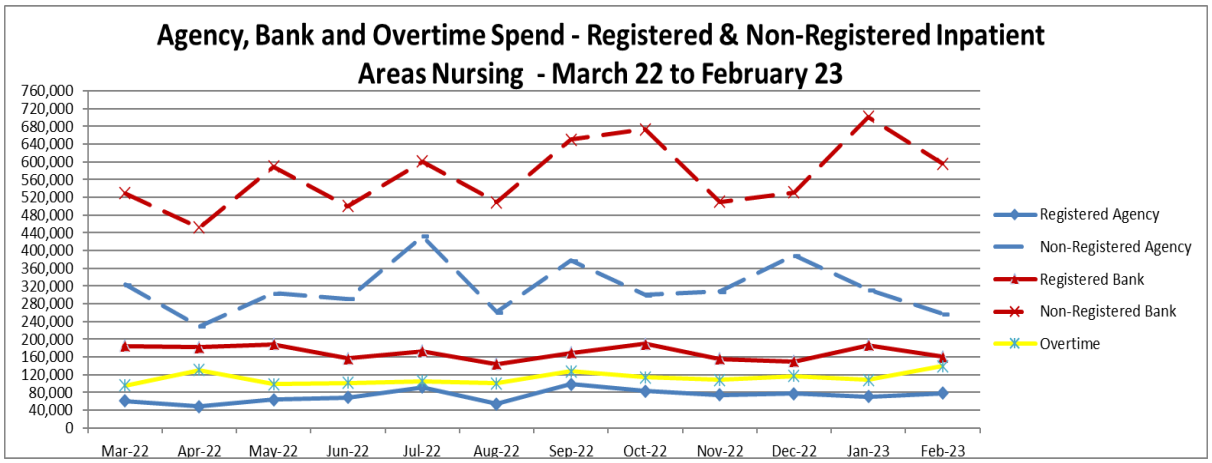
Financial challenges remain in respect of both bank and agency spending. There is an understanding nationally that the flexible staffing workforce is an integral part of the modern workforce. However, the drive remains to reduce the spending on these groups, in particular agency spend. Safer staffing will be supporting the recently constituted Agency Spend Scrutiny and Management Group chaired by the Head of Recruitment and Resourcing. This has recently been divided into two groups; one group will be chaired by the Chief People Officer (the accountable director for each care group will discuss their current agency usage), the second group will look at the strategical reduction of agency usage. This group's focus is to identify both individual and staff group efficiencies to both avoid and reduce dependency on agency use. The Trust has a target of seeing a £1.7m reduction in agency spend by April 2024 to meet our financial control target of 3.7% agency spend.

The graphs below show the percentage of bank, agency, and substantive costs within inpatient services. Bank and agency spend equates to 40% of our inpatient HCA spend and 15% of Registered Nurses. We are looking at ways of reducing this with improvements in recruitment and retention as well as fast tracking agency staff onto bank.

The two graphs below show there was an overall fluctuation in spend reflective of substantive staff in post and the usage of the flexible staffing resource throughout the year and our latest reference point of February 2023 shows a decrease of £157,842 on spend

on inpatient staffing. Since October 2022 there has been little fluctuation in the substantive spend.





10. Safecare

We have introduced SafeCare into the Forensic Care Delivery Unit with initial mixed results. We have engaged with staff pre, and post roll out and have started implementing actions following lessons learned. These include:

- More in-depth training on the clinical aspect of the tool
- Further engagement with the service managers to include walk arounds and invite to the ward manager events to discuss usage and outcomes
- Offering SafeCare champion training so experts are at hand
- Refreshing the questions and answers (Q&As) to reflect the discussions had during the walk rounds
- Giving access to bank and agency staff, along with training, to promote consistency of usage

We will be using these actions for the future roll out project that is being presented to Operational Management Group in April.

11. Safer staffing in the community

To support safer staffing in the community, there has been engagement with our community colleagues to:

- Offer support where staffing shortages have been identified
- Recruit bank specialists to support the services
- Support the Allied Health Professional locum requirement
- Gain a better understanding of the individual area staffing challenges and requirements

The flow chart below outlines the actions taken to support the community teams:

12. Achievements to note

It is important to acknowledge our successes within safer staffing and to learn from the times when we get it right. In summary, some key points to note are:

- Recruitment is going well and there continues to be more starters than leavers
- The standard of applicant is high and strong candidates are being recruited
- Face to Face Assessment centres are back in place to support the recruitment of quality candidates
- In-country recruitment event has led to 102 job offers being made (12 Registered General Nurses for the community in Barnsley)
- Involvement with National Performance Advisory Group ensures best practice observed for flexible staffing

13. Future Actions

Safer staffing remains an area of focus for the Trust and as identified within this report there is still work to do to achieve consistent safe staffing that is experienced by our workforce and our service users.

New plans for Quarters 1 and 2 2023/24 include:

- Ensuring that community staff teams continue to be brought onto health roster in line with the rest of the Trust, using the awarded funding for developing this project plan (End of April 2023)
- Supporting with the development of retention plans
- Ensuring that the Care Certificate is rolled out for bank staff to engage in (April 2023)
- Discussions at safer staffing groups and relaunching the pilot implementation of the staffing judgement tool within Community Teams (May 2023)
- Embedding the MHOST within our inpatient wide establishment review plan
- Utilising the Staff Bank forums to better understand why staff remain on the bank and offer alternatives to leaving the Trust altogether (update in next 6 monthly report)
- Expanding the bank to support other areas including Allied Health Professionals (AHPs) and community teams (ongoing)
- Continuing with the roll out of the acuity staffing management tool and take the project plan for completion to the Operational Management Group (OMG) in April 2023
- Working with OMG to review how we capitalise on opportunities arising from new national workforce initiatives (e.g., nursing associates, advanced clinical practitioners)
- Contributing to implementation of the Trust's Recruitment & Retention Strategy
- Maintaining links with NHS England on Return to Practice programme for nurses, financial support for the introduction of Nurse Associates and encouraging collaborative banking and agency intelligence, particularly across integrated care systems
- Recruiting onto the Peripatetic Workforce and offer continued support through the flexible staffing resource

We will also continue to progress with actions from previous reports which includes:

<u>Build upon and improve data in exception reports</u>
We continue to review and adapt the relevant information to ensure that an accurate overview and narrative is provided with regards to safer staffing. This allows the Trust to focus their resources appropriately and safely. Monthly exception reports continue to highlight wards and teams where staffing levels fall below 90% overall and below 80% for registered staff. This in turn has allowed the continued refinement of local escalation plans to support inpatient wards who are experiencing staffing challenges.

<u>Extend and maximise functionality of the current e-rostering system</u>
A report is sent weekly to the inpatient ward managers and general managers providing an analysis of each ward's staffing and use of the e-roster system. This allows for preparation for expected pressures and ensures that we extend our challenging processes (undertaking a check and challenge of rosters to ensure planning is optimal) in line with Lord Carter's report. We will be looking to ensure consistency with this requirement across our services.

<u>Provide effective and efficient support to meet establishment templates</u>
We continue to use the robust process that is in place to ensure any changes to the establishment templates support the effective and safe management of resources. This

has been particularly helpful in the current transformation work. The ongoing establishment review will ensure this is completed for all inpatient wards.

Involvement in the National Performance Advisory Group
We continue to ensure appropriate representation within the National Performance Advisory Group for Safer Temporary Staffing, which will ensure the Trust is kept abreast of changes and involved in national developments around Safer Staffing. We continue to collaborate with North East and Yorkshire NHS trusts to gain a consensus on reporting and managing safer staffing.

Continue to develop, manage, and deploy the peripatetic workforce
A proposal to reintroduce a peripatetic workforce has been supported however, recruitment has been hampered by the need to fill all vacancies within our teams. We have assessment centres at the end of April looking at recruiting into the first 20 posts.

Enhance the availability of resources within the Trust Staff Bank
The Trust continues to respond to flexible staffing requirements by increasing the number, and activity, of staff on the Trust bank. There has also been a dedicated resource to engage with agencies which has seen an increase in our locum fill. We continue to use the accelerated process for getting agency staff onto bank and bank staff into substantive roles.

Participate and provide support to the collaborative bank project as well as Service Line Agreements (SLAs) with neighbouring Trusts
The proposal for a collaborative bank with Bradford District Care and Leeds & York Partnership Trusts has been paused due to issues between the software providers and we are looking at a proposal to move this on which was presented in March 2023.

Use the Mental Health Optimal Staffing Tool (MHOST) within a wider establishment review
We have used this tool effectively in staff modelling and template review processes. It will be included in an inpatient establishment review which has recently commenced.

Relaunch the implementation of a staffing judgement tool within community teams
Due to pressures of acuity and resources this action is currently paused to allow the integration of the safer staffing community and inpatient services to continue and allow the review the terms of reference and membership.

Capitalise on opportunities arising from new national workforce initiatives
A group has been established to look at new roles within the workforce and how we can develop them into our teams.

Continue to lead on the centralised band 5 recruitment project
Although there will be a small number who will accept alternative offers, this will continue unabated with our rolling adverts. The numbers have traditionally increased from March onwards and we anticipate no reason this should change.

Care Certificate is rolled out for bank staff
We have a proposal about how the care certificate can be offered to bank staff to ensure a commonality of knowledge and understanding of the role and this will be presented at April's Safer Staffing group for discussion before sending to OMG with a recommendation.

14. Summary

The Trust continues to make progress against the safer staffing agenda whilst recognising it continues to face significant challenges in relation to safer staffing and ensuring the quality of care we deliver, whilst also making the Trust a great place to work.

There are staffing hotspots within some of our inpatient services, community physical health teams and our community mental health teams, where recruitment and retention of suitably skilled and experienced staff remains as an ongoing challenge. The impact of this on broader team wellbeing, development and retention is evident in the morale of teams.

Significant work is taking place across the Care Groups, the Peoples Directorate and the Nursing, Quality and Professions Directorate to ensure that our staffing needs are understood, any risks are identified and addressed and that we create a sustainable, happy, healthy workforce of the future, however many of the solutions take time to implement and the impact of change to be noted, often leaving our front line colleagues feeling unheard, stressed or pressured.

Delivering high quality care to the right people, at the right time, in the right place is the reason we deliver health services. Utilising the Trust values and the evidence-based tools available to support our decision making will ensure we continue to make progress in this area. Supporting our existing workforce to continue living the Trust values every day is essential to ensuring colleagues remain within our services and continue to deliver the high standards of care they strive for.

Actions are in place to monitor and mitigate risks, and escalation processes are well embedded to ensure our clinical teams feel supported. There are further opportunities to hear the voice of our service users and frontline colleagues and ensure they are aware of the actions which are in place to support them and the broader workforce, and these are being explored.

Ensuring that we have completed the establishment reviews on older people's, forensic and working aged adult care delivery groups will focus our recruitment attention and staffing resources to ease the pressure of acuity in our teams. Building in a regular review process will ensure that this remains relevant and central to our decision-making regarding resources and staffing.

To continue the delivery of safe and effective care, the Trust needs to remain innovative, pragmatic, and receptive to change. Using the staff survey and staff groups will help to ensure that we remain an employer of choice who invest in staff and continue to attract talent to the organisation.

Monthly reporting will continue through our integrated performance report and will be monitored through the Trust's governance processes.

15. Recommendation

Trust Board are asked to **NOTE** and **COMMENT** on the content of this report and consider the actions identified for the next reporting period.

Paper prepared by:
Colin Hill, Specialist Advisor for Safer Staffing
Carmain Gibson-Holmes, Deputy Director of Nursing, Quality and Professions

Supported by:
Emma Cox, Associate Director of Nursing and Quality
Richard Butterfield, Head of Recruitment and Resourcing
Rozeen Mahroof, Senior Finance Manager

Appendix 1
Trust Board Safer Staffing Checklist

1. Do Boards fully understand the specific characteristics of Mental Health that will have an impact on the approach to capacity and capability? Do they have a clear vision and values around quality and safety and how it is defined differently in a Mental Health setting?
   Board receives regular presentations on staffing (e.g., IPR reports, regular assurance visits from Board members to the wards/departments to learn about and understand the services better (e.g., Quality and Exec Trio visits).
2. Are there processes for escalating issues identified by staff, patients, or relatives or responsive to the quickly changing acuity and unpredictability of Mental Health services? Acuity is regularly and routinely monitored on wards including need for 1:1 observation. On call arrangements mean staffing issues can be escalated quickly and senior managerial support sought. Staffing issues are captured via Datix system and regular reporting to safer staffing group.
3. Is there a clear methodology for the planning and deployment of staffing that is firmly rooted in an evidence-based approach? How can the calculator tools be best deployed in delivering this?
   Originally the Trust has developed a bespoke decision support tool which was utilised to decide on the original staffing templates. We have moved to utilising the most up to date evidence tool available which has been utilised in staff reviews to date and will be for the Trust-wide inpatient establishment review. E-rostering extrapolates where fill rates fall below optimum levels and managers are asked for exception reports on why, mitigation and actions to prevent recurrence.
4. What practical steps are being taken to develop sound skills in professional judgement because of the less predictable nature of Mental Health services?
   Managers are empowered to use a range of interventions (e.g., use of bank/agency etc.) to ensure safer staffing where unexpected demand is encountered. Widespread roll out of dashboards and benchmarking across the organisation continues to improve data fields available to support professional judgement. Specialist Advisor for Safer Staffing is available to offer advice and support as required.
5. How are the needs of Mental Health service users incorporated in staffing?
   Services are planned and designed in consultation with service users and carers. Transformation of care pathways ensures that they are contemporary and relevant.
6. As well as staffing measures outlined by the NQB are their measures of improvement or performance that reflect some of the unique characteristics of Mental Health services and specific clinical drivers?
   Complex benchmarking and performance data is widely available throughout the organisation and drills down to Team level. Clinical metrics in relation to incidents such as violence and aggression are also available and reviewed regularly.
7. How this ward staffing information might be presented differently within a Mental Health setting where the ward-based Team is not the only valuable resource available? Monthly reporting on Trust website and safer staffing exception report shared with all services monthly and summary information provided in IPR.
8. How are the challenges of filling specific Mental Health roles handled e.g., recruitment training etc.? We have particularly good relationships with providers of undergraduate education and have recently invested in improvements to the Practice Placement Quality Team to ensure we remain the local employer of choice. We attend national recruitment events and are lead providers in a regional collaboration looking at international recruitment. Training needs are reviewed across the organisation each year and training programmes commissioned to support. Supervision and appraisal also support identification of training/learning needs.
9. How is the commissioner kept informed about best practice in Mental Health so that informed commissioning decisions are made?
   Local CCG Quality Boards receive updates on how the organisation is performing in relation to safer staffing.

Appendix 2

Example of a Localised Escalation Plan

Stages	Who does this involve	Detail of step	Names	Responsibility
Across the wards	Stanley, Nostell, Poplars, Crofton, Walton	Check excess staff including office days.	Ward staff	Ward Manager/Matrons/On call manager/ Senior Nurse
Additional hours to existing staff	Ward and Unit staff	Offer alternative days off etc. to staff.	Ward staff	Ward Manager/ On call Manager/Matrons
Bank Staff	SWYT bank office	Send through health roster.	Bank staff	Ward Manager/Nurse in Charge/On call manager/ Matrons
Overtime offered	Trust Staff	Overtime is available to cover vacant shifts.	Substantive staff	Matrons/ General Manager
Agency Staff	SWYT bank office/ out of hours direct to agency	Send through health roster/ call direct.	Agency Staff	Ward Manager/ on call manager/ Matrons
Review seconded staff	Ward Staff	Review all staff secondments.	Ward Staff	Matrons/ General Manager
Review staff on sick (incl. long term) regarding temporary alternative duties to support services and return to work.	Staff on Sick	Review alternative duties for appropriate staff currently off sick.	Substantive staff	Ward Managers & Matrons/ General Manager
Review alternative roles for staff who are working from home due to being classed as extremely clinically vulnerable due to COVID-19 or other pandemics	Staff judged to be clinically extremely vulnerable	Review of staff in this group to redeploy into appropriate alternative roles.	Substantive staff Bank Staff	Ward Managers & Matrons/ General Manager/ Safer Staffing lead
Review staff leave and offer carry forward to next year if necessary	Ward Staff	Look at flexibility within planned annual leave.	Substantive staff	General Manager

Check registered nursing staff availability from other services	Psychiatric liaison Team, CMHT, IHBT, EIS. On Wakefield site: Forensic services via Newton Lodge and Horizon Centre. Across the Trust: Barnsley then C&K.	Assess whether other areas can support the inpatients safely. Ensure that staff have the correct skill set and adjust interventions accordingly.	Staff who have the appropriate training and knowledge. All registrants.	General Manager for AWA General Manager for Community Teams. Deputy Director
Identify non-clinical registered nursing staff (e.g., managers, PGC, nurse consultants) who can cover shifts or parts of shifts or carry out tasks within their capabilities i.e., audits, supervision	Within Care Group. Across the Trust: Nursing and Professions Directorate, L&D, EMT.	Access support from non-clinically based registrants	Can be provided by Safer Staffing Office or Workforce Information	General Manager
Temporarily Redeploy Community/non-ward clinical staff from within Care Group on secondment	Any Professional registrant who is on an external secondment	Review all secondments external to the Care Group and evaluate whether they can be temporarily stopped.	General Managers Workforce Information	General Manager Deputy Director
Temporarily Redeploy registered nursing staff from other areas on secondment	Any Professional registrant who is on an external secondment	Review all secondments external to the Care Group and evaluate whether they can be temporarily stopped.	General Managers Workforce Information	General Manager Deputy Director

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 11.1

Private/Public paper:	**Public**		
Title:	**South Yorkshire Integrated Care System (SY ICS) Update including Mental Health, Learning Disability and Autism Provider Collaborative (MHLDA)**		
Paper presented by:	Mark Brooks - Chief Executive Salma Yasmeen - Director of Strategy & Change/Deputy Chief Executive		
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	The development of joined-up care through Place and system working is central to the Trust's strategy, and is supportive of our mission- to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is to update the Trust Board on key developments in SY ICS and the SY MHLDA provider collaborative and linked programmes and to update on partnership developments in Barnsley.		
Strategic objectives:	Improve Care	✓	
	Improve Health	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):	• 1.1 The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place. • 1.2 The focus on integrated care models at place may result in unwarranted variation and differences in standards and could potentially impact the sustainability of smaller specialist services. • 3.2 Failure to develop strong relationships with integrated care systems, places, and provider collaboratives results in services that do not meet local needs or are unsustainable.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place- based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.		

Any background papers / previously considered by:	The Trust Board receive regular updates on the progress and developments in the SY ICS, including the development of the provider collaborative.
Executive summary:	From 1 July 2022, NHS South Yorkshire Integrated Care Board (ICB) took on the commissioning responsibilities of clinical commissioning groups and will lead the integration of health and care services across South Yorkshire. The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative continues to develop. Work continues with our partners in Barnsley to evolve and develop place-based partnership governance arrangements. We have continued to develop the partnership with primary care as part of the recently formed Health and Care Alliance. A business plan is being progressed, and work has continued on the priorities including improving annual health checks for people with learning disabilities and mental health, frailty and ageing well, and improving early mental health support for people in the community. Priorities for 23/24 will be discussed at a workshop at the end of April. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register and will need to be kept in view as the SY ICS and MHLDA Provider Collaborative develops. New risks may emerge.
Recommendation:	**Trust Board is asked to NOTE the SY ICS update.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023

Agenda item – 11.1 South Yorkshire update including South Yorkshire Integrated Care System (SY ICS)

1. Introduction

The purpose of this paper is to update the Trust Board on key developments in the South Yorkshire Integrated Care System (SY ICS) and the South Yorkshire Mental Health, Learning Disability & Autism Provider Collaborative (SY MHLDA) and linked programmes, and also on partnership developments in Barnsley.

The paper summarises key developments from recent Integrated Care Board (ICB) and place-based meetings.

2. South Yorkshire Integrated Care Partnership

South Yorkshire Integrated Care Board

Member	Chief Executive
Items discussed	<u>Update from meeting of 5th April 2023</u> This was a development session of the Integrated Care Board. Key items discussed included: • The planning for, and risks associated with, industrial action were discussed. • It was highlighted that the Hewitt Review has now been published and, at the time of the meeting, was being reviewed in greater detail to enable wider discussion at a future meeting. • Staff survey results have been received. • There was recognition that the financial plan submitted nationally is still showing a deficit, which is unlikely to be accepted. Further submissions will be required, and there will be particular focus on the level of pay growth assumed. • A draft of the joint forward plan required by the end of June was provided, and the process for finalising it was discussed. Key points raised included being clear on what is achievable, particularly in the early years of the plan. The easy-read version was very well received. • The process for re-designing the operating model in response to the recently announced requirement to reduce integrated care board running costs by 30% was outlined. An additional meeting was held at the end of March to agree the transfer of commissioning responsibilities for pharmaceutical, ophthalmology and dentistry services from NHS England.

Date of next meeting	Next meeting in public scheduled for 3rd May 2023.
Further information:	https://southyorkshire.icb.nhs.uk/our-information/meetings-and-papers

3. South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative

Member	Chief Executive
Items discussed	Update from meeting of 15th March 2023 There has not been a further meeting of the Mental Health, Learning Disability & Autism (MHLDA) provider collaborative since the last Trust Board meeting. As a reminder, key items discussed at the March MHLDA meeting included: • The patient story covered the patient journey through the adult mental health services at Rotherham, Doncaster and South Humber (RDaSH). • The base data from the collaborative into the South Yorkshire integrated care system joint forward plan was provided. Consideration was given to how this can be summarised and made accessible for staff, service users, families and carers. • There was recognition of the challenge facing integrated care boards of having to deliver a 30% cost saving over the next two years and what this could mean for the collaborative. • The communication and engagement plan was received. • An outline of the inpatient quality transformation programme was provided. • An initial draft of the integrated performance report structure and layout for the collaborative was provided. • The final version of the joint working agreement and Terms of Reference for the Committees in Common were agreed and can now be taken to Trust Boards for approval.
Date of next meeting	Next meeting scheduled for 10th May 2023.

4. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

Member	Chief Executive and Chair
Items discussed	Update from meeting on 30th March 2023 Key items discussed included: • Barnsley Borough resident patient story. • Place Involvement Report- an update was given on progress on the development of the partnership

	approach to involving people, their carers, and local communities. • Place Director update. • There was concern raised regarding industrial action by junior doctors and call for additional support from community, primary care and social care. • Barnsley Place achievements. • Feedback from South Yorkshire Integrated Care Partnership Board. • South Yorkshire Integrated Care Partnership Strategy. • Operational plan- areas raised as needing continued focus include GP appointment targets, dental activity, improving access to mental health services for children and young people (some commissioned activity not counted), IAPT access, and out of area placements. • Development of the Barnsley Health & Care Plan update (including intermediate care review update)- work has continued to engage with key stakeholders in the development of the Barnsley Place Plan and Health Inequalities Plan 2023-25, led by the Place Partnership Delivery Group. Further work to ensure close alignment between the Health Inequalities and Place Plans and to place and system strategy is due to take place. It is intended to align timescales for finalising Place Plans with the other places across South Yorkshire. Therefore, the Place Partnership Board is expected to receive the final Place Plan in April 2023. • Barnsley Primary Care Practice Delivery Agreement 2023/24. • Quality and Safety Report. • Draft Place financial position update 2023/24- the financial position has improved to support wider system pressures this year. Continued pressures include prescribing, continuing care and complex care placements. Next year a financial deficit is expected. A check and challenge is planned with mental health providers in South Yorkshire including SWYPFT. A financial improvement approach was set out which was supported. • Performance dashboard (including SY ICB Performance Report). • Committee minutes and assurance reports. • Updates and escalations from partners.
Date of next meeting	Next meeting scheduled for 27th April 2023. This will be a development session.

Barnsley Place Partnership Delivery Group

Member	Director of Strategy and Change/Deputy Chief Executive
Items discussed	Update from meeting on 14th March 2023 Key items discussed included: • Programme highlights exceptions reporting- no new exceptions were reported. • Place Plan update- it was updated that a development session was held with the Place Committee. Priorities were supported with the suggestion to consider how impact of the plan is measured. The plan has been discussed with the 2030 Board and Stronger Communities Partnership and supported. • Financial Plan update- an update was shared which presented a challenging picture. • Intermediate Care Review- the review has commenced. • Feedback from Barnsley 2030 Board.
Date of next meeting	Next meeting scheduled for 9th May 2023

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair and Director of Strategy and Change/ Deputy Chief Executive
Items discussed	Update from meeting on 29th March 2023 Agenda items included: • Deep dive: frailty and dementia. • Learning Disability (LD) health checks: Nudge theory pilot- a strategic health facilitator for LD is now in post. There has been an improvement in uptake of health checks compared to the same period last year- March data indicates 79.8% of patients on the LD register have had an annual health check. It has been agreed to pilot the Behavioural Science Nudge theory within two practices in Barnsley, from April focusing on those who are projected to have low uptake rates for annual health checks. • Public involvement. • Alliance workshop.
Date of next meeting	A workshop is planned for 28th April 2023.

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change/ Deputy Chief Executive
Items discussed	Update from meeting on 2nd February 2023 Agenda items included: • Barnsley Health and Wellbeing Board draft Terms of Reference- the updated Terms of Reference have now been formally adopted. • South Yorkshire Integrated Care Strategy- Health and Wellbeing Board members considered and approved the contents of the Integrated Care Strategy for South Yorkshire. • Barnsley 2030 - Healthy Barnsley thematic update- an update was provided to describe the work of the Barnsley 2030 Board to date, particularly in relation to the Healthy Barnsley theme. Interconnectivity between the Barnsley 2030 Board and the Health and Wellbeing Board was discussed. • Creativity and wellbeing update and planning for creativity and wellbeing week 2023 update- commitment was given to support the next creativity and wellbeing week in May. • Better Care Fund report. • Integrated Care Partnership (ICP) strategy.
Date of next meeting	The next meeting to be confirmed.
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=143

Recommendation

To receive papers and note updates from SY ICB and Barnsley place.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 11.2

Private/Public paper:	**Public**		
Title:	**West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update.**		
Paper presented by:	Salma Yasmeen - Director of Strategy and Change/Deputy Chief Executive Sean Rayner - Director of Provider Development		
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	The development of joined-up care through Place and system working is central to the Trust's strategy, and is supportive of our mission - to help people reach their potential and live well in their community. The Trust Values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership focusing on developments that are of importance or relevance to the Trust. The paper also includes an update on key developments in the three districts in West Yorkshire that the Trust provides services (Calderdale, Wakefield, Kirklees).		
Strategic objectives:	Improve Care	√	
	Improve Health	√	
	Improve Resources	√	
	Make this a great place to work		
BAF Risk(s):	• 1.1 The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place. • 1.2 The focus on integrated care models at place may result in unwarranted variation and differences in standards and could potentially impact the sustainability of smaller specialist services. • 3.2 Failure to develop strong relationships with integrated care systems, places, and provider collaboratives results in services that do not meet local needs or are unsustainable.		

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place-based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.
Any background papers / previously considered by:	Strategic discussions and updates on the West Yorkshire Health & Care Partnership developments and place-based developments have taken place regularly at Trust Board.
Executive summary:	From 1 July 2022, NHS West Yorkshire Integrated Care Board (ICB) took on the commissioning responsibilities of clinical commissioning groups and will lead the integration of health and care services across West Yorkshire. Work continues in each of the places that make up the partnership to evolve and develop place-based partnership governance arrangements and services. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements.
Recommendation:	**Trust Board is asked to RECIEVE and NOTE the update on the development of Integrated Care Systems and collaborations:** ○ **West Yorkshire Health and Care Partnership;** ○ **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.** **Receive the minutes of relevant partnership boards/committees.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023

Agenda item 11.2

West Yorkshire Health & Care Partnership (WYHCP) - including the Mental Health, Learning Disability and Autism Collaborative and Place-Based Partnerships Update

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership (WYHCP), focusing on developments that are of importance or relevance to the Trust. The paper also includes an update on key developments in the three districts in West Yorkshire that the Trust provides services (Calderdale, Wakefield, Kirklees).

From 1 July 2022, NHS West Yorkshire Integrated Care Board (ICB) took on the commissioning responsibilities of clinical commissioning groups and will lead the integration of health and care services across West Yorkshire.

The partnership continues to develop the governance arrangements, which remain in development after 1 July 2022 and will need to be reviewed and adapted as they bed in. Formal reviews will be at 12 and 18 months which have been built into all aspects of the arrangements.

All nomination and appointment processes to the Board include a commitment to improve the diversity of the Partnership's leadership and to ensure a spread of representation across places. Work continues in each of the places that make up the partnership to evolve and develop place-based partnership governance arrangements. The Trust has continued to work with partners in each of its places to support the development of place-based arrangements.

The paper summarises key developments from recent ICB and place-based meetings.

2. West Yorkshire Health and Care Partnership

Updates from key meetings of the West Yorkshire Health and Care Partnership are summarised below.

West Yorkshire Integrated Care Board

Member	Mental Health, Learning Disability and Autism services are represented by Sara Munro, Chief Executive of Leeds and York Partnership NHS Foundation Trust, as partner member of the Integrated Care Board.
Items discussed	Update from meeting of 21st March 2023 Agenda items included: • Chair and Chief Executive's reports. • Board Assurance Framework- this was approved. • Focus on VCSE. • Integrated Performance Dashboard including financial performance. • Winter performance update. • Corporate Risk Register. • Committee Alert, Advise and Assure (AAA) Reports. • Strategy and planning update. • Financial planning 2023/24. • Pharmacy, optometry, dental (POD) delegation. • Specialised commissioning. • Policies.
Date of next meeting	Next meeting scheduled for 16th May 2023.
Further information:	NHS West Yorkshire ICB Board meeting - Tuesday 21 March 2023 :: West Yorkshire Health & Care Partnership

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	Update from meeting of 7th March 2023 Agenda items included: • Current context. • Tackling health inequalities for black, asian and minority ethnic communities and colleagues- an update was provided on the progress made on the delivery of the Tackling Health Inequalities for Black, Asian and Minority Ethnic Communities and Colleagues Review and subsequent action plan specifically focusing on improving safe access to work for ethnic minorities in West Yorkshire and ensuring the Partnership's leadership is reflective of communities. • Partnership's Five Year Strategy – a final draft of the strategy was shared, which reflected the comments provided by place-based Health and Wellbeing Boards since the December 2022 update. This was approved. A public launch of the strategy will take place post-election. Work is also currently underway to develop the plans to deliver the strategy through the Joint

	Forward Plan which will be owned by the West Yorkshire Integrated Care Board. • Partnership's Climate Change Strategy- a draft of the strategy was shared and members of the Board asked to provide comments. It is intended to continue to engage with partners across the system with a view to finalising the document later in Spring 2023.
Date of next meeting	Next meeting scheduled for 6th June 2023.
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard Meeting papers are available here: West Yorkshire Health and Care Partnership Board meeting - Tuesday 7 March 2023 :: West Yorkshire Health & Care Partnership (wypartnership.co.uk)

West Yorkshire Mental Health, Learning Disability and Autism Partnership Board

Member	Director of Provider Development, Chief Operating Officer and Medical Director
Items discussed	The next meeting is scheduled for 20th April 2023. Agenda items include: • Chair's update. • Workforce. • Children and young people's mental health. • Neurodiversity priorities. • Complex rehabilitation. • Older people's transformation. • Suicide prevention. • West Yorkshire Mental Health Learning Disability and Autism Plan • Escalations from workstreams.
Date of next meeting	Next meeting scheduled for 9th May 2023.

Wakefield

The Trust continues to be a pro-active partner in the Wakefield District Health and Care Partnership (DHCP) and associated work, leading in specific areas, for example, the Wakefield Mental Health Alliance.

Wakefield District Health and Care Partnership Committee

Member	Chief Executive (deputy - Director of Provider Development)
Items discussed	Update from meeting on 23rd March Key items discussed included: • Place Leader Report- it was noted that a review of functions, structures and ways of working of the NHS West Yorkshire Integrated Care Board and wider Integrated Care System (ICS) is taking place. • Report from the Chair of the Provider Collaborative. • Public health profiles - Wakefield Gypsy and Travellers Health Needs Assessment- a Wakefield District Gypsy and Traveller Health Needs Assessment (HNA) was undertaken in 2022, coordinated and produced by Leeds Gypsy and Traveller Exchange (GATE), in partnership with Wakefield Council. There were 10 recommendations produced based on research findings, including identifying a senior champion to support the work. • Children's Services update- the summary of partnership activity was provided as a follow-up to the schools' survey and covered the wide range of work taking place under the five priorities of the Children and Young People's Plan 2022-2025: Our Safety, Our Health, Our Education, Our Futures and Our Identity. • Mental Health Investment Standard priorities 2023/24- the Committee noted the Mental Health Alliance (MHA) process undertaken to develop the proposed Mental Health Investment Standard (MHIS) work programme for 2023/24 and approved the recommended priorities for recurrent funding, and for non-recurrent funding from planned phasing/mobilisation of recurrent priorities. • Summary of 2022/23 Quarter 3 Quality, Safety and Experience report. • Performance Exception Report. • Finance update. • Wakefield Place Risk Register. • New Southgate boundary changes- New Southgate Surgery has requested to change its practice boundary. The committee approved the change to the practice boundary effective from 1 April 2023. • Primary Care Commissioning Intentions- the commissioning intentions were supported and approved by the Committee. • Issues to alert, advise or assure the ICB Board on. • Receipt of minutes from the sub-committees.
Date of next meeting	Next meeting scheduled for 23rd May 2023.
Further information	Meeting papers are available here:

	Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk)

Wakefield Provider Collaborative

Member	General Manager, Wakefield Community Services
Items discussed	Update from development session on 18th April 2023 Key items discussed included: • Current role, function and membership of the Provider Collaborative and strategic context for change. • Reviewing the Provider Collaborative- there were discussions as to what has worked well, what hasn't worked well, and what needs to be considered going forward. • Alliances and programmes. • Outcomes framework.
Date of next meeting	Next meeting scheduled for 16th May 2023.

Wakefield Mental Health Alliance

Member	Director of Provider Development (Chair), with Trust representative as a member.

Items discussed	The next meeting is scheduled for 19th April 2023. Agenda items include:
	
	• Wakefield Poverty Support Services mapping.
	• Mental Health Alliance Dashboard.
	• Standing item updates.
	  ○ Mental Health Emergency Dept Strategy Group.
	  ○ Psychology T&F.
	  ○ Emotional well-being procurement.
	  ○ Older People and Dementia Group.
	  ○ Community Mental Health Transformation.
	  ○ NHS 111 roll out.
	  ○ VCSE funding coordination group.
	• 2023/24 prioritisation process discussion.
	• 2023/24 Wakefield priorities.
	  ○ Contribution to the West Yorkshire Mental Health, Learning Disabilities and Autism Plan.
	  ○ Contribution to Wakefield Place Plan.
	• Mental Health Alliance stakeholder meeting update.
	• Children and young people bereavement update.
	• Older people's mental health business case.
	• Partner updates.
	• Wakefield Provider Collaborative.
	• Wakefield District Health and Care Partnership feedback.

	• Wakefield Health And Wellbeing Board feedback. • West Yorkshire ICS MHLDA Programme feedback. • Alliance forward planning.
Date of next meeting	Next meetings scheduled for 17th May 2023.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Provider Development)
Items discussed	Update from meeting on 9th March 2023 The agenda was focused on Health and Wellbeing Priorities. Key items discussed included: • Children and young people- a presentation was given by Vicky Schofield, Corporate Director, Children and Young People, plus colleagues from the Wakefield Families Together Partnership including Trust staff. • Overview and Scrutiny Committee papers.
Date of next meeting	Next meeting to be confirmed (will be confirmed at Annual Council in May 2023).
Further information	Papers and draft minutes are available at: Health and Wellbeing Board - Wakefield Council

Calderdale

SWYPFT is a strong partner in delivering the Calderdale Vision 2024 and Calderdale Cares. We have continued to work with partners to develop a place-based approach.

Calderdale Cares Partnership Board

Member	Chief Executive
Items discussed	Update from meeting on 30th March 2023 • Deep Dive: General Practice- the Adults Health and Social Care Scrutiny Board has undertaken a review of General Practice in Calderdale. The report from this makes seven recommendations on communication, retention of staff and workforce, complaints, General Practice management systems, partnership work, General Practice administration and the Fuller Report. The recommendations were fully supported, and it was agreed that these would be progressed through the new Primary Care Strategy Group • Primary Care Strategy Group- terms of reference were approved. • Talking Therapies procurement- a paper was shared setting out the background and context of the review of Talking Therapies arrangements in Calderdale.

	• Place Lead Report- particular reference was given to the impact of industrial action. • Risk Register. • Place Quality and Safety Report. • Place Finance Report. • Place Performance Report. • Transformation Leadership Group – Update on Forward Plan and Terms of Reference. • Place Committee work plan and future agenda items. • Matters for Escalation for inclusion on the Triple `A` Report. • Papers received for information: - Calderdale Clinical and Professional Forum. - Transformation and Leadership Delivery Group.
Date of next meeting	Next meeting scheduled for 25th May 2023.
Further information	Further information and meeting minutes can be found here: https://www.calderdalecares.co.uk/about-us/meeting-papers/

Calderdale Cares Community Programme Board

Member	Deputy Director Strategy and Change
Items discussed	The Calderdale Cares Community Programme Board meetings now alternate between business meetings and workshops. The latest meeting was a workshop. Update from workshop of 13th April 2023 Items discussed included: • Recap of vision, plans and themes- the developing work on neighbourhood working, integrated teams and the role of the multi-disciplinary team was discussed. • Estates- there was a discussion about primary care estate. This was facilitated by the National Association of Primary Care (NAPC) who are leading a piece of work on primary care estate across West Yorkshire. The discussions focused on the type of estate required by primary care, identifying important principles and considering creative approaches to estate.
Date of next meeting	Next meeting is scheduled for 11th May 2023.
Further information	Papers are available on the Future NHS platform for those with an account. https://future.nhs.uk/CalderdaleCCPBoard/view?objectId=36472912 Accounts can be set up at: https://future.nhs.uk/system/register

Calderdale Health and Wellbeing Board

Invited Observer	Director of Nursing & Quality
Items discussed	The April meeting of the Health and Wellbeing Board was cancelled. Update from meeting of 9th March 2023 • Update on membership of the Board. • Health and Wellbeing Strategy - update on Developing Well Report. The Calderdale Wellbeing Strategy 2022-27 sets out ambition that children aged between the ages of 6 and 25 should have hope and aspiration. In January 2022 the Developing Well strategic board was established to drive and coordinate work to achieve this ambition. Progress of this work was outlined. • 2023 Calderdale Community Information Directory briefing- a paper was shared and supported to develop a Calderdale Community Information Directory (CID), as part of an integrated digital platform, to support Calderdale's communities. • Health and Care priorities update.
Date of next meeting	Next meeting to be confirmed.
Further information	Papers and draft minutes are available at: https://calderdale.moderngov.co.uk/ieListDocuments.aspx?CId=148&MId=2732&Ver=4

Kirklees

The Kirklees Delivery Collaborative is now meeting on a regular basis.

The Kirklees Mental Health Alliance continues to meet and progress workstreams. Governance arrangements for the Alliance have been aligned to the new Kirklees place governance arrangements from 1 July 2022.

Kirklees ICB Committee

Member	Chief Executive (deputy – Director of Provider Development)
Items discussed	Update from meeting on 8th March 2023. Items discussed included: • People story. • Kirklees Urgent Community Response Service review and future recommendations. • Discharge update. • Update on the development of the Kirklees Health and Care Plan. • Kirklees Financial Plan update.

	• Accountable Officer's Report. • Kirklees Place Quality Report. • Finance and Contracting Report. • Performance Report against Key Performance Indicators for 2022/23. • High Level Risk Report. • Committee work plan.
Date of next meeting	Next meeting scheduled for 10th May 2023.
Further information	Further information and papers are available at: Kirklees ICB Committee papers - NHS Kirklees Clinical Commissioning Group (kirkleeshcp.co.uk)

Kirklees Integrated Health and Care Partnership Forum

Member	Director of Provider Development
Items discussed	Update from meeting of 6th April 2023 Items discussed included: • Kirklees Health and Care Plan- an update on the development of the Kirklees Health and Care Plan was shared. • Delivering Mid Yorkshire Hospitals Future 23-28: Update on development of Mid Yorkshire Hospitals new Trust Strategy- an overview of the new Mid Yorkshire Hospitals Trust Strategy 'Delivering MY Future' was shared. • Work plan.
Date of next meeting	Next meeting scheduled for 4th May 2023.

Kirklees Health and Wellbeing Board

Invited Observer	Director of Provider Development
Items discussed	Update from meeting of 30th March 2023 Key agenda items included: • Kirklees Safeguarding Adults Board Annual Report 2021-2022. • Implementing the Kirklees Health and Wellbeing Strategy Progress Report- an update on the implementation of the Kirklees Health and Wellbeing Strategy. • Kirklees Health and Wellbeing Strategy Priorities- Connected Care and Support. • Kirklees Health and Wellbeing Strategy Priorities - Healthy Places.

	• Kirklees Health and Wellbeing Strategy Priorities - Mental Wellbeing Update. • Agenda planning for 2023/24.
Date of next meeting	Next meeting to be confirmed.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Kirklees Delivery Collaborative

Member	Director of Provider Development
Items discussed	Update from meeting on 6th March 2023 Key agenda items included: • Starting Well, Living Well, End of Life- an overview of the Kirklees life course approach was given. • Services delivered in the Community Service Specification- an overview was given of the revised Community Service specifications ahead of taking these through the governance process for sign off. These included Community Nursing, Care Home Support Team, OPAT IV Therapy, Tissue Viability and Wound Care, and Tuberculosis specifications. • ICB Harmonisation of Commissioning Policies.
Date of next meeting	Next meeting scheduled for 15th May 2023.

Kirklees Mental Health Alliance

Member	Director of Provider Development (Co-Chair), with Trust representative as a member.
Items discussed	Update from meeting on 3rd April 2023 • Patient story • Rehab and Recovery deep dive. • Programme highlight reports (by exception only). • Strategic developments- WY MHLDA Partnership Board. • Investments- Health Psychology (CHFT) • Forward Plan.
Date of next meeting	Next meeting scheduled for 15th May 2023

Recommendations:

Trust Board is asked to:

- **Receive and note the update on the development of Integrated Care Systems and collaborations:**
    - **West Yorkshire Health and Care Partnership;**
    - **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.**

- **Receive the minutes of relevant partnership boards/committees.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 11.3

Private/Public paper:	**Public**		
Title:	**Specialised NHS-Led Provider Collaboratives and Alliances - Update**		
Paper presented by:	Adrian Snarr - Director of Finance, Estates and Resources Sean Rayner - Director of Provider Development Salma Yasmeen - Director of Strategy and Change/ Deputy Chief Executive		
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	The development of joined- up care through partnership working is central to the Trust's strategy, and is supportive of our mission- to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is to provide the Trust Board with: 1. An update on key developments within the West Yorkshire and South Yorkshire and Bassetlaw Specialised NHS-Led Provider Collaboratives and key priorities that are of relevance to the Trust. 2. An update on the Phase 2 Provider Collaboratives.		
Strategic objectives:	Improve Care	✓	
	Improve Health	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):	• 1.1 The new NHS landscape of integrated care boards, place-based partnerships and provider collaboratives could lead to changes and variations in local priorities resulting in service inequalities, and differences in our offer in each place. • 1.2 The focus on integrated care models at place may result in unwarranted variation and differences in standards and could potentially impact the sustainability of smaller specialist services. • 3.2 Failure to develop strong relationships with integrated care systems, places, and provider collaboratives results in services that do not meet local needs or are unsustainable.		
Contribution to the objectives of the Integrated Care System/Integrated	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through provider collaboratives, and also developments and discussions in progress where relevant.		

Care Board/Place based partnerships	
Any background papers / previously considered by:	Strategic discussions and updates on Provider Collaboratives and developments have taken place regularly at Trust Board.
Executive summary:	**West Yorkshire Specialised NHS-Led Provider Collaboratives** In West Yorkshire, the Trust is Co-ordinating Provider of the Adult Secure Provider Collaborative, and a partner in the Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) and Adult Eating Disorder (AED) Provider Collaboratives, for which Leeds and York Partnership NHS Foundation Trust (LYPFT) is the co-ordinating provider. All Provider Collaboratives continue to experience staffing challenges (medical and nursing). Pressures have resulted in reduced capacity/ activity in the West Yorkshire CYPMH and AED Provider Collaboratives this reporting period. The Adult Secure Provider Collaborative Board has continued to meet and progressed among a range of items: • Development and prioritisation of patient pathways in West Yorkshire- work on the Community Pathway has been a key focus. • Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow. • Involvement in national work to revise the secure service specifications. • Support for improvement plans. For the 12 months to March 2023 the collaborative operated with a financial surplus, which has been allocated to providers in line with the risk and reward share. The Adult Eating Disorders Provider Collaborative for the 12 months to March 2023 reported a deficit position of £101k. This is a deterioration against a break-even plan, and can be attributed to deficits against the out of area budget and the cross flows income target, due to reduction of referrals and admissions from out of area. The CYPMH Provider Collaborative reported a surplus of £1,003k for the 2022/23 financial year. **South Yorkshire and Bassetlaw Provider Collaboratives** In South Yorkshire and Bassetlaw, the Trust is Co-ordinating Provider of the Adult Secure Provider Collaborative. The Provider Collaborative Oversight Group for the collaborative is in place, ensuring oversight of the Trust's commissioning responsibilities which reports into the Trust's Collaborative Committee.

	The draft 'Lead Provider' contract has been shared with the Trust by NHS England (NHSE) and discussions are ongoing, pending outcome of ongoing negotiations with Independent Sector partners. For the 12 months to March 2023 the collaborative operated at breakeven. However, there is financial risk associated with agreement of contract with one independent sector provider. Risk share discussions continue with partners in South Yorkshire. **Phase 2 Provider Collaboratives** The Trust has undergone a process of 'due diligence' and have developed a Memorandum of Understanding (MOU) to support a transition period of handover from NHSE to the West Yorkshire Provider Collaborative Commissioning Hub. A recommendation of go live of 1st April 2023 was supported by the Collaborative Committee on 7th February 2023 and Trust Board on 28th February 2023 subject to the MOU with NHSE being in place. This was supported by partners at the West Yorkshire Specialised Mental Health, Learning Disabilities and Autism Programme Board on 24th March, and both the South Yorkshire and Bassetlaw and Humber and North Yorkshire Commissioning Hubs. The FCAMHS Provider Collaborative went live on 1st April 2023. Work is underway by the West Yorkshire Specialised Provider Collaborative Commissioning Hub to shadow the existing governance arrangements for FCAMHS within SWYPFT as Co-ordinating Provider (FCAMHS Board, established contract monitoring and quality arrangements) in order to define their role within these in the future and ensure clear delineation between provider and commissioner functions. An expression of interest has been developed by LYPFT to be co-ordinating provider for the Perinatal Provider Collaborative, with input from partners via the Perinatal Partnership Board. This was shared with all partner Boards and submitted in March 2023. **Risk Appetite** The development and delivery of Provider Collaboratives is in line with the Trust's risk appetite.
Recommendation:	**Trust Board is asked to RECEIVE and note the Specialised NHS-Led Provider Collaboratives update.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023

Agenda item 11.3

Specialised NHS-Led Provider Collaboratives and Alliances - Update

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the Specialised NHS-Led Provider Collaboratives, focusing on developments that are of importance or relevance to the Trust. The paper includes updates on the West Yorkshire and South Yorkshire & Bassetlaw Provider Collaboratives where the Trust is a Co-ordinating Provider or partner, and an update on the national Phase 2 Provider Collaboratives.

2. Phase 1 Provider Collaboratives

In **West Yorkshire**, Provider Collaboratives have been established for national Phase 1 services:

- Adult Low and Medium Secure Services - co-ordinated by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).
- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - co-ordinated by Leeds and York Partnership NHS Foundation Trust (LYPFT).
- Adult Eating Disorder Services - co-ordinated by LYPFT.

In addition to being Co-ordinating Provider for Adult Secure, the Trust is a partner in both the Adult Eating Disorder and CYPMH Provider Collaboratives.

The Adult Eating Disorder Collaborative went live on 1st October 2020, and the CAMHS and Adult Secure Collaboratives 1st October 2021 (with transitional support from NHSE/I until 31st March 2022).

In **South Yorkshire and Bassetlaw**, Provider Collaboratives have also been established for all national Phase 1 Services:

- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - co-ordinated by Sheffield Children's Hospital.
- Adult Eating Disorder Services - co-ordinated by Rotherham Doncaster and South Humber NHS Foundation Trust.
- Adult Secure Services - co-ordinated by SWYPFT.

The Adult Eating Disorder and CYPMH Provider Collaboratives went live on 1st October 2022, and the Adult Secure Provider Collaborative on 1st May 2022.

Although the South Yorkshire Integrated Care System does not now include the Bassetlaw population, for the purpose of the Phase 1 services the Provider Collaboratives continue to include the Bassetlaw population. Hence Bassetlaw is still included in the title.

3. Phase 1 Provider Collaboratives - West Yorkshire

Recent developments for all West Yorkshire Provider Collaboratives include:

- Implementation of quality surveillance process(es) for out of area placements, resulting in better oversight of the care delivered to those originating from West Yorkshire.

- Further development of Standard Operating Procedures (SOPs) for all West Yorkshire Provider Collaboratives, for example a SOP for temporary reduced activity/closure to admissions.

- Implementation of a new approach to contract meetings. “Service Review Meetings” have been initiated and now include a deep dive narrative/presentation by providers. It is anticipated this will complement data collection for quality oversight.

- Understanding the new Patient Safety Incident Response Framework (PSIRF). The Commissioning Hub held its first Commissioner-led PSIRF oversight group in February 2023, and continue to work with providers to map out existing commissioner oversight arrangements and to clarify plans for future commissioner oversight.

All Provider Collaboratives continue to experience staffing challenges (medical and nursing), and this issue has been a focus, with continued support from West Yorkshire integrated care system (ICS) recruitment and retention workstreams. Pressures have resulted in reduced capacity/ activity in the West Yorkshire CYPMH and AED Provider Collaboratives this reporting period.

3.1 West Yorkshire Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Board has continued to meet and progressed among a range of items:

- Development and prioritisation of patient pathways in West Yorkshire- work on the Community Pathway has been a key focus.
- Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow.
- Involvement in national work to revise the secure service specifications.
- Support for improvement plans across the collaborative.

For the 12 months to March 2023 the collaborative operated with a financial surplus, which has been allocated to providers in line with the risk and reward share.

Due to ongoing staffing challenges (medical and nursing), one provider paused to admissions for a period of several weeks from January. Following implementation of a restoration plan and successful locum recruitment to medical posts, the provider re-opened to admissions in March within the agreed (8 weeks) timescale. This has resulted in increased activity and improved occupancy within this provider.

SWYPFT, in its role as Lead Provider, have been carrying out visits to each of the in-area partners in order to review how the collaborative is operating, and any learning from the first 18 months as a collaborative. An Adult Secure Provider Collaborative Board development session is planned for July 2023 in order to share learning from these visits, and to discuss future plans for the collaborative.

There has been a focus on progressing the 2022/23 Lead Provider Contract Variation. This has now been agreed, and signed by SWYPFT. 2022/23 contract variations with in-area partners are now being progressed to signature as a priority.

The most recent meeting of the Collaborative Committee of the Trust Board took place on 4th April 2023, with a further meeting planned for 5th June 2023.

3.2 West Yorkshire Adult Eating Disorders Provider Collaborative

There have been ongoing challenges regarding the physical health monitoring for Adult Eating Disorder patients under the care of the Provider Collaborative (CONNECT Community). Short and medium-term options to address this are being developed.

Due to current staffing challenges, the Provider Collaborative have continued to adopt an interim admission process to consider the acuity of each admission and ability to manage complex care. This has resulted in a lower occupancy, and a further risk of increased out of area admissions. An action plan is in place to address the staffing challenge.

The original Adult Eating Disorder Provider Collaborative business case assumed a level of income generation from other provider collaboratives placing patients in West Yorkshire. The national ambition for provider collaboratives to place patients close to home has resulted in a reduction of referrals and admissions from out of area, which negatively impacts on income.

At month 12, a deficit position of £101k is reported. This is a deterioration against a break-even plan and can be attributed to deficits against the out of area budget and the cross flows income target. As a result of the deficit position in year, ordinarily the collaborative would initiate the risk share agreement and split this risk between LYPFT, SWYPFT and Bradford District Care NHS Foundation Trust. However, the providers have agreed that LYPFT fund this deficit in 2022/23 with the repayment of this risk being the first call on any surpluses generated in 2023/24.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

Due to current staffing challenges, Red Kite View continues to operate at reduced occupancy. A restoration and re-occupancy plan has been developed, with regular status reports being generated and shared. Nevertheless, this has resulted in increased use of out of area beds.

Significant challenge has been felt across the intensive care pathway for the CYPMH. Whilst a number of supportive and operational actions were established, cumulative incidents prompted a decision, with patient safety at the centre, between the provider and West Yorkshire Specialised Provider Collaborative Commissioning Hub that Red Kite View Psychiatric Intensive Care Service (PICU) would close for a period of time to restore safe service delivery and staff care.

A surplus of £1,003k is reported for the 2022/23 financial year, an improvement of £1,259k against plan. This can be attributed to reduced general and eating disorder placements, and lower secure activity. The surplus will be reinvested in the provider collaborative via an Investment Fund, for the benefits of service users.

4. Phase 1 Provider Collaboratives - South Yorkshire

4.1 South Yorkshire Adult Secure Provider Collaborative

The Collaborative went 'live' on 1st May 2022, with the Trust as 'Co-ordinating Provider'.

Key areas of focus have included the following:

- Governance structures are in place, with attendance from SWYPFT as Co-ordinating Provider. The Commissioning Hub is fully established.
- The Provider Collaborative Oversight Group for the collaborative provides oversight of the Trust's commissioning responsibilities. This reports into the Trust's Collaborative Committee.
- The draft Co-ordinating Provider contract has been shared with the Trust by NHS England/Improvement. This has been reviewed by the Commissioning Hub and discussions with NHSE/I remain ongoing, pending outcome of negotiations with Independent Sector partners.
- Risk share discussions continue between providers.

Due to ongoing negotiations between NHSE, the Commissioning Hub and one of the independent sector partners in South Yorkshire, the Trust has been unable to sign the Lead Provider Contract at this stage.

For the 12 months to March 2023 the collaborative operated at breakeven. However, there is financial risk associated with agreement of contract with one independent sector provider.

5. Phase 2 Provider Collaboratives

The following services were intended to be part of Phase 2 of the Provider Collaboratives Programme:

- Adult Secure: Adult Low and Medium Secure Acquired Brain Injury and Deaf Services, Women's Enhanced Medium Secure Services, High Secure Services.
- Children and Young People's Mental Health Services (CYPMHS): Children's (Under 13s), CYPMHS Medium Secure and CYPMHS Medium Secure LD Services, Deaf CYPMHS, Forensic CYPMHS.
- Specialist Services: Obsessive Compulsive Disorder and Body Dysmorphic Disorder Services, Tier 4 Personality Disorder Services, Non-secure (Acute) Deaf Services.
- Perinatal: Specialist inpatient services and associated teams (e.g. outreach).

NHSE undertook consultation for phase 2 Adult Secure and CYPMH services. Following consultation, Adult Low and Medium Secure Acquired Brain Injury and Deaf Services, Women's Enhanced Medium Secure Services will continue to be commissioned directly by NHS England and Improvement (NHSE) with a national ring-fenced budget. NHSE remains accountable and is responsible for the commissioning of these services but delegates specific functions to placing or host Lead Providers.

Work is underway to consider how the services reviews for Medium Secure CYP and Under 13s can be aligned to developing a PC approach.

The National Specialised Commissioning Team have determined that Obsessive Compulsive Disorder and Body Dysmorphic Disorder Services, Tier 4 Personality Disorder Services, Non-secure (Acute) Deaf Services are not appropriate for a Provider Collaborative approach at this time.

In West Yorkshire, the Trusts who comprise the WY MHLDA collaborative have agreed a set of principles to determine which Trust is our preferred option to be the co-ordinating provider ('lead provider' in NHS England terminology) for particular services that might have commissioning responsibility delegated from NHS England or the WY Integrated Care Board, which has guided discussions.

5.1 Forensic CAMHS

The National Specialised Commissioning Team engaged CYPMH Lead Providers and regional colleagues to discuss recommendations for Forensic CAMHS (FCAMHS).

The national direction is that Forensic CAMHS services should be commissioned through CYPMH provider collaboratives. However, the Trust and our regional Specialised Commissioning Team have advocated nationally that the existing Yorkshire and Humber regional FCAMHS service works well as it is and that there is effectively a lead provider model already in place, with SWYPFT as co-ordinating provider.

An options analysis was considered at the May meeting of the West Yorkshire Specialised Mental Health Learning Disability and Autism Programme Board and support gained for SWYPFT to be 'co-ordinating provider' for FCAMHS across Yorkshire and Humber due to the fact SWYPFT currently provides the full pathway of care and across the appropriate geography.

This planned approach was outlined to wider partners across Yorkshire and Humber in a letter from Keir Shillaker and Sarah Sams on behalf of the WY Mental Health, Learning Disability and Autism (MHLDA) Collaborative in August 2022. Support for this approach was confirmed, subject to a Board with equal membership of all key partners being established to oversee the quality assurance, service delivery, planning, finance, and positive impact of the Forensic CAMHS service across the region. It is envisaged this will build on the existing FCAMHS Board.

NHSE/I have developed a standard operating procedure (SOP) to support with operationalising the FCAMHS recommendations, coproduced with experts by profession and experience.

The Trust has undergone a process of 'due diligence' and have developed a Memorandum of Understanding (MOU) to support a transition period of handover from NHSE to the West Yorkshire Provider Collaborative Commissioning Hub.

A recommendation of go live of 1st April 2023 was supported by the Collaborative Committee on 7th February 2023 and Trust Board on 28th February 2023 subject to the MOU with NHSE being in place. This was supported by partners at the West Yorkshire Specialised Mental Health, Learning Disabilities and Autism Programme Board on 24th March, and both the South Yorkshire and Bassetlaw and Humber and North Yorkshire Commissioning Hubs. The FCAMHS Provider Collaborative went live on 1st April 2023.

Work is underway by the West Yorkshire Specialised Provider Collaborative Commissioning Hub to shadow the existing governance arrangements for FCAMHS within SWYPFT as Co-ordinating Provider (FCAMHS Board, established contract monitoring and quality arrangements etc) in order to define their role within these in the future and ensure clear delineation between provider and commissioner functions.

5.2 Perinatal Mental Health

At national level, it has been approved that the NHS-Led Provider Collaborative model is implemented for Specialised Perinatal Mental Health services.

Within West Yorkshire, Leeds and York Partnership NHS Foundation Trust (LYPFT) has been identified as coordinating provider for Perinatal Mental Health services (using the agreed set of principles), because LYPFT currently provides the full pathway of care and across the appropriate geography.

This planned approach was outlined to wider partners across Yorkshire and Humber in a letter from Keir Shillaker and Sarah Sams on behalf of the WY Mental Health, Learning Disability and Autism (MHLDA) Collaborative in August 2022. There are collective concerns across the region regarding process/expectation, availability of data and the importance of retaining local responsibility for community perinatal provision, and discussions with NHSE are ongoing.

In November 2022, NHSE/I published the Perinatal Provider Collaborative selection process. Lead Provider (coordinating provider) applications were invited. An expression of interest has been developed by LYPFT, with input from partners via the Perinatal Partnership Board. This was shared with all partner Boards, and submitted in March 2023.

Recommendation:

Trust Board is asked to:

Receive and note the Specialised NHS-Led Provider Collaboratives update.

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Trust Board 25 April 2023
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**Trust Board self-certification (G6/CoS7) – compliance with NHS provider licence conditions**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	Julie Williams - Director of Corporate Governance Andy Lister - Head of Corporate Governance (company secretary)		
Mission/values:	Good governance supports the Trust to deliver its mission and adhere to its values.		
Purpose:	To provide assurance to Trust Board that it is able to make the required self-certifications that the Trust complies with the conditions of the NHS provider license.		
Strategic objectives:	Improve Health	✓	Please remove as appropriate
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All risks.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The self-certification process provides evidence to assure the Board that the Trust is operating in line with its licence. It also provides assurance to partners and the system through publication on the Trust website.		
Any background papers / previously considered by:	Trust Board and Finance, Investment & Performance Committee has received updates on the development of the 2023/24 operational plan, most recently at the Trust Board meeting held on 28 March 2023. The attached document is reviewed and updated annually and was last presented to Trust Board on 26 April 2022. A further self-certification in the form of a corporate governance statement will come to Trust Board on 27 June 2023.		
Executive summary:	**Background** This retrospective report (1 April 2022 to 31 March 2023) is in line with the licence provider requirements for the year 2022/23. NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health		

and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

As part of the annual planning arrangements, NHS England requires the Trust to make a number of governance declarations.

Trust Board is required to make self-certifications (G6/CoS7) in relation to:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (as required by condition G6(3) of the NHS Provider Licence) (appendix 1 – NHS provider licence conditions); and
- If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated service (as required by condition CoS7(3) of the NHS Provider Licence) (appendix 1 – NHS provider licence conditions).

It is expected a further self-certification (FT4) is required by 30 June 2023 and this will come to the Trust Board meeting on 27 June 2023:

- The provider has complied with required governance arrangements (as required by condition FT4(8) of the NHS Provider Licence); and
- The training of Governors (as required by s151(5) of the Health and Social Care Act 2012).

Self-certification - part one (G6/CoS7)

Trust compliance with its Licence

The Licence is a requirement of the Health and Social Care Act 2012 and is the mechanism by which NHS Improvement/Monitor regulates providers of NHS services, both NHS and non-NHS. The provider licence is split into six sections, which apply to different types of providers. From 1 April 2013, all foundation trusts were automatically issued with a licence as the Health and Social Care Act 2012 specified that foundation trusts were to be treated as having met all the licence criteria.

In the main, the licence requires the Trust to adhere to (and provide evidence that it has done so) certain conditions, which it does as part of its existing governance and reporting arrangements. The attached paper (appendix 1) provides assurance to Trust Board that the Trust meets the conditions of its Licence and identifies potential areas of risk.

From the assurance provided, Trust Board is asked to certify that "***the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution***".

Providing commissioner requested services (CRS)

CRS designation is not simply a standard contract with a commissioner to provide services. CRS are services that commissioners consider should

	continue to be provided locally, even if a provider is at risk of failing financially and which will be subject to regulation by NHS England. Providers can be designated as providing CRS because: • there is no alternative provider close enough • removing the services would increase health inequalities • removing the services would make other related services unviable. The attached paper (appendix 1) sets out the way the Trust complies with the continuity of services conditions in the NHS provider licence. From the assurance provided, Trust Board is asked to certify that ***"the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking into account distributions which might reasonably be expected to be declared or paid for the period of 12 months"***.
Recommendation:	**Trust Board is asked to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to compliance with the conditions of its Licence.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023

NHS provider licence

This paper is intended to provide assurance that the Trust complies with the terms of its licence and sets out a broad outline of the licence conditions and any issues for Trust Board to note. Over the last twelve months NHS Improvement and NHS England have merged under a single structure as NHS England. All references in document this will therefore be NHS England.

The provider licence is split into six sections, which apply to different types of providers.

1. **General conditions (G)** – general requirements applying to all licensed providers.
2. Obligations about **pricing (F)** – obliges providers to record pricing information, check data for accuracy and, where required, charge commissioners in line with tariff. Applies to all licensed providers who provide services covered by national tariff.
3. Obligations around **choice and competition (C)** – obliges providers to help patients make the right choice of provider, where appropriate, and prohibits anti-competitive behaviour where against patients' interests. This applies to all licensed providers.
4. Obligations to enable **integrated care (IC)** – enables the provision of integrated services and applies to all licensed providers.
5. Conditions to support **continuity of services (CoS)** – allows NHS England (NHSE) to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty. Applies to providers of commissioner requested services (CRS) only.
6. Governance licence **conditions for Foundation Trusts (FT)** – provides obligations for Foundation Trusts around appropriate standards of governance. Applies to Foundation Trusts only.

Condition	Provision	Comments
Section 1 - General conditions (G)		
G1: Provision of information	Obligation to provide Monitor (referred to as NHSE) with any information it requires for its licensing functions.	The Trust is currently obliged to provide NHSE with any information it requires and, within reasonable parameters, to publish any information NHSE requires it to. We have systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust. Conditions are broad, so there is a potential risk of increased burden in the future
G2: Publication of information	Obligation to publish such information as NHSE may require.	
G3: Payment of fees to Monitor (NHSE)	Gives NHSE the ability to charge fees and for	There are currently no plans to charge a fee to

Condition	Provision	Comments
	licence holders to pay them.	Licence holders. Trust Board should note that there is currently no provision in the budget for additional fees and this would, therefore, become a cost pressure.
G4: Fit and proper persons	Prevents licences from allowing unfit persons to become or continue as governors or directors.	The Care Quality Commission (CQC) published the fit and proper person requirements to take effect from 1 October 2014. The Trust has included the requirement for members of Trust Board to make a declaration against the requirements on an annual basis to the Trust Board and has robust arrangements in place for new appointments to the Board (whether non-executive or executive). The Trust Board declaration and register of fit and proper persons, interests and independence policy was last reviewed and approved by Trust Board on 28 March 2023. Executive and Non-Executive Directors complete fit and proper person declarations every year and any declarations of interest are published on the Trust's website. All governors of the Members' Council are required to make a declaration of interest on commencement and on an annual basis which is reported to the Members' Council. The Members' Council declaration and register of interests, gifts and hospitality policy was last reviewed and approved by Members' Council on 11 May 2021. The declarations are published on the Trust's website. The Code of Conduct for Governors is now part of the Trust Constitution and new governors are briefed on this on commencement of their duties.
G5: Monitor guidance	Requires licensees to have regard to Monitor (NHSE) guidance.	The Trust responds to guidance issued by NHSE. Submissions and information provided to NHSE are approved through relevant and appropriate authorisation processes.

Condition	Provision	Comments
G6: Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	The Trust has systems and processes in place to ensure it complies with its Licence and this is co-ordinated by the Director of Finance & Resources and the Corporate Governance Team.
G7: Registration with the Care Quality Commission	Requires providers to be registered with the CQC and to notify NHSE if their registration is cancelled.	The Trust is registered with the CQC.
G8: Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.	The Trust's website sets out the service directories for each Care Group (CG) and the relevant access criteria for the services.
G9: Application of section 5 (which relates to continuity of services)	Sets out the conditions under which a service will be designated as a CRS	Covers all services which the licensee has contracted with a Commissioner to provide as a Commission Requested Service (CRS). See CoS1.
Section 2 - Pricing conditions (P)		
P1: Recording of information	Obligation of licensees to record information, particularly about costs.	The Trust responds to guidance and requests from NHSE. Information provided is approved through the relevant and appropriate authorisation processes. The Trust's accounting systems and processes ensure appropriate recording of cost information. The Trust's accounts are subject to external audit each year and its controls and processes are subject to both internal and external audit each year
P2: Provision of information	Obligation to submit the above to NHSE.	
P3: Assurance report on submissions to Monitor	Obliges licensees to submit an assurance report confirming that the information provided is accurate.	
P4: Compliance with the National Tariff	Obliges licensees to charge for NHS health care services in line with national tariff.	All contracts are agreed annually and are in line with the national tariff. The Trust continues to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance.
P5: Constructive engagement concerning local tariff modifications	Requires licence holders to engage constructively with commissioners and to reach agreement locally before applying to NHSE for a modification.	All contracts are agreed annually and are in line with the national tariff. The Trust continues to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance. see C2.
Section 3 - Choice and competition (C)		
C1: Patient choice	Protects patients' rights to choose between	The Trust has in place a service directory setting

Condition	Provision	Comments
	providers by obliging providers to make information available and act in a fair way where patients have a choice of provider.	out the services available. Commissioners monitor the Trust's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirements.
C2: Competition oversight	Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	Trust Board has reviewed its position and considers that it has no arrangements that could be perceived as having the effect of preventing, restricting or distorting competition in the provision of health services. The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board and Members' Council decide to consider any structural changes, such mergers or joint ventures. In July 2022 the Health and Social Care Bill went live. The Trust has continued to engage in partnership working, place agreements and provider collaboratives as integrated care systems have developed over the last 12 months. The Trust Board and Finance Committee receive updates of tenders and service developments being undertaken.
Section 4 - Integrated care condition (IC)		
IC1: Provision of integrated care	Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services.	The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care and is involved in several collaboratives which are developing new ways of working and new models of delivery. A number of services are provided through partnership working with local stakeholders. The Trust plays an active role in Integrated Care Systems in West Yorkshire and South Yorkshire and is a signatory to a Memorandum of Understanding with both. The Trust is also fully engaged in place-based arrangements in our respective localities. The Trust is now coordinating provider for adult secure services in West Yorkshire and South Yorkshire.

Condition	Provision	Comments
Section 5 - Continuity of service (CoS)		
CoS1: Continuing provision of commissioner requested services (CRS)	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	Under the Trust's 22/23 contracts with each ICB place there are no services classified as commissioner requested/essential services.
CoS2: Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek NHSE's consent before disposing of these assets if NHSE has concerns about the licensee continuing as a going concern.	The majority of Trust services are classed as CRS and all assets associated with these services are classed as restricted and can be identified by the Trust. Any changes to estate and the asset base are discussed with commissioners in relation to the provision of services. The Trust has an asset register in place. The Trust is only required to seek NHSE's consent for disposal of assets if NHSE is concerned about its ability to continue as a going concern. The Trust Board reviews and approves a going concern statement with appropriate rationale provided by the Director of Finance & Resources on an annual basis.
CoS3: Standards of corporate governance and financial management (Monitor/NHSE risk rating)	Licensees are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern.	The Trust has robust and comprehensive corporate and financial governance arrangements in place. Any adjustments have been approved through Trust Board during the year. Corporate and Financial governance arrangements remain subject to both internal and external audit annually. All audit plans are agreed by the Audit Committee and similarly all audit reports are received and reviewed at the Audit Committee
CoS4: Undertaking from the ultimate controller	Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	Does not apply to the Trust.
CoS5: Risk pool levy	Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails).	There is currently no risk pool levy in place.
CoS6: Co-operation in the event of financial stress	Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate	The Trust submits monthly financial returns in line with all NHS providers. Given our good underlying

Condition	Provision	Comments
	with NHSE.	financial performance, we are not currently in or expecting to be in financial distress and thus are not partaking in any finance specific reviews with NHSE. As a provider currently placed within Segment two, we continue to follow the single oversight framework requirements.
CoS7: Availability of resources	Requires licensees to act in a way that secures resources to operate commissioner requested services (CRS).	The Trust has sound and robust processes and systems in place to ensure it has the resources necessary to deliver CRS.
Section 6 - Foundation Trust conditions (FT)		
FT1: Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to NHSE.	See G1. The Trust is currently obliged to provide NHSE with any information it requires, including information to update its entry on the register of NHS foundation trusts and has processes in place to ensure it complies with such requirements
FT2: Payment to NHSE in respect of registration and related costs	The Trust would be required to pay any fees set by NHSE.	NHSE has undertaken not to levy any registration fees on foundation trusts without further consultation.
FT3: Provision of information to advisory panel	NHSE has established an independent advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel.	The independent advisory panel was established by Monitor in April 2013 and the Trust provided a briefing on the Panel to the Members' Council. This Panel has since been disbanded by NHSE.
FT4: NHS Foundation Trust governance arrangements	Gives NHSE continued oversight of the governance of foundation trusts.	The Trust has sound governance processes in place and reviews of these arrangements are a core part of the internal audit annual work programme. This has been evidenced in the outcome of the well-led reviews carried out by the CQC in both 2018 and 2019.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 12.2

Private/Public paper:	**Public**		
Title:	**Audit Committee Annual Report 2022/23 including updated Terms of Reference and 2023/24 workplans for Trust Board committees**		
Paper presented by:	**Mike Ford – Audit Committee Chair**		
Paper prepared by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Mission/values:	A strong and effective Board and committee structure enables the Trust to achieve its vision and goals and maintain a sustainable and viable organisation.		
Purpose:	The purpose of this paper is: • To provide assurance to Trust Board that its committees operate effectively and meet the requirements of their terms of reference. • Make suggested improvement to Board and sub-committee arrangements. • Support the Annual Governance Statement		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Audit Committee annual reported provides assurance to Trust Board that Committees are adhering to their terms of reference to demonstrate their effectiveness and integration. This allows Trust Board to ensure the organisations effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnership and Integrated Care Board.		
Any background papers / previously considered by:	Committee annual reports were considered at the following meetings: • Audit Committee 11 April 2023. • Clinical Governance & Clinical Safety Committee 14 March 2023 • Equality, Inclusion and Involvement Committee 14 March 2023 • Finance, Investment & Performance Committee 20 March 2023 • Mental Health Act Committee 7 March 2023 • People & Remuneration Committee 21 March 2023 • Collaborative Committee 4 April 2023 Annual reports from each committee were considered by the Audit Committee on 11 April 2023.		

Executive summary:	The Audit Committee is required under its terms of reference to review other risk Committees' effectiveness and integration to provide assurance to Trust Board that: • risk is effectively managed and mitigated within the organisation; • Committees are fulfilling their terms of reference; and • integration between Committees avoids duplication. The Committee agreed to combine this process with the production of the Annual Governance Statement (AGS). Trust Board committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their terms of reference. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met, and to address and mitigate risk. As part of this process, Trust Board committees are required to produce an annual report, an annual work programme, undertake an annual self-assessment, and review their terms of reference. The Audit Committee received an annual report, work programme, and updated Terms of Reference from each committee at its meeting on 11 April 2023. April. The reports were presented by each committee Chair and/or lead Director to provide assurance against their terms of reference, A summary is contained within the Audit Committee annual report to Trust Board. Updated committee Terms of Reference and workplans are provided for the final approval of Trust Board

Recommendation:	**Trust Board is asked to:**
	• **RECEIVE the annual report from the Audit Committee as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through:**
	  ○ **committees meeting the requirements of their Terms of Reference;**
	  ○ **committee work programmes are aligned to the risks and objectives of the organisation within the scope of their remit; and**
	  ○ **committees can demonstrate added value to the organisation.**
	• **APPROVE the update to the Terms of Reference for the:**
	  ○ **Audit Committee;**
	  ○ **Clinical Governance and Clinical Safety Committee;**
	  ○ **Equality, Inclusion and Involvement Committee;**
	  ○ **Finance, Investment & Performance Committee**
	  ○ **Mental Health Act Committee;**
	  ○ **People and Remuneration Committee;**
	  ○ **Collaborative Committee**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023

Audit Committee Annual Report 2022/23

1. Purpose of report

The purpose of the report is to provide a summary of the Audit Committee's activities during the financial year 2022/23, and to provide assurance and evidence to Trust Board of its effectiveness and impact through compliance with its Terms of Reference.

2. Terms of Reference and Audit Committee duties

The Audit Committee is a formal Committee of Trust Board, which provides the Board with assurance that the Trust is discharging its responsibilities in relation to the following.

- The establishment and maintenance of effective systems and processes that provide internal control within the organisation, particularly, review of all risk and control related disclosure statements, such as the Annual Governance Statement and value for money audit opinion.
- The effectiveness of the governance arrangements that cover evidence of achievement of corporate objectives and the adequacy of the assurance framework.
- The effectiveness of policies and processes to ensure compliance with regulatory frameworks, including Monitor's (referred to as NHS Improvement's) risk assessment framework.
- The effectiveness of systems of internal control for the management of risk including the risk strategy, risk management systems and the risk register.
- The effectiveness of policies and procedures to prevent and manage fraud and compliance with regulatory requirements monitored through the Counter Fraud and Security Management Service.
- Overview of the work of other Committees to provide Trust Board with assurance in relation to the overall effectiveness of governance arrangements through the committee structure.

Changes to Committee Terms of Reference

At its meeting on 11 April 2023, the Committee reviewed its Terms of Reference and were recommended for final formal approval by the Trust Board on 25 April 2023.

Reporting to Trust Board

Under its terms of reference, the Audit Committee is required to produce a brief annual report on its activities, which is presented formally to Trust Board. The Committee's minutes are presented to the Trust Board once ratified.

Membership

The Committee is made up of Non-Executive Directors and members from 1 April 2022 to 31 March 2023 were as follows.

Name/role	Attendance 2022/23
Mike Ford, Non-Executive Director - Committee chair	5/5
Mandy Rayner (formerly Griffin), Non-Executive Director	4/5
David Webster, Non-Executive Director	4/4

The Director of Finance and Resources attends as lead Director.

3. Review of Audit Committee activities

The Audit Committee's activities during the year have been cross referenced to its Terms of Reference.

3.1 Governance, risk management and internal control

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation.

	Progress
Review all risk and control related disclosures, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances.	As part of its consideration of the annual report, and accounts, the Committee received and recommended for approval the Chief Executive's Annual Governance Statement for 2021/22. The Committee also received the statement from external audit for those with responsibility for governance in relation to 2021/22 and the Head of Internal Audit opinion.
Review underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principle risks and the appropriateness of the disclosure statements (above), including the fitness for purpose of the assurance framework.	The Committee was presented with the external audit plan for 2022/23. Significant audit risks were outlined as follows. - Management override of controls - Validity of accruals - Deferral of lead provider income These were noted by the Committee and the Trust's annual report will specifically outline the management action to address these risks, explaining the mitigating action in place to address the risks or, where appropriate, an explanation as to why the Trust does not consider these to be risks, and explaining its tolerance of any residual risk. The Trust Board has agreed to conduct the full process to develop the Board Assurance Framework (BAF), which is presented quarterly to Trust Board. As such the fitness for purpose of the BAF is currently covered at Trust Board
Review policies and processes for ensuring compliance with relevant regulatory, legal or code of conduct requirements, including the Monitor risk assessment framework.	The Committee last reviewed and approved the Trust Standing Financial Instructions and Scheme of Delegation in January 2023. Any issues or breaches are updated at each Committee meeting. This was supported for approval by Trust Board. The Risk Management Governance Framework came to the Committee in April 2022 and was supported for approval to Trust Board. In July 2022 the Committee received the updated Risk

	Progress
	Management Procedure.
Review the systems for internal control, including the risk management strategy, risk management systems and the risk register.	Approval of the Trust's Risk Management Governance Framework is a matter reserved for Trust Board. As stated above this was approved in April 2022. The Committee receives a report at each meeting on the triangulation of risk, performance and governance, which provides assurance that all key strategic risks are captured by the risk management process, that risks are appropriately highlighted and managed through governance committees and operational meetings, and there is a clear link between risk management and identifying areas of poor performance by the cross-reference of performance reporting to the risk register. The Committee finds this report particularly helpful in supporting scrutiny of performance and risk through Trust Board. The corporate / organisational risk register is reviewed quarterly by Trust Board and risks aligned to the Committee are reviewed at each meeting.
Review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service.	See section 3.3.
Review the work of other Committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.	See section 4.2.
Review the arrangements that allow Trust staff to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.	Updates in relation to 'whistleblowing' arrangements and Freedom to Speak Up Guardians are provided to the People & Remuneration Committee.

3.2 Internal Audit

The Committee shall consider the appointment of the internal auditor (for approval by Trust Board) and ensure that there is an effective internal audit function, established by management, that meets Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chair, Chief Executive and Trust Board.

	Progress
Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.	Through a procurement framework and tender process, 360 Assurance were re-appointed as the Trust's internal auditor from 1 April 2022 for a period of 3 years with an option to extend to 5 years. Under the Public Sector Internal Audit Standards, all internal audit service providers are required to develop an internal audit charter, which is a formal document that defines the activities, purpose, authority and responsibilities of internal audit at the Trust. It also ensures the internal audit service provided to the Trust meets the requirements of both Professional Internal

	Progress
	Auditing Standards and 360 Assurance's own Internal Audit Manual.
Review and approval of the Internal Audit strategy and programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	The Internal Audit Annual Plan for 2022/23 was presented to and approved by the Committee in April 2022. This followed a period of engagement with the Chair of the Audit Committee and Director of Finance, Estates & Resources. The plan provides a risk-based analysis of the Trust's operations, utilising the Trust Board assurance framework, reflecting the Trust's corporate objectives, priorities and areas identified for improvement. Progress against the plan is reviewed at every meeting and this includes reports on the Trust's progress against actions identified to address recommendations made by internal audit. Regular meetings are held between the Head of Internal Audit and Director of Finance & Resources to monitor progress against the work plan.
Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2021/22. This provided significant assurance. The Audit Committee have reviewed and received interim reports regarding the development of the Head of Internal Audit Opinion for 2022/23. A further update is being provided at the Audit Committee meeting in April 2023. The Committee receives audit reports and audit findings in line with the audit plan. The recommendations are followed up to ensure actions are taken in line with the action plans agreed. At the time of writing this initial draft report for the 2022/23 programme, 7 internal audit reports to date have been completed and presented to the Committee. Of these, there were: - 5 'significant assurance' reports; - 1 'substantial' assurance report - 1 'limited assurance' report Completion of further reports is expected during the year-end process and this report will be updated to include those conclusions prior to presenting this report to the Trust Board. Management action has been agreed for all recommendations. These are reported to the Committee and, where appropriate, progressed by 360 Assurance. In the main, there are no significant outstanding actions.
Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation.	The ongoing adequacy of resources is assessed as part of the review of the internal audit plan and monitoring progress. No significant issues have been raised in-year.
An annual review of the effectiveness of internal	Performance is reported to the Committee through

	Progress
audit.	the internal audit progress report at each meeting and a summary included in the internal audit annual report. In previous years the Committee and other relevant staff have also completed an established internal audit questionnaire to obtain feedback on the performance of internal audit.

3.3 Counter Fraud

The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service. The Committee shall also review the work and findings of the Local Counter Fraud Specialist as set out in the NHS Counter Fraud Authority Standards for Providers and as required by the NHS Counter Fraud Authority.

	Progress
Consideration of the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal.	Through a procurement framework and tender process, 360 Assurance was appointed as the Trust's Local Counter Fraud Specialist from 1 April 2022. This has now been amalgamated into one provider and contract.
Review the proposed work plan of the Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures.	360 Assurance presented a programme of work to the Committee in April 2022, which was approved. The Committee receives a Counter Fraud update report at each meeting to identify progress and any significant issues for action.
Receive and review the annual report prepared by the Local Counter Fraud Specialist.	The Committee received a progress report from the Local Counter Fraud Specialist at each meeting during 2022/23
Receive update reports on any investigations that are being undertaken.	These are included in the progress reports to the Committee.
Have a responsibility to refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority	These would be included in the progress reports to the Committee as applicable.

3.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to their work.

	Progress
Consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit.	Following a re-procurement exercise during 2020, the Members' Council approved a proposal to re-appoint Deloitte as the Trust's external auditor from 1 October 2020 for an initial period of three years with the ability to extend to up to five years. Members of the Audit Committee and the Deputy Lead Governor for the Members' Council were involved in the tender process.
Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.	The Audit Committee is expected to receive and approve the Annual Audit Plan in April 2023. Progress against the plan is monitored, where appropriate, at each meeting. Regular updates are provided at each Committee.

	Progress
Discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.	The fee for Deloitte was approved as part of the re-appointment process in 2020. A formal audit plan was presented to and approved by the Committee in April 2023. This included an evaluation of risk, which is summarised under section 3.1 above.
Review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses.	The Audit Committee received and approved: - the statement for those with responsibility for governance in relation to 2021/22 accounts; - final reports and recommendations as scheduled in the annual plan.
Review of each individual provision of non-audit services by the External Auditor in respect of its effect on the appropriate balance between audit and non-audit services.	Deloitte has not been engaged to provide any non-audit services during 2022/23.

3.5 Financial reporting

	Progress
The Committee has responsibility for approving accounting policies.	The Committee considered and approved changes to accounting policies at its meeting in January 2023. These changes were supported by the Trust's external auditor. For 2022/23, changes are very minimal. Further guidance may be provided before the year-end, which will be communicated to the Audit Committee when available.
The Committee has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and charitable Funds, and the Quality Accounts/Report and to make a recommendation to the Chair, Chief Executive and Director of Finance on the signing of the accounts and associated documents prior to submission.	The Committee recommended to the Trust Board for approval the annual report and accounts for 2021/22 at its meeting in June 2022 prior to submission to NHS England (Monitor). As part of the consideration of the auditor's report, the Committee received and reviewed the Use of Resources Assessment for 2021/22. Revised arrangements were put in place for the Quality Account in 2021/22 and these were reviewed and recommended for approval by the Clinical Governance and Clinical Safety Committee. The Committee also recommended for approval the stand-alone annual report and accounts for charitable funds in July 2022 in draft form. The final accounts went to the Charitable Trustee Committee.
The Committee also ensures that the systems for, and content of, financial reporting to Trust Board are subject to review so as to be assured of the completeness and accuracy of the information provided.	The internal audit programme includes routine testing of the Trust's financial reporting systems; however, financial reporting and scrutiny remains with Trust Board and Finance, Investment and Performance Committee, including any review of the adequacy of reporting. The Committee also receives a detailed report on procurement activity at each meeting, which monitors non-pay spend and progress on tenders, the use of single tender waivers, and progress against the Procurement Strategy and associated cost improvement programme. The Committee is also required, on behalf of Trust Board, to approve the methodology for determining the Trust's reference cost

	Progress
	submission. This was considered in the July 2022 meeting.
The Committee also: - reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation; - examines circumstances associated with each occasion Standing Orders are waived; - reviews the schedules of losses and compensations on behalf of Trust Board.	The Committee last reviewed the Standing Financial Instructions in January 2023 and supported their approval by Trust Board. Changes to the Trust's Scheme of Delegation were also considered by the Committee in January 2023 and it supported their approval by the Trust Board. There were no occasions when Standing Orders were waived in 2022/23. The losses and special payments report is received by the Committee at each meeting.

4. Review of Audit Committee administrative arrangements

The Committee met the requirement for the number of meetings in the year and has been quorate at each meeting. Agendas were reviewed regularly by the Chair of the Committee and Director of Finance, Estates and Resources as part of the agenda setting process.

The requirement to send papers out five working days prior to the meeting has been met throughout the year.

5. Audit Committee self-assessment

In line with the Terms of Reference, the Audit Committee has an agreed self-assessment process. The proforma used is that recommended by the Audit Committee Handbook. The self-assessment has eight sections:

- Composition, establishment and duties;
- Compliance with the law and regulations governing the NHS;
- Internal control and risk management;
- Internal audit;
- External audit;
- Annual accounts;
- Administrative arrangements
- Other issues

The self-assessment survey was only completed by members of the Audit Committee. It was identified that while committee effectiveness surveys would be reviewed for 23/24 for other Board committees, the Audit Committee effectiveness survey should remain in place as it is aligned to the Audit Committee handbook.

The Terms of Reference were approved by the member of the Audit Committee and the lead director in Audit Committee on 10 January 2023. A small number of changes were made based on recommendations of the Aqua review, internal audit and the counter fraud specialist.

The Terms of Reference were amended to reflect a recent review conducted by "Aqua" as part of the Trusts preparation for a well led inspection by the Care Quality Commission (CQC). "Aqua" identified that the Audit Committee terms of reference should document that at least one non-executive member of the committee should have recent and relevant finance experience.

Feedback from the head of internal audit, in the Audit Committee meeting on 10 January 2023, asked for the terms of reference to be updated to align with the Healthcare Finance Management Association (HFMA) Audit Committee Handbook as below:

- The Chair of the Audit Committee is appointed by Trust Board and the Chair of the Committee cannot be the Chair of the Trust.
- The Audit Committee will meet with the External Auditor and Head of Internal Audit in private, on at least one occasion, per year.
- The External Auditor and Head of Internal Audit have the right of direct access to the Audit Committee Chair.

The Counter fraud specialist also asked for the following updates to be made:

- The Committee shall review the work and findings of the Local Counter Fraud Specialist as set out in the Government Functional Standard 013: Counter Fraud (Functional Standard)
- The Committee has a responsibility to refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority

Following approval by Audit Committee the terms of reference were then approved by Trust Board on 31 January 2023.

The work programme for 2022/23 has been updated and agreed by the Chair of the Committee and lead director.

6. Governance assurance

6.1 Review of committee effectiveness

Each Committee has Terms of Reference and is required to produce an annual report outlining achievements against objectives and compliance with Terms of Reference. The annual reports, work programmes and updated terms of reference were provided to the Audit Committee to provide assurance to Trust Board.

6.2 Audit Committee review of the effectiveness of Trust Board committees

In April 2010, the Audit Committee agreed an approach and process to fulfilling its role to provide oversight and assurance to Trust Board on the effectiveness of the other sub-committees of the Board.

The committees assumed within scope of the Audit Committee review are:

- Clinical Governance and Clinical Safety Committee;
- Equality, Inclusion and Involvement Committee
- Mental Health Act Committee;
- Workforce and Remuneration Committee
- Finance, Investment and Performance Committee

The draft annual report, annual work programme and the outcome of self-assessments for these committees will be provided to the Audit Committee on 11 April 2023 for 2022/23. The purpose of the review is for the Audit Committee to provide assurance to Trust Board that:

- each meets the requirements of its Terms of Reference;
- each work programme is aligned to the risks and objectives of the organisation, which are in the scope of its remit;
- each can demonstrate added value to the organisation.

The review was undertaken as part of formal Audit Committee business with committee chairs and lead directors invited to present to provide assurance to the Audit Committee on the assurance each committee has provided to Trust Board in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other committees.

Audit Committee

Chair – Mike Ford; Lead Director – Adrian Snarr – Director of Finance, Estates and Resources

Key areas highlighted for 2022/23 are:

- Review of all year-end reporting documents including accounting policies in advance of accounts preparation. enabling approval to be recommended to the Board and within required timescales.
- Review and comment on the Annual Governance Statement.
- In-depth review of issues where it has been felt there are specific areas of risk or concern including cyber security.
- Regular update and review of internal audit and counter fraud programmes of work, including updates on implementation of agreed actions
- Engagement with external audit to agree audit plan, review areas of risk and receive external audit reports. including updates on implementation of agreed actions
- Oversight of Board and Committee governance arrangements given the Trust response to Covid-19.
- Approved the internal audit and counter fraud plans for 2022/23.
- Regular review of organisational risks allocated to the Committee by the Trust Board.
- Review of Trust Standing financial instructions, with particular focus on the operation of provider collaboratives which have material levels of income for the trust.

Clinical Governance and Clinical Safety Committee

Chair – Nat McMillan; Lead Director – Darryl Thompson – Chief Nurse and Director of Quality and Professions

Key areas highlighted for 2022/23 are:

- Updates about the developing Quality Strategy have been received by the committee throughout the year, and the strategy itself was recommended for Board approval in March 2023.
- The Committee received updates throughout the year in relation to the changes to the Smoking Policy
- Updates around the progress of the Patient Safety Strategy have been received throughout the year.
- The Suicide Prevention Strategy 2022 – 2025 was approved by the committee in October 2022
- The Committee noted in January 2023 that the Review of Learning from Healthcare Deaths Policy has been extended to January 2024 by the Executive Management Team
- The Trust's new Quality Priorities were approved by the committee in April 2022
- The Committee approved the Quality Account for 2021/22 in May 2022
- The Committee received reports on waiting lists improvement plans for ADHD, Learning Disabilities, and Psychological Therapy in April 2022 and February 2023
- There is a standing item on the Committee agenda for each meeting for updates on topical, legal and regulatory risks, as part of the Chief Nurse Report.

- The Committee continued its review of the implementation of the Trust's priority programmes from a clinical and quality perspective during the year and receives a regular exception report as well as more detailed presentations as appropriate.
- The Committee also considers items from the Integrated Performance report, ensuring that progress is monitored in addressing our key strategic objectives.
- The Committee continued to receive 'alert, advise, assure' updates from its formal sub-groups covering Drugs and Therapeutics, Safety & Resilience, Safeguarding children and vulnerable adults, infection prevention and control, reducing restrictive physical interventions, improving clinical information group, clinical governance group, clinical ethics advisory group, physical health and QUIT, to ensure the Trust is discharging its statutory responsibilities and duties
- During the year, the Patient Safety Strategy Group continued to provide assurance, through the Chief Nurse / Direct of Quality & Professions and the Chief Medical Officer, to the Committee in relation to patient safety and learning lessons from incidents.
- The Committee received The Medical Education Strategy in February 2023.
- The Committee received the Annual Ligature Report in November 2022
- The Committee receives a report on progress to address issues raised by the CQC during any visits. This is now considered through the regular review within the Quality and Regulatory Oversight Report.
- The Committee received the NICE guidance annual report in May 2022 to provide assurance that the Trust is meeting these obligations.
- The Patient Safety Strategy Implementation Group Annual update was received in July 2022
- The Quality Monitoring Visits annual report was received in September 2022.
- Each committee now receives a Care Group Quality and Safety Report, informed by the current integrated performance report but reviewed through a governance, quality and safety lens. This is co-authored by the Chief Operations Officer, Chief Nurse / Director of Quality and Professions and Chief Medical Officer
- The Committee received quarterly serious incident reports, the 'Our Learning Journey' annual report for detailed scrutiny on behalf of Trust Board, and the reviewed the annual Incident Management and Learning from Healthcare Deaths Report in June 2022 prior to submission to Trust Board.
- During the year, the Committee received annual reports covering medicines management, reducing restrictive physical interventions, clinical audit and service effectiveness (CASE), emergency preparedness, resilience and response (EPRR), mandatory training, and whistleblowing (including freedom to speak up guardians).
- The Committee also received an update in relation to the independent review of the Mental Health Act (MHA) report.
- The Safeguarding Annual Report was reviewed by the committee in July 2022.
- The infection prevention and control annual report was reviewed by the committee in July 2022.
- The Committee received the annual ligature report in November 2022
- The Committee provided detailed scrutiny on behalf of Trust Board of quarterly serious incidents reports.
- It also reviewed the annual Incident Management and Learning from Healthcare Deaths Report Trust Board in June 2022, prior to submission to Trust Board.
- The committee received regular updates throughout the year with regards to patient experience and complaints. It also received the Patient Experience (including complaints) annual report in July 2022
- The Committee reviewed the annual Incident Management and Learning from Healthcare Deaths Report Trust Board in June 2022, prior to submission to Trust Board.
- The Committee received the clinical audit and practice effectiveness (CASE) annual plan in June 2022.

- The Committee received a report on apparent suicides in May 2022, and the 'Our Learning Journey' report in February 2023, that focuses on learning from incidents.
- The Committee receives the quarterly Patient Experience (previously Customer Services) report includes reporting on the Friends and Family Test (FFT) which is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience and this feedback should be used to improve services for service users. This information is also included in the Integrated Performance Report to Trust Board
- The Committee also received the Patient Experience (including complaints) annual report in July 2022.
- The Committee receives updates on CQC mental health in-patient surveys and community mental health surveys.

Equality, Inclusion and Involvement Committee

Chair – Marie Burnham; Lead Director – Salma Yasmeen – Director of Strategy and Change

Key areas highlighted for 2022/23 are:

The Committee received reports on the following:

- Equality and diversity annual report prior to Trust Board.
- Implementation of plan and Progress on peer support workers
- Delivery on carers agenda and accreditation
- Introduced a new Care Group report on equality and involvement received from the different care groups.
- Equality and Involvement exception and highlight report delivered majority of annual action plan with significant outcomes as set out in the report.
- Development of Equality Dashboard aligned to CORE20 PLUS 5 and captures data by deprivation index.
- Development of approach to addressing inequalities including deep dives and use of data to support service change.
- Embedding the Insight report and approach to capturing Service users public and partner voice
- The Committee monitored the Trust's progress against the equality standards including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES); and the Trusts progress against the Equality Delivery System 2 (EDS2).
- Received feedback from staff equality networks.
- Reviewed inclusive leadership and development programme updates.
- The Committee met all requirements set out in its terms of reference, including completing the annual self-assessment and report.
- In addition to the Committee members, meetings are regularly attended by representatives from the Trust's staff equality networks, staff side, Trust care groups equality forums, an elected governor, and staff from our equality and engagement team.
- Received first update on implementation of social responsibility and sustainability strategy and development of key priority areas.

Finance, Investment & Performance

Chair – David Webster; Lead Director – Adrian Snarr – Director of Finance, Performance and Estates

Key areas highlighted for 2022/23 are:

- Went through a lot of change in 2022/23, with 2x FDs and 2x lead chairs, nevertheless have regularly reviewed financial performance and will deliver strong financial performance.
- Received these report and forecasts timely, understanding what impacts financial and operational performance.
- Reordered the agenda and workplan fairly significantly to provide greater time for performance, and ensure meetings are focussed, so are not simply going through the motions.
- By the end of the year, have got into a good place with the agenda and everything is up to date with strong papers and focus on improvement.
- Received and reviewed any plans, investments and opportunities ahead of wider Board updates, enabling the committee to discuss prior to gaining formal approval.
- Reviewed the financials linked to provider collaborative.
- Reviewed capital expenditure.
- Reviewed the risks delegated by the Board.
- Received updates to new/key finance/performance projects, namely Patient Level costing and IPR redevelopment.
- Received benchmarking reports and investment updates including progress of delivering against these.

Mental Health Act Committee

Chair – Kate Quail*;* Lead Director – Dr Subha Thiyagesh – Chief Medical Officer

Key areas highlighted for 2022/23 are:

Standing Items for each Mental Health Act Committee meeting in 2022/23.

Committee reported on the following to provide assurance to Trust Board on Trust compliance with its regulations and Standing Orders:

Audit - The Committee oversees a programme of audit, carried out by the Mental Health Act (MHA) Administrators. Reports presented in 2022/23 included:

- Section 132 (patients' rights) – MHA Office Deep dive
- Advocacy services report
- Restricted High-Risk People in the Community
- Community Treatment Order annual summary report
- Consent to Treatment – record of assessment of capacity and of Responsible Clinician informing service user of Second Opinion Appointed Doctor outcomes; Recording of capacity to consent to treatment record.
- Section 17 leave review

The Committee receives and scrutinises quarterly monitoring information through the performance report at each meeting**;** receiving exception reports, including mandatory MHA and Mental Capacity Act (MCA) training compliance; Complaints, compliments and concerns.

MHA/ MCA Code of Practice Oversight Group provides feedback and assurance on key issues including seclusion and segregation and reducing restrictive practice.

Legal updates, including case law and 'horizon scanning' alert Committee to issues, publications or forthcoming legislation and the impact on and implications for the Trust. Any potential risks to the Trust are identified and a mitigation plan developed. During 2022/23 this included:

- CQC Monitoring the MHA annual reports -2020/21 and 2021/22

- (MCA)/ Liberty Protection Safeguards (LPS) code of practice and regulations consultation; and Gap analysis on Trust's readiness for new MCA/LPS.
- Mental Health Bill – briefings; and Gap analysis providing assurance the Trust is well prepared.

'The Act in Practice' - practical application of the MHA in the Trust - provides assurance of compliance with the MHA and Code of Practice. In 2022/23 this focused on BAME groups and inequalities related to accessing SWYPFT mental health services; and CAMHS service user journeys and legal frameworks.

Associate Hospital Managers (HMs) **–** provided ongoing scrutiny and perspectives on the Trust's use of the MHA. MHAC formally receives minutes from the HMs' Forum. The Forum Chair attends Committee and raises any issues arising from appeals and/or raised by the Forum. 4 HM Forum meetings this year, primarily for training. All HMs attended the required number of Hearings in the year. All HMs received an annual personal review with the MHAC Chair or other MHAC Non-Executive Director. Committee received an Annual Report on this process.

Consideration of organisational risk register and MHAC Risk Register **-** MHAC Risk Register to monitor any new risks relating to the implementation of and compliance with current mental health legislation and to monitor, review and update previous ones identified. No current risks identified on this.

Care Quality Commission Mental Health Act visit reports and action plans.

Quality Improvement (QI**)** MHAC remains strongly focused on improvement and the MHA Administrators and clinical staff continue to be successful in using QI approaches to improve service delivery and compliance, for example Cancellation of S17 Leave – compliance increased in Forensic services**,** from 38% in Q3 2021/22 to 87% in Q3 2022/23.

Service User Experience and Addressing Inequalities.

- MHAC initiated a 'Discovery Interview' pilot on the Forensic wards which provided an inclusive approach for patients to share their experiences of being detained under the MHA and staying on a Forensic ward. The findings reported to MHAC; some actions had already taken place as a result. It was agreed remaining findings be addressed by the Trust's existing improvement workstreams and processes with an update to MHAC in 2023.
- Committee focused on the experience of young people and families: 3 Act in Practice sessions on service users' journeys: use of legal frameworks; collaborative care planning; joint working between CAMHS and Adult Services to support a young person detained to an acute trust.
- MHAC commissioned a report – 'BAME Groups and inequalities related to accessing SWYPFT mental health services', which summarised differences in relation to prevalence, access and outcomes for service users from black and Asian & minority ethnic communities within SWYPFT compared with national benchmarking and published data.

People & Remuneration Committee

Chair – Mandy Rayner; Lead Director – Greg Moores – Chief People Officer

Key areas highlighted for 2022/23 are:

- The Committee received updates on the Clinical Excellence Awards Scheme and ratified payments in line with national guidance given at the time.
- The Committee agreed to a pay uplift for the Chief Operating Officer and the Director of Strategy in line with national benchmarking rates from 1 April 2022.
- The Committee agreed pay uplifts in line with the national uplift for the Director of Nursing (now Chief Nurse), Professions and Quality and Director of Provider Development from 1 April 2022
- The Committee agreed the pay rate for the Director of Finance, Resources and Estates.
- The Committee agreed the pay rate for the Chief People Officer.
- The Committee agreed an uplift for Consultants on local pay arrangements in line with the national uplifts for Doctors and Dentists
- The Committee oversaw the process for the appointments of the Chief People Officer in April 2022 and the Director of Finance, Resources and Estates in August 2022
- A report was received by the Committee from the Guardian of Safe Working in September 2022 and scheduled to be received in March 2023.
- The Committee received an FTSU update report in July 2022 and the annual FTSU Report is scheduled to be received in March 2023.
- The Committee received regular updates on the delivery plan to support the Workforce Strategy Making SWYPFT a Great Place to Work. A comprehensive set of performance indicators are reported on at every meeting.
- There has been major focus on the wellbeing of our staff during the last 12 months recognising the pressures they have been under. The Trust's wellbeing plan and initiatives, our support for the increase in the cost of living were received and supported by the Committee in January 2023.
- Mandatory training has been closely monitored and a deep dive into those areas that are below our targets was shared with a recovery plan received by the Committee in January 2023
- From November 2022 a new item was added to the agenda on Agency Usage, this will form part of the ongoing work plan.
- Risks from the corporate/organisational risk register aligned by the Trust Board to the Committee are reviewed as a standing item at each Committee meeting. There was a particular focus on the risk of industrial action from November 2022 and at every meeting since then.
- Risks from the corporate/organisational risk register aligned by the Trust Board to the Committee are reviewed as a standing item at each Committee meeting. This included a consolidation of risks around capacity and capability.

The Collaborative Committee

Chair – Mike Ford; Lead Director – Adrian Snarr – Director of Finance, Estates and Resources

Key areas highlighted for 2022/23 are:

- Ensured regular review of performance (finance, contracting, quality, commissioning) of the Specialised Provider Collaboratives for which the Trust is Coordinating Provider.
- Ensured oversight of the commissioning response to any significant quality concerns.
- Regularly reviewed the risks allocated to the Committee by Trust Board and kept under review any risks required to be escalated to Trust Risk Register.
- Received regular reports on the Yorkshire and Humber Phase 2 Provider Collaboratives.
- Reviewed due diligence for the Yorkshire and Humber Forensic CAMHS Provider Collaborative for which the Trust will be Co-ordinating Provider.

- Received reports on the Specialised Provider Collaboratives where the Trust is a partner- the West Yorkshire Children and Young People's Mental Health Provider Collaborative and Adult Eating Disorder Provider Collaborative.
- Received Commissioning Intentions for the Specialised Provider Collaboratives for which the Trust is Coordinating Provider.
- Received findings of external reports/investigations including learning from Edenfields. The Committee introduced a joint section of the Committee for West Yorkshire Provider Collaborative and South Yorkshire and Bassetlaw Provider Collaborative Colleagues to ensure learning in relation to quality monitoring and best practice was shared between the provider collaboratives.
- Ensured that as the Committee develops, best practice is shared between the provider collaboratives.
- Conducted regular reviews of the agenda and workplan to ensure the combined skills of both West Yorkshire and South Yorkshire attendees are used in the most effective way to provide assurance and insight to Committee members.
- Review of the Committee's Terms of Reference, particularly to ensure that the learning through the year on the balance of the agenda between executive assurance and detailed operational oversight is appropriately reflected in an updated Terms of Reference.

The Audit Committee will review the documents and presentation on the work of the committees and consider if it was sufficient to enable the Chair of the Audit Committee to support an assurance to Trust Board that the integrated governance arrangements in the Trust were operating effectively and that committees:

- had met the requirements of their Terms of Reference.
- had followed a workplan aligned to the risks and objectives of the organisation, within the scope of each committee's remit; and
- could demonstrate added value to the organisation.

6.3 Independent review of the Trust's governance arrangements

In 2014, Monitor (now known as NHS England) stated its expectation that all foundation trust boards would carry out an external review of their governance arrangements every three years.

Monitor issued guidance to support Trusts in ensuring they are 'well-led,' which supported the NHS response to the Francis Report and was aligned with the assessment the Care Quality Commission (CQC) makes on whether a foundation trust was well-led as part of its revised inspection regime.

In 2015/16, Deloitte undertook an independent review in line with the framework which included interviews and focus groups with Trust Board, key stakeholders, the Members' Council and staff. There were no 'material governance concerns' arising from the review, with a number of developmental areas recommended further work and an action plan developed.

In 2016, an internal audit review of the action implementation as part of an audit on corporate governance arrangements received 'significant assurance'.

In 2017, NHS Improvement aligned its well-led review to the CQC well-led key lines of enquiry.

In April 2018, the CQC undertook a well-led review of the Trust which with the well-led domain rated as 'GOOD'.

In 2018/19, an internal audit review of governance was conducted to provide independent assurance of the robustness and effectiveness of the governance arrangements in place at Trust Board committee level; and undertake a deep dive of the Clinical Governance and Clinical Safety Committee which received 'significant assurance'.

In June 2019, CQC undertook a further well-led review and was rated as 'GOOD'.

Given the impact of the Covid-19 pandemic the CQC has not undertaken any well led reviews during 2020/21, 2021/22 or 2022/23.

7. Conclusion

In summary, the Annual Report of the Audit Committee will be used as evidence the Committee has discharged its responsibilities in relation to its statutory obligations and Terms of Reference. This includes providing the Trust Board with assurance on the effectiveness of other committees which is part of the Audit Committee role in supporting integrated governance.

South West Yorkshire Partnership NHS Foundation Trust

AUDIT COMMITTEE
Terms of Reference
To be approved by Trust Board 25 April 2023

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Audit Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Audit Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Audit Committee's prime purpose is to keep an overview of the systems and processes that provide controls assurance and governance within the organisation as described in the Annual Governance Statement on behalf of Trust Board and that these systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring independent verification on systems for risk management and scrutiny of the management of finance. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
Taking guidance from Monitor (referred to as NHS England & Improvement) and the Department of Health into consideration, neither the Chair of the Trust or the Chief Executive attends this Committee unless invited to do so. The Chair of the Committee is appointed by Trust Board and the Chair of the Committee cannot be the Chair of the Trust.
The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors. At least one Non-Executive member of the Committee should have recent and relevant financial experience.

Membership as at 1 May 2022
Chair – Non-Executive Director – Mike Ford
Non-Executive Director - David Webster
Non-Executive Director - Mandy Rayner.

Attendance
The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Company Secretary also attends meetings. Representatives of internal and external audit

are also invited and expected to attend. The local counter fraud specialist is required to attend a minimum of two meetings a year.
The Chair of the Trust, the Chief Executive, other Directors, and relevant officers attend the Audit Committee by invitation. Administrative support is provided by the Personal Assistant to the Director of Finance and Resources.

Quorum

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

Frequency of meetings

The Committee will meet a minimum of four times per year to reflect best practice. The Audit Committee will meet with the External Auditor and Head of Internal Audit in private, on at least one occasion, per year. The Chair of the Committee, External Auditor or Head of Internal Audit may request a meeting if they consider one is necessary. The External Auditor and Head of Internal Audit have the right of direct access to the Audit Committee Chair.
There will also be an additional annual meeting to approve the annual report, accounts and Quality Accounts.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation, and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain external legal or other independent professional advice and to secure the attendance of external bodies or individuals with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Health and Safety - (moved across from Clinical Governance and Clinical Safety Committee wef 1st April 2022)

Duties

<u>Governance, risk management and internal control</u>
The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation. In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by Trust Board.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principal risks and the appropriateness of the above disclosure statements. This includes assessing the fitness for purpose of the assurance framework including risk appetite and providing assurance that action plans are in place to address significant control issues.
- The policies and processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements, including the NHS England & Improvement risk assessment framework.
- The systems for internal control including the risk management strategy, risk management systems and the risk register.
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service.
- The work of other committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.

In carrying out its work, the Committee will primarily utilise the work of Internal and External Audit; however, it will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. The Committee will use the Trust's Assurance Framework to guide its work and that of the audit and assurance functions reporting to it.

The Committee will also review arrangements that allow Trust staff (and other individuals where relevant) to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Committee will ensure that:

- Arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
- Ensure safeguards for those who raise concerns are in place and that these safeguards operate effectively.
- Such processes enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure valid concerns are promptly addressed.
- These processes reassure individuals raising concerns that they will be protected from potential negative repercussions.

<u>Internal Audit</u>

The Committee shall consider the appointment of the Internal Auditor (for approval by Trust Board) and ensure there is an effective internal audit function established by management that meets Public Sector Internal Audit Standards, that provides appropriate independent assurance to the Audit Committee, Chief Executive, Chair and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation or dismissal.
- Review and approval of the Internal Audit approach, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.

- Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between internal and external auditors to optimise audit resources.
- Ensure the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit.

External audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to its work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as NHS England & Improvement's rules permit.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses.
- Review of each individual provision of non-audit services by the External Auditor in respect of its effect on the appropriate balance between audit and non-audit services.

The Committee will also advise the Members' Council with regard to the appointment and removal of the Trust's external auditors and, to inform this advice, carry out a market testing exercise for the appointment of the external auditor at least every five years.

Counter fraud

The Committee shall review the work and findings of the Local Counter Fraud Specialist as set out in the Government Functional Standard 013: Counter Fraud (Functional Standard)and as required by the NHS Counter Fraud Authority. In particular:

- Consider the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal;
- Review the proposed work plan of the Trust's Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures;
- Receive and review the annual report prepared by the Local Counter Fraud Specialist;
- Receive update reports on any investigations that are being undertaken.
- Have a responsibility to refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority

Financial reporting

The Committee has responsibility for approving accounting policies. It also has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and for charitable funds, and the Quality Accounts/Report on its behalf and to make a recommendation to the Chair and Chief Executive on the signing of the accounts and associated documents prior to submission to NHS England & Improvement, Trust Board and the Members' Council.

In particular, the Committee shall focus on:

- Changes in, and compliance with, accounting policies and practices.
- Major judgemental areas.
- Significant adjustments arising from the annual audit.
- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee.
- Unadjusted misstatements in the financial statements.
- Letters of representations.
- Explanations of significance variances.

The Committee also ensures that the systems for, and content of, financial reporting to Trust Board, including those of and for budgetary control, are subject to review so as be assured of the completeness and accuracy of the information provided to Trust Board.

The Committee also:

- Reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation before these are laid before Trust Board;
- Examines the circumstances associated with each occasion Standing Orders are waived.
- Reviews schedules of losses and compensations on behalf of Trust Board.

Other Compliance

1. To provide assurance that the Trust has effective arrangements for the management of safety and emergency response including through the receipt of assurance reports provided by the Health and Safety TAG.

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include any reviews by the Department of Health and Social Care, arms-length bodies, or regulators/inspectors (e.g. Care Quality Commission and NHS Improvement, NHS Resolution, etc) professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Relationship with the Members' Council

To reflect best practice and NHS England & Improvement's Code of Governance, Trust Board will consult with the Members' Council annually on the Audit Committee's terms of reference. At the discretion of the Chair of the Committee and/or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance

through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Approved by Trust Board:
Next review due: April 2024

Audit Committee Work Programme for 2023/24			2023/24				
			11th	26th	11th	10th	9th
Standard Items	**Lead**	**Type**	April	June	July	October	January
Welcome & apologies for absence:	**Chair**	**Verbal**	X	X	X	X	X
Declaration of any conflict of interest.	**Chair**	**Verbal**	X	X	X	X	X
Minutes of the meeting held on xxxxx.	**Chair**	**Paper**	X	X	X	X	X
Matters arising & action log from the meeting held on the xxxx.	**Chair**	**Paper**	X	X	X	X	X
Actions delegated to FIP Committee from Trust Board.	**Chair**	**Paper**	X	X	X	X	X
Items to redact from public facing minutes due to being commercial in confidence	**Chair**	**Verbal**	X	X	X	X	X
Annual assurance update on progress against external audit actions	**RA**	**Verbal**	X				
(new IA request to be added to work programmes and agenda's)							
Corporate Governance							
Consideration of items from the Organisational Risk Register allocated to the Audit Committee	**JW**	**Paper**	X	X	X	X	X
Review of process to develop the assurance framework	**JW**	**Paper**					X
Triangulation of risk, performance and governance	**JW**	**Paper**	X	X	X	X	X
Risk management framework/procedure	**JW**	**Paper**	X		X		
Declaration of interest annual update	**JW**	**Paper**			X		
SFI and scheme of delegation update	**RA**	**Paper**	X	X	X		
Review other 'risk' committees' effectiveness and integration for annual report to Trust Board.							
· PRC (attached) - MR	**MR**	**Paper**	X				
· FIP (attached) - CJ	**CJ**	**Paper**	X				
· CGCS (attached) - NM	**NM**	**Paper**	X				
· MHA (attached) - KQ	**KQ**	**Paper**	X				
· EII (attached) - MB	**MB**	**Paper**	X				
Audit Committee annual report, effectiveness	**MF**	**Paper**	X				
Audit Committee ToR	**MF**	**Paper**	X				
Board Committee effectiveness surveys to be reviewed for 23-24		**Paper**					
Audit Committee work plan for 2023/24	**MF**	**Paper**	X	X	X	X	X
Year End Accounts and VFM							
Annual governance statement (AGS)	**AS**	**Paper**	X	X			
Annual account progress update	**RA**	**Paper**	X	X			X
FT ARM update	**RA**	**Paper**	X				X
Review of final draft accounting policies	**RA**	**Paper**	X				X
Review of accounts	**RA**	**Paper**		X			
External Audit							
External audit plan, risks and control measures - progress	**CJ**	**Paper**	X	X	X	X	X
Internal Control and Risk Management							
Procurement report ink waivers	**TC**	**Paper**	X		X	X	X
Losses and special payments	**RA**	**Paper**	X		X	X	X
Treasury management update	**RA**	**Paper**	X		X	X	X
Internal Audit and Counter Fraud							
Internal audit progress update including	**LR**	**Paper**		X	X	X	X
· draft head of internal audit opinion (HOIA) – stage 3 (attached)	**LR**	**Paper**	X	X			
· Internal audit plan for 23/24 – 360 Assurance	**LR**	**Paper**	X	X	X	X	X
· Shared full IA reports where limited opinions	**LR**	**Paper**	X	X	X	X	X
Internal Audit Annual report	**LR**	**Paper**		X			
Counter fraud progress report – 360 Assurance	**CC**	**Paper**		X	X	X	X
Counter Fraud - Annual return CFFR	**CC**	**Paper**		X			
Digital & Cyber							
Systems Development Update report	**PF**	**Paper**	X			X	
Cyber progress report	**PF**	**Paper**			X		X
Costing							
Update on national cost collections, deadlines and process	**RA**	**Paper**			X		
EPPR & H & S (New)							

EPPR Update (new)	**NP**	**Paper**			X		X
H & S Update (new)	**RW**	**Paper**			X		X
H & S (Annual Report) (new)	**RW**	**Paper**			X		
Other							
Policy updates (if any)	**Various**	**Paper**		X	X	X	X
Approval of Charitable funds annual report and accounts	**TBC**	**Paper**			X		
Non Exec meeting with internal & external audit	**Chair**	**Verbal**		X			
Other Ad hoc updates as needed (if any)	**Various**	**Paper**	X	X	X	X	X
Agreement of committee meeting dates for 2023/24.	**Chair**	**Verbal**	X	X	X	X	X
Any other business	**Chair**	**Verbal**	X	X	X	X	X
Meeting evaluation & confirmation of:							
a. Meeting effectiveness	**Chair**	**Verbal**	X	X	X	X	X
b. Significant issues to report to the Board of Directors. · Alert, advise, assure	**Chair**	**Verbal**	X	X	X	X	X
c. Changes in level of assurance	**Chair**	**Verbal**	X	X	X	X	X
d. Agreed actions	**Chair**	**Verbal**	X	X	X	X	X
Review committee timetable/work programme (attached)	**Chair**	**Paper**	X	X	X	X	X

NHS
South West Yorkshire Partnership
NHS Foundation Trust

CLINICAL GOVERNANCE AND CLINICAL SAFETY COMMITTEE
Terms of Reference
To be approved by Trust Board 25 April 2023

All Trust Board Committees are responsible for scrutinising and providing assurance to Trust Board on key issues allocated to them by the Board. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice. On behalf of the Trust Board, it will have an oversight of clinical risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Clinical Governance and Clinical Safety Committee is chaired by a Non-Executive Director. Two other Non-Executive Directors (NED) also sit on the Committee as well as relevant Directors of the Trust.

Membership as at 1 April 2023:
Chair - Non-Executive Director - Natalie McMillan
Non-Executive Director – Marie Burnham (Chair of the Trust)
Non-Executive Director - Kate Quail
Lead Director – Chief Nurse / Director of Quality & Professions – Darryl Thompson
Chief Medical Officer - Dr Subha Thiyagesh
Chief Operating Officer, Carol Harris

Attendance
The Deputy Director of Nursing, Quality & Professions is in attendance at each meeting. Clinical representatives and relevant Trust officers are invited to meetings as appropriate to ensure the remit of the Committee is adequately covered. The Chief Executive, other Directors, and relevant officers attend the Clinical Governance and Clinical Safety Committee by invitation. Administrative support is provided by the Personal Assistant to the Chief Nurse / Director of Quality and Professions.

Quorum

The quorum will be two Non-Executive Director members and the Lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of ten times per year.

It is the responsibility of the lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-groups including but not limited to:

- Drugs and Therapeutics (Medicines Management);
- Safeguarding (vulnerable adults and children);
- Infection Prevention and Control;
- Reducing Restrictive Physical Interventions group;
- Clinical Governance Group;
- Improving Clinical Information Group;
- Clinical Ethics Advisory Group and
- Improving Clinical Information Group.
- Physical Health
- QUIT

Duties

The Committee provides assurance to Trust Board on service quality, practice effectiveness and the application of controls assurance in relation to clinical services and ensures the Trust is discharging its responsibilities with regard to clinical governance and clinical safety.

<u>Strategy and policy</u>

1. To approve relevant strategies and policies on behalf of the Trust Board
2. To monitor implementation of strategic objectives relevant to clinical governance, care delivery and practice effectiveness, such as implementation of care management processes and clinical information management, providing assurance to Trust Board that these are appropriately managed and resourced.

Clinical governance

3. To provide assurance to Trust Board that appropriate and effective clinical governance arrangements are in place throughout the organisation through receipt of exception reports from relevant Directors to demonstrate that they have discharge their accountability for parts of their portfolios relating to clinical governance. This covers the areas of practice effectiveness, drugs and therapeutics, infection prevention and control, diversity, information governance and clinical documentation, managing violence and aggression, medical education, safeguarding children, research and development, compliance, and health and safety.
4. To provide assurance to Trust Board that the Trust is meeting national requirements for clinical governance and clinical safety.
5. To assure Trust Board that the Executive Management Team and Business Delivery Units have systems in place that encourage and foster greater awareness of clinical governance and clinical safety throughout the organisation, at all levels.

Compliance

6. To monitor, scrutinise and provide assurance to Trust Board on the Trust's compliance with national standards, including the Care Quality Commission, the quality elements relating to NHS Improvement (NHSI) and NICE guidance.
7. To provide assurance to the Trust Board that the Trust is compliant with relevant legislation.
8. To provide assurance that the Trust has effective arrangements for the prevention and control of infection, safeguarding adults and children, information governance and records management.

Clinical safety management

9. To provide assurance to the Trust Board that environmental risks, including those identified as a result of PLACE inspections or environmental audit, are addressed and monitor appropriate action plans to mitigate these risks.
10. To provide assurance to the Trust Board that robust arrangements are in place for the proactive management of complaints, adverse events and incidents, including scrutiny of quarterly and annual reports on incidents and complaints and implementation of action plans.
11. To provide assurance to Trust Board that there are robust systems for learning lessons from complaints, adverse events and incidents, and action is being taken to minimise the risk of occurrence of adverse events.
12. As delegated by Trust Board, to monitor implementation of action plans relating to reviews of complaints by the Health Service Ombudsman and of action plans identified through independent inquiry reports relating to the Trust.

Public and service user experience

13. To provide assurance that there are appropriate systems in place to enable the views and experiences of service users and carers, and clinicians to shape service delivery.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting wherever practical. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees. When a new Committee is formed it is incumbent upon all Committees to ensure that there are clear lines of accountability and that workplans / responsibilities are aligned and work is not duplicated. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

Reports being received as per the internet meetings governance framework

Ensure that the terms of reference template allows for the clear capture of information required by and reporting requirements into each committee

Next review due: April 2024

South West Yorkshire Partnership NHS Foundation Trust

Clinical Governance and Clinical Safety Committee
Annual Work Programme
2023 – 2024

Agenda Item	Author	April	May QA	June	July	Sept	Oct	Nov	Jan 24	Feb 24	Mar 24	Send to Board on
1. Standard Opening Items												
Welcome & Apologies		X	X	X	X	X	X	X	X	X	X	
Declarations of Interest		X	X	X	X	X	X	X	X	X	X	
Minutes of Previous meeting		X	X	X	X	X	X	X	X	X	X	
Action Log		X	X	X	X	X	X	X	X	X	X	
Committee Related Risks (alternate)		X		X		X		X		X		
Actions from Trust Board		X	X	X	X	X	X	X	X	X	X	
Staff/Team story		X	X	X	X	X	X	X	X	X	X	
2. Quality Improvement												
Chief Nurse Report		X	X	X	X	X	X	X	X	X	X	
Quality Accounts Production Update (standing item)		X		X		X		X		X		
Approval of Quality Accounts			X									**May TB**
Clinical Audit and Service Effectiveness (CASE) Annual Plan 2021 / 2022				X								
Quality Monitoring Arrangements		X			X		X		X			

Agenda Item	Author	April	May QA	June	July	Sept	Oct	Nov	Jan 24	Feb 24	Mar 24	Send to Board on
Quality Monitoring – Annual Report						X						
Consideration of external audit report on Trust Quality Accounts				X								Reflection or Board
Quality and Regulatory Oversight Paper	X	X	X	X	X	X	X	X	X	X	X	
Care Quality Commission in-patient and community surveys (Inpatient survey every 2 years)						X						
Patient Safety Strategy Update		X			X			X			X	
Patient Experience Update		X			X			X			X	
Waiting List Management Report		X			X			X			X	
Quality Strategy (*Sept 2022)*						X				X		Trust Board
3. Key Clinical Risks												
Care Group and Safety Report	CH	X	X	X	X	X	X	X	X	X	X	
4. Assurance												
Safer Staffing Report (6 monthly)		X						X				April and Nov
<u>Serious Incidents Quarterly Reports</u> Annual Report 21/22 (inc LeDer & Q4) 2022 Q4 (inc in annual report) 2022/2023 Q1 2022/2023 Q2 2022/2023 Q3				X		X		X		X		Q4 and annual for June Sept Nov March

Agenda Item	Author	April	May QA	June	July	Sept	Oct	Nov	Jan 24	Feb 24	Mar 24	Send to Board on
Committee Annual Report and Annual Governance Statement											X	For Audit Committee and Board
Internal Audit Reports (as appropriate)		X		X		X		X			X	
NICE Annual Report				X								
Patient Led Assessment of the Care Environment (PLACE) Report						X						
RRPI Annual Report					X							
Safeguarding Annual Report						X						
Patient Experience / Customer Services Report Annual Report				X								June annual report only
Customer Services Policy						X						To Board
Infection Prevention & Control Annual Report				X								
Drug & Therapeutics Annual Report					X							
Review of Healthcare Deaths Policy									X			To Board
Annual Nurse Revalidation Report										X		TB 2023
Annual Ligature Report								X				Nov
Medical Appraisal / Revalidation Report						X						Sept
Medical Education Report								X				Nov
Complex Case Incident Report **PRIVATE**		X	X	X	X	X	X	X	X	X	X	
Apparent Suicide Report			X									

Agenda Item	Author	April	May QA	June	July	Sept	Oct	Nov	Jan 24	Feb 24	Mar 24	Send to Board on
Learning Journey Report									X			
EPRR Policy ***(next due at Trust Board Nov 2024)***												
Sexual Safety Report					X						X	
IPC BAF											X	
Reports from Sub-Committees		X	X	X	X	X	X	X	X	X	X	
5. Standard Closing Items												
Serious Incident verbal update **PRIVATE**		X	X	X	X	X	X	X	X	X	X	
Issues and items to bring to the attention of Trust Board & other Committees		X	X	X	X	X	X	X	X	X	X	
Review of Committee related Risks and any Exception Reports as required		X	X	X	X	X	X	X	X	X	X	
Work Programme		X	X	X	X	X	X	X	X	X	X	

Strategies and Policies due to CGCS

Name	Date	Notes
Suicide Prevention Strategy	October 2025	
R&D Strategy	November 2025	

Customer Services Policy	March 2026	

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EQUALITY, INCLUSION AND INVOLVEMENT COMMITTEE
Terms of Reference
To be approved by Trust Board 25 April 2023

The Committee is a Committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by the Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Equality, Inclusion Involvement Committee's prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through involvement and promoting the values of inclusivity and treating people with respect and dignity. The Committee will develop and oversee a strategy, including an approach to positive action, to improve access, experience and outcomes for people from all backgrounds and communities, including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities. On behalf of the Trust Board, it will have oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Equality, Inclusion and Involvement Committee is chaired by a Non-Executive Director. At least one other Non-Executive Director also sits on the Forum as well as relevant Directors of the Trust.

Membership as at 1 July 2022
Chair – Chair of the Trust – Marie Burnham
Non-Executive Director – Erfana Mahmood
Non-Executive Director – Mike Ford
Chief Executive – Mark Brooks
Salma Yasmeen – Director of Strategy (Lead Director)
Chief People Officer – Greg Moores

Attendance
Technical support is provided by the Trust Marketing, Communication, Engagement and Inclusion Lead who is a regular attendee at Committee meetings. A Governor (appointed by the Members' Council), the staff side representative with lead for equality and diversity, a representative from each of the staff equality networks (when required), and a representative for each BDU equality forum, is also invited to attend meetings. Other directors and relevant officers attend the Committee by invitation. Administrative support is provided by the Personal Assistant to the Lead Director.

Quorum
The quorum will be half of the membership which must include one Non-Executive Director

and one Director; however, members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of four times per year and be reviewed every twelve months.

Duties

- To promote the values of inclusivity, mainstreaming equality, diversity, involvement and inclusion across the Trust.
- To monitor, scrutinise and provide assurance to Trust Board that the Trust has a co-ordinated approach to promoting the values of inclusivity developed in partnership with other key stakeholders including service users, carers, staff and Members' Council.
- To monitor and provide assurance to Trust Board that the Trust is embedding diversity and inclusion and involvement in all its activities and functions.
- To provide assurance to Trust Board that the Trust is advancing equality of opportunity and fostering good relations with all communities that its serves
- To monitor, scrutinise and provide assurance to Trust Board that the Trust is compliant with legal and national guidance, including Equality Delivery System (EDS2), the Workforce Race Equality Standard (WRES), and the Workforce Disability Equality Standard (WDES).
- To agree an annual work plan that links to the Trust's strategic direction, workforce plan and the wider priority programmes and to monitor progress.
- To monitor implementation of strategic objectives relevant to sustainability, providing assurance to Trust Board that these are appropriately managed and resourced.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the approved minutes of Committee at the next Trust Board meeting following the Committee meeting at which they are approved. The Committee will also report to the Board annually on its work (see above).

All Trust Board committees have a responsibility to ensure they foster and maintain relationships and links between the Forums / Committees and Trust Board. Each committee also has a responsibility to ensure actions identified and agreed are placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Trust Board will receive bi-annual updates from the Committee about the management and resourcing of strategic objectives relevant to sustainability.

Reporting requirements into the Committee

The Equality Inclusion and Involvement Committee received regular performance reports on Equality Standards, Equality Delivery System and Equality Impact Assessments., plus feedback from staff networks and development programmes.

The Committee receives the annual reports on equality and diversity, Workforce Disability Equality Standard and Workforce Race Equality Standard before submission to Trust Board.

The Committee will receive an annual Equality Inclusion and involvement report

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Next review: April 2024

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Equality, Inclusion & Involvement Committee
Annual Work Programme
2023-2024

Agenda item/issue	Jun	Sept	Dec	Mar
Section 1 - Standing items				
Declarations of Interest	X	X	X	X
Minutes of previous meeting and action log	X	X	X	X
Actions from Trust Board	X	X	X	X
Consideration of items from the corporate/organisational risk register allocated to the Committee	X	X	X	X
Context report – national, regional & local	X	X	X	X
Section 2- Insight, feedback and programme updates				
Insight report (twice yearly)		X		X
Staff network report	X	X	X	X
Care group highlight report (previously called BDU report)	X	X	X	X
Patient/public story/campaign (film)	X	X	X	X
Sustainability reporting (twice yearly)	X		X	
Section 3 – Strategy & Policy				
Equality, inclusion & involvement annual action plans				X
Overview of equality inclusion & involvement policies as appropriate (review every 3 years)				X
Section 4- Performance Reports				
Performance dashboard	X	X	X	X
Equality & involvement action plan highlight report • Staff survey • Inclusive leadership and development programme	X	X	X X X	X
Equality Standard update (WRES & WDES)	X	X	X	X
Equality Delivery System 2 (EDS2) update		X		X
Internal audit reports as appropriate	X	X	X	X
Section 5 - Annual items				

Equality, involvement, communication and membership Annual Report for Trust Board (deferred to December)		~~X~~	X	
Workforce Disability Equality Standard (WDES) for Trust Board		X		
Workforce Race Equality Standard (WRES) for Trust Board		X		
Commitment to carers report			X	
Committee strategy session		X	X	
Section 6 Governance				
Committee annual report				X
Revised Committee membership & ToR as necessary				X
Annual review of Committee effectiveness				X
Section 7 – Standard Closing Items				
Agreement of Committee meeting dates and work programme for following year			X	
Items to bring to the attention of Trust Board	X	X	X	X
Review of risks	X	X	X	X
Work programme	X	X	X	X

South West Yorkshire Partnership NHS Foundation Trust

FINANCE, INVESTMENT & PERFORMANCE COMMITTEE
Terms of Reference
To be approved by Trust Board 25 April 2023

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Finance, Investment & Performance Committee was established in 2019. The Terms of Reference of the Committee will be reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Finance, Investment & Performance Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Finance, Investment & Performance Committee's prime purpose is to provide oversight and challenge of the Trust's financial performance and financial plans to ensure the Trust and the services it provides remain financially sustainable. It will also review capital plans with particular focus on the scrutiny of major investments, including post evaluation reviews. The committee will also review the overall performance metrics of the Trust to identify key trends and issues. This may result in direction being given to other committees of the Board to carry out more detailed review and determine where corrective action needs to be taken. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors and three executive Directors. At least one Non-Executive member of the Committee should have recent and relevant financial experience.

Membership as at 21 November 2022
Chair – Non-Executive Director – David Webster
Non-Executive Director – Natalie McMillan
Non-Executive Director – Kate Quail
Chief Executive – Mark Brooks (to 7 August 2022)
Director of Finance and Resources – Adrian Snarr (lead director from 8 August 2022)
Chief Operating Officer – Carol Harris

Attendees as at 21 November 2022
Director of Nursing, Quality and Professions – Darryl Thompson
Chief People Officer – Greg Moores
Deputy Director of Finance – Robert Adamson
Deputy Director of Corporate Governance – Julie Williams

Attendance

The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Chair of the Trust, other Directors, and relevant officers attend the Finance, Investment and Performance Committee by invitation. The Director of Nursing, Quality and Professions will be asked to attend Committee when there are such items on the agenda that would warrant his attendance e.g. when discussing cost improvement projects or other measures to underpin our financial position. Administrative support is provided by the Personal Assistant to the Lead Director.

Quorum

The quorum will be two Non-Executive Director members and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

At its meeting on 21 November 2022, the Committee reviewed its Terms of Reference. Given its relative infancy as a formal committee no changes were recommended to the Terms of Reference. This was endorsed by the Trust Board on 29 November 2022. As part of this review, the frequency of meetings has been updated from being monthly to 8 meetings per year.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Duties

<u>Finance</u>

The Committee will focus on the following in respect of the financial affairs of the Trust:

- Oversee and evaluate financial strategy;
- Seek assurance on delivery of financial and operational targets (through the integrated performance report);
- Consider forecasts for financial and operational information;
- Assess risks and seek assurance on mitigating action;
- Review proposed annual financial plan;
- Review proposed three and five year financial plans;
- Seek assurance on delivery of the cost improvement programmes (CIPs);
- Oversee delivery of the financial sustainability plan;
- Review Trust's service line financial reporting; and
- Consider the Trust's performance using benchmarking information including that included in the model hospital.

<u>Investment</u>

The Committee will focus on the following in respect of Trust investments:

- Approve business cases as required by Trust Standard Financial Instructions (SFIs) and oversee the post implementation review process for these; and
- Review the annual, three year and five year capital plans for the Trust.

Performance
The Committee will focus on the following in respect of Trust performance:

- Review areas of performance through deep dives into areas of focus and concern related to the integrated performance report. This will include reviewing issues and risks for corrective action.
- Provide information to other Trust committees on these key trends and issues which may require corrective action to be taken; and
- Receive and review NHS benchmarking reports.

In carrying out its work, the Committee will primarily utilise internal expertise. Where required it will seek reports and assurances from Directors and managers concentrating on the delivery of financial plans, investment criteria and over-arching Trust performance.

Relationship with the Members' Council

At the discretion of the Chair of the Committee and/or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Next review due: April 2024

FIP Workplan 2023/24			April	June	July	September	October	November	January	March
Standard Items	Lead	Type								
Welcome & Apologies for absence	Chair	Verbal	X	X	X	X	X	X	X	X
Declarations of Interest	Chair	Verbal	X	X	X	X	X	X	X	X
Minutes of meetings	Chair	Paper	X	X	X	X	X	X	X	X
Matters arising & action log	Chair	Paper	X	X	X	X	X	X	X	X
Actions delegated to FIP from Trust Board	Chair	Paper	X	X	X	X	X	X	X	X
Finance										
Monthly Finance Report*	FD	Paper	X	X	X	X	X	X	X	X
West & South Yorkshire Collaborative Financial Updates	FD	Paper	X	X	X	X	X	X	X	X
Forecast Update	FD	Paper		X	X	X	X	X	X	X
Financial Sustainability	FD	Paper		X		X		X		X
Non-Recurrent expenditure update & tracker	FD	Paper			X				X	
Costing Update	FD	Paper		X		X		X		X
Annual Plan	FD	Paper	X						X	X
Investment										
Bids & Tenders	FD	Paper	X		X		X		X	
MHIS Investment Progress Report	FD	Paper	X		X		X		X	
Capital Focussed Progress Report	FD	Paper	X		X		X		X	
Investment Requests	TBC	Paper				Ad-hoc				
Performance										
Monthly Performance Review	TBC	Paper	X	X	X	X	X	X	X	X
Risk Register	FD	Paper	X	X	X	X	X	X	X	X
Financial Benchmarking	FD	Paper		X		X		X		X
Performance Benchmarking	COO	Paper		X		X		X		X
Other										
Horizon Scanning	FD	Paper				Ad-hoc				
AOB	Chair	Verbal	X	X	X	X	X	X	X	X
Next Meeting Date	Chair	Verbal	X	X	X	X	X	X	X	X
Meeting Evaluation & confirmation of										
Effectiveness	Chair	Verbal	X	X	X	X	X	X	X	X
Alert, Advise, Assure - Items to report to Board	Chair	Verbal	X	X	X	X	X	X	X	X
Changes in level of assurance	Chair	Verbal	X	X	X	X	X	X	X	X
Agreed Actions	Chair	Verbal	X	X	X	X	X	X	X	X
Review Workplan	Chair	Paper	X	X	X	X	X	X	X	X
Items to redact from public facing minutes due to being commercial in confidence	Chair	Verbal	X	X	X	X	X	X	X	X

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South West Yorkshire Partnership
NHS Foundation Trust

MENTAL HEALTH ACT COMMITTEE
Terms of Reference
To be approved by Trust Board 25 April 2023

All Trust Board Committees are responsible for scrutiny and providing assurance to Trust Board on key issues allocated to them by the Board. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. It is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Mental Health Act Committee is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as 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. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Mental Health Act Committee is chaired by a Non-Executive Director. Two other Non-Executive Directors also sit on the Committee as well as relevant Directors of the Trust.

Membership as at 31 March 2023
Chair – Non-Executive Director - Kate Quail
Non-Executive Director – Erfana Mahmood
Non-Executive Director – Mandy Rayner (Griffin)
Lead Director – Chief Medical Officer - Dr Subha Thiyagesh
Chief Nurse and Director of Quality & Professions – Darryl Thompson

Attendance
One Independent Associate Hospital Manager (the Chair of the Hospital Managers' Forum), is invited to attend each meeting. The Director of Services (Adults and Older Peoples Mental Health), the Assistant Director of Legal Services; and Clinical Legislation Manager are in attendance at meetings. The Committee also has scope to invite other external individuals on an ad-hoc basis where it is felt expertise or specialist advice is required.

The Chief Executive, other Directors, and relevant officers attend the Mental Health Act Committee by invitation. Administrative support is provided by the Personal Assistant to the Chief Medical Officer.

Quorum

The quorum will be two Non-Executive Director members and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of four times per year to reflect availability of quarterly reports.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees and reporting requirements into the Committee

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-groups including but not limited to:

- Associate Hospital Managers' Forum
- MHA/MCA Code of Practice Oversight Group – workstreams include: 136 MHA Policy; Leave implementation group; Seclusion and Segregation and Reducing Restrictive Practice; and Section 132/132a and 131 patients' rights

The Committee receives regular reports on risk and assurance including statistical information on the use of the MHA 1983 and MCA 2005 in the form of the quarterly performance report.

Duties

1. To monitor the Trust's implementation of, and compliance with, current mental health legislation and proposed changes to such legislation, in particular the Mental Health Act 1983 and the Mental Capacity Act 2005, within the Trust taking into account best practice.
2. To consider the implication of any changes to legislation and regulations within a local context.
3. To receive reports from Associate 'Hospital Managers' in their role of hearing appeals and to scrutinise the processes for and outcome of appeals and tribunals.
4. To ensure there is an appropriate number of Hospital Managers in place with the appropriate skills and experience to fulfil their role.
5. To monitor trends in the application of the Mental Health Act 1983 (and any new Mental Health Acts or revisions to the existing Act) within the Trust and make recommendations where necessary.

6. To receive reports following Care Quality Commission (CQC) Mental Health Act visits for information and comment and to ensure appropriate action is agreed and implemented within the organisation.
7. To scrutinise delivery against the Trust's action plan developed as a result of the Care Quality Commission's Annual Report as instructed by Trust Board.
8. To receive Trust policies relating to the Mental Health Act and Mental Capacity Act which have been approved by the Executive Management Team.
9. To receive policies reviewed/updated by the Trust's Policy Group.
10. To scrutinise the application of these policies throughout the Trust.
11. To address training issues in terms of delegation of responsibilities under the Mental Health Act 1983.
12. To address quality issues in terms of delegation of responsibilities under the Mental Health Act 1983.
13. To manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation.
14. To request specific reports relevant to the application of the Mental Health Act.
15. To undertake duties relevant to the Committee set out in the 'Duties of Hospital Managers' Policy.
16. To provide assurance that there are appropriate systems in place to enable the views and experiences of service users, carers and clinicians to shape service delivery in relation to the Mental Health Act 1983 and the Mental Capacity Act 2005.
17. To consider, in all its functions, the experience and views of service users, carers and families, with a particular focus on those from vulnerable groups, Black Asian and Minority Ethnic communities and all those who have protected characteristics.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting at which the minutes are ratified, wherever practical.
The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal working groups.

Next review due: April 2024

South West Yorkshire Partnership NHS Foundation Trust

Mental Health Act Committee annual work programme 2023-24

Agenda item/issue	May 2023	Aug 2023	Nov 2023	March 2024
1. Standard opening Items				
Introductions, Apologies, Notice, Quorum, Declaration of interests	X	X	X	X
Actions delegated from Trust Board	X	X	X	X
2. Quality Improvement				
The Act in practice	X	X	X	X
CQC State of Care Report	X			
CQC Improvement plan – (when received)				
CQC monitoring the MHA report 2020/21	X			
Updates from Independent Hospital Managers	X	X	X	X
Service user engagement/experience	X	X	X	X
3. Key Clinical Risks				
Update on topical, legal and regulatory risks & Horizon Scanning	X	X	X	X
Focus on the clinical impact /risks relating to the use of the Mental Health Act/Mental Capacity Act/Deprivation of Liberty	X	X	X	X
Consideration of items from organisational risk register relevant to MHA Committee and any Exception Reports as required	X	X	X	X
4. Compliance and Assurance				
Quarterly Monitoring information – Mental Health Act statistics	X	X	X	X
Independent Hospital Managers' - Forum notes	X	X	X	X
Compliments, complaints and concerns in relation to the Mental Health Act	X	X	X	X
Noting the policies relating to the Mental Health Act and Mental Capacity Act agreed by Executive Management Team	X	X	X	X
MHA/MCA Code of Practice Oversight Group feedback	X	X	X	X
MHA/MCA/DoLs mandatory training update	X	X	X	X
Audit and compliance reports	X	X	X	X
Care Quality Commission MHA visit reports & outstanding action/progress reports	X	X	X	X
Cancellation of escorted S17 leave	X	X	X	X

Agenda item/issue	May 2023	Aug 2023	Nov 2023	March 2024
Medication compliance with T2 & T3	X	X	X	X
Medication compliance with treatment form	X	X	X	X
5. Standard Closing items				
Issues and items to bring to the attention of Trust Board & other Committees	X	X	X	X
Committee Work Programme	X	X	X	X
Annual items – Audits/ reviews				
Contemporaneous record of capacity to consent to treatment - review				X
RC responsibility to provide Second opinion reasons to service user - review				X
Section 132 (patients' rights) – MHA Office Deep dive		X		
Advocacy services report (Independent Mental Capacity Advocate / Independent Mental Health Act Advocate / general advocacy)		X		
Community Treatment Order review			X	
Annual review of Hospital Managers' arrangements			X	
Section 17 leave review				X
Mental Health Act Committee annual report to Trust Board				X

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PEOPLE AND REMUNERATION COMMITTEE
Terms of Reference
To be approved by Trust Board on 25 April 2023

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The People and Remuneration Committee (formerly known as Workforce and Remuneration Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role and revised membership.

The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose

The People and 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 as appropriate that actively contribute to the achievement of the Trust's aims and objectives.

The Committee also has delegated authority to approve any termination payments for the Chief Executive and Executive Directors. Additionally, the Committee is responsible for ratifying Clinical Excellence Awards for Consultant Medical Staff.

The Committee also supports and monitors the Great Place to Work Strategy and considers issues and risks relating to the broader People strategy.

On behalf of Trust Board, it reviews in detail key workforce performance issues, and takes ownership of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, and giving assurance to the Board around the management of such risks.

The Committee will support the development of an organisational culture where staff feel free, safe and able to raise concerns at work without fear of suffering a detriment. This includes supporting the lead Freedom to Speak Up Guardian to actively encourage and promote the Trust's commitment to the principles of Freedom to Speak Up which ensures the safety and welfare of Staff, Service Users, Carers and Visitors.

In August 2022 a decision was taken to separate the people and remuneration aspects of the Committee and the terms of reference were amended to reflect this new structure.

Membership, attendance and duties for each part of the Committee are stipulated below.

The Committee will deal with people matters at all meetings. Should any remuneration matters arise, through update or as part of an annual process they will be added to the agenda. Remuneration must be discussed by the Committee at least once a year to approve the remuneration report as part of the Annual report and accounts.

Membership

Membership of the Committee is comprised of the Chair of the Trust, two Non-Executive Directors and the Chief Executive.

Membership for People and Remuneration items as at 17 January 2023
Chair – Non-Executive Director – Mandy Rayner
Non-Executive Director – Marie Burnham (Chair of the Trust);
Non-Executive Director – Nat McMillan;
Chief Executive (non-voting Committee member) – Mark Brooks.

Attendance

People items

The Chief People Officer is in attendance at meetings as lead Director and provides advice and support to the Committee. The Chief Operating Officer is also in attendance. Administrative support is provided by the Personal Assistant to the Chief People Officer. Also in attendance, at the request of the Committee will be members of the People Directorate, Senior Leadership team and the Deputy Director of Corporate Governance.

Remuneration items

The Chief Executive is a non-voting member of the Committee and will take no part in or be present for any items relating to his/her own personal remuneration or conditions of service. The Chief People Officer is in attendance at meetings as lead Director and provides advice and support to the Committee. Administrative support is provided by the Personal Assistant to the Chief People Officer.

Quorum

People and Remuneration

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of the Chief Executive, the Chair of the Committee will decide whether it is appropriate for the Deputy Chief Executive to attend as a non-voting member.

Frequency of meetings

People

The Committee will meet no less than four times per year to discuss people matters.

Remuneration

The Committee will meet no less than once a year to discuss remuneration matters.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

People and Remuneration

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent

professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

People

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees including but not limited to:

- Clinical Excellence Awards Panel.

Remuneration

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Duties

People

1. To approve recommendations of the Clinical Excellence Awards Panel for Clinical Excellence Awards to Consultant Medical Staff.
2. To support the strategic development of human resources and workforce development and consider issues and risks relating to the broader workforce strategy.
3. On behalf of Trust Board, to monitor progress of the Workforce Strategy and review in detail key workforce performance issues.
4. To have oversight of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.
5. To consider future national developments which could impact on the Trust's strategic workforce objectives.
6. To have oversight of the Trust's approach to Freedom to Speak Up including receiving at least 2 reports every year, one of which should be the annual report, from the lead Freedom to Speak Up Guardian.
7. On behalf of the Trust Board, to monitor progress of the Freedom to Speak Up Strategy and action plan and review in detail relevant performance indicators.
8. To listen to staff experience and stories at each meeting.
9. To receive regular reports from the Guardian of Safe Working.
10. To receive regular reports and updates from the Agency Scrutiny Group.

Remuneration

1. To develop and determine appropriate pay and reward packages for the Chief Executive, Executive Directors and other designated senior managers and other locally determined pay arrangements that actively contribute to the achievement of the Trust's aims and objectives, are affordable and are in line with the Trust's financial strategy. Specifically to:

   a) determine the remuneration arrangements for Executive Directors and to agree individual salary levels for Executive Directors;
   b) to determine any annual uplift, for example, cost of living, for the Chief Executive and Executive Directors;
   c) to ratify remuneration arrangements for senior management posts;
   d) to approve any annual uplifts in pay structures and any performance-related pay arrangements for senior posts;
   e) to approve any termination payments to the Chief Executive and Executive Directors and ensure these are properly calculated and reasonable with regard to probity and value for money;
   f) to receive a report from the Chief Executive of any proposed termination payments to be made to senior managers.

2. Under delegated authority from Trust Board as deemed appropriate for each circumstance, to agree and oversee the process for the appointment of the Chief Executive and Executive Directors of the Trust.
3. To receive an annual report from the Chief Executive documenting the performance of executive directors in relation to the achievement of the Trusts Strategic Objectives.

Monitoring

People and Remuneration

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

People and Remuneration

Trust Board will receive the minutes of the Committee at the next Trust Board meeting following the Committee meeting. Confidential personnel matters will go to the private session of Trust Board, if appropriate, and the decisions of the Committee in relation to specific salary matters are reported to the Non-Executive Directors of the Trust only. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

Next review: April 2024

NHS
South West Yorkshire Partnership
NHS Foundation Trust

People and Remuneration Committee annual work programme 2023-24

Agenda item/issue	Mar	May	Jul	Sept	Nov	Jan
Integrated Workforce Performance Report	X	X	X	X	X	X
Great Place to Work Strategy – Annual Review and Objective Setting						
Great Place to Work Strategy – Report on Delivery Plan	X	X	X	X	X	X
Strategic workforce risks	X	X	X	X	X	X
Horizon Scanning	X	X	X	X	X	X
Staff Stories	X	X	X	X	X	X
Annual Review of Executive Directors' performance and objective setting			X			
Workforce Plan	X			X		
Flexible Workforce- including Bank and Agency	X				X	
Review of Executive Directors' Pay				X		
Consultants' Clinical Excellence Awards				X		
Gender Ethnicity and Disability Pay Gap Audits and Action Plan	X					X
Annual Report including Committee Effectiveness Review			X			
Review of Terms of Reference			X			
WRES Report and Action Plan				X		
WDES Report and Action Plan				X		
Staff Survey Results and Action Plan		X			X	
Wellbeing Annual Review			X			
Freedom to Speak Up Reports (6 monthly update)						X
Annual Review of Temporary Staffing (including off payroll appointments, agency, locum, bank, etc)			X			
Annual Review of Recruitment and Retention		X				
Freedom to Speak Up Annual Review		X				

Agenda item/issue	Mar	May	Jul	Sept	Nov	Jan
Mandatory Training Annual Report				X		
Guardian of Safe Working Report	X	X		X	X	
Appointment of Executive Directors	X	X	X	X	X	X
Directors' Remuneration	X	X	X	X	X	X
Remuneration arrangements for senior management posts outside of Agenda for Change	X	X	X	X	X	X
Approval of senior managers' redundancy / termination pay	X	X	X	X	X	X
Reporting of any redundancy payments	X	X	X	X	X	X
Update on Employment Tribunals	X	X	X	X	X	X
Workforce Internal Audit Reports	X	X	X	X	X	X
Actions from Trust Board	X	X	X	X	X	X
Chief People Officer remarks / updates	X	X	X	X	X	X
FTSU steering group update	X	X	X	X	X	X
Agency Scrutiny Group	X	X	X	X	X	X

South West Yorkshire Partnership NHS Foundation Trust

COLLABORATIVE COMMITTEE
Terms of Reference
For approval by Trust Board 25 April 2023

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Collaborative Committee was established in May 2023. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Committee is subject to an Effectiveness Review every 12 months.

The Collaborative Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

Purpose

The Collaborative Committee's purpose is to ensure delineation between provision and commissioning responsibilities (finance, contracting, planning and quality assurance) of the West Yorkshire Adult Secure Provider Collaborative, South Yorkshire Adult Secure Provider Collaborative and other specialised mental health provider collaboratives as appropriate where SWYPFT is the Co-ordinating Provider, and to seek assurance that the Trust's commissioning responsibilities as Co-ordinating Provider are being fulfilled.

The Collaborative Committee will seek assurance on behalf of Trust Board that contractual monitoring, financial, quality and performance management of the Provider Collaboratives are being undertaking and ensure information taken to Trust Board is sound, valid and complete. On behalf of the Trust Board, the Committee will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Day to day provision of patient care will continue to be the responsibility of Providers within the relevant collaborative.

This approach will ensure delineation between the provider and commissioning functions of the Provider Collaborative.

The Committee will also seek assurance of the financial and operational performance of wider specialised mental health provider collaboratives where SWYPFT is a partner.

Membership

Taking guidance from Monitor (referred to as NHS England) and the Department of Health into consideration, neither the Chair of the Trust or the Chief Executive attends this Committee unless invited to do so. The Committee is always chaired by a Non-Executive

Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors.

Membership of the Committee is as follows:

Chair – Non-Executive Director – Mike Ford
Non-Executive Director- Chair of Finance, Investment and Performance Committee- David Webster
Non-Executive Director- Erfana Mahmood

Attendance

Representatives are also invited and expected to attend as follows.

- Executive Lead Director for Commissioning (Director of Finance and Resources)
- Chief Medical Officer
- Assistant Director of Corporate Governance, Performance and Risk
- Head of Commissioning (West Yorkshire Specialised Provider Collaborative Commissioning Hub)
- Provider Collaboratives Director (SYB Mental Health Provider Collaborative Commissioning Hub)
- Associate Director Provider Collaboratives and Planning
- Clinical Lead (West Yorkshire Adult Secure Provider Collaborative)
- Clinical Director (SYB Mental Health Provider Collaborative Commissioning Hub)
- Quality and Governance Lead (West Yorkshire Commissioning Hub)

The Chair of the Trust, the Chief Executive, other Directors, and relevant officers attend the Collaborative Committee by invitation. Administrative support is provided by Corporate Governance admin support team.

Quorum

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

Frequency of meetings

The Committee will meet a minimum of bi-monthly. The Chair of the Committee may request an additional meeting if they consider one is necessary.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference. The Committee work programme will be agreed at the beginning of each year and the commissioning risks facing the organisation, and agreed with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain external legal or other independent professional advice and to secure the attendance of external bodies or individuals with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

The Collaborative Committee will receive minutes and/or reports from the following groups and any other relevant groups as considered appropriate:

- West Yorkshire Adult Secure Provider Collaborative Board.
- South Yorkshire and Bassetlaw Adult Secure Provider Collaborative Oversight Group.
- West Yorkshire Specialised Mental Health Learning Disability and Autism Programme Board.
- South Yorkshire and Bassetlaw Provider Collaborative Partnership Board.

Duties

Financial assurance

The Committee shall receive updates on the financial performance of the Provider Collaboratives and seek assurance that effective financial governance systems and processes are in place. In particular, the Committee will:

- Maintain oversight of the financial position of the Provider Collaboratives, for which SWYPFT is the Co-ordinating Provider.
- Seek assurance from the Provider Collaboratives for which SWYPFT is the Co-ordinating Provider of the robustness of the risk assessments underpinning financial forecasts.
- Provide onward assurance to the SWYPFT Board that financial planning is effectively established and managed, and that risks to delivery of plans and any significant service impacts or risks are effectively managed or mitigated.
- Following review and recommendation from the relevant Provider Collaborative Oversight Group (e.g. WY Adult Secure Provider Collaborative Board and SYB Provider Collaborative Oversight Group), ratification of business cases (for both new service proposal and reduction of service delivery and investments and/or disinvestments).
- Seek assurance of in year performance against commissioned services and financial plans and examine the effectiveness of any remedial action plans.
- Seek assurance on the delivery of agreed improvement programmes to reduce cost and increase efficiency including assurance on benefits realisation and value for money.
- Seek assurance of the financial position of Specialised Provider Collaborative where SWYPFT is a partner.

The Committee will ensure that the systems for, and content of, financial reporting to Trust Board, are subject to review so as be assured of the completeness and accuracy of the information provided to Board.

Contracting

The Collaborative Committee will:

- Seek assurance that for Provider Collaboratives where SWYPFT is Co-ordinating Provider contracts are negotiated in line with standard procedures, and implemented enabling the Provider Collaborative to deliver its aims.
- Agree formal Commissioning Intentions.

Risk Management

The Collaborative Committee will:

- Receive Provider Collaborative risk registers, where SWYPFT is Co-ordinating Provider.
- Discuss and review any issue likely to require inclusion on, or modification to the risk register.
- Escalate risks to Trust Board where required.

Oversight of quality assurance and improvement

The Collaborative Committee will:

- Seek assurance from the relevant Provider Collaborative oversight group (e.g. WY Adult Secure Provider Collaborative Board and SYB Provider Collaborative Oversight Group) that the Provider Collaboratives have robust processes in place to monitor performance, including out of area placements.
- Seek assurance from the relevant Provider Collaborative oversight group that robust processes are in place to monitor the quality of provision of provider collaborative partners, and provider onward assurance to Trust Board.
- Seek assurance from the relevant Provider Collaborative oversight group that there are governance arrangements in place to manage quality concerns including those identified as a result of case manager reviews, incidents, or external review inspections are addressed and monitored, and appropriate action plans are in place to mitigate these risks, and provide onward assurance to Trust Board.
- Seek assurance that that there are robust systems for learning lessons from complaints, adverse events and incidents, and action is being taken to minimise the risk of occurrence of adverse events.
- To provide assurance to Trust Board that there are robust systems for learning lessons from complaints, adverse events and incidents, and action is being taken to minimise the risk of occurrence of adverse events.

Other Assurance Functions

The Collaborative Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the Provider Collaborative.

These will include any reviews by the Department of Health and Social Care, arms-length bodies, or regulators/inspectors (e.g. Care Quality Commission and NHS Improvement, NHS Resolution, etc) professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

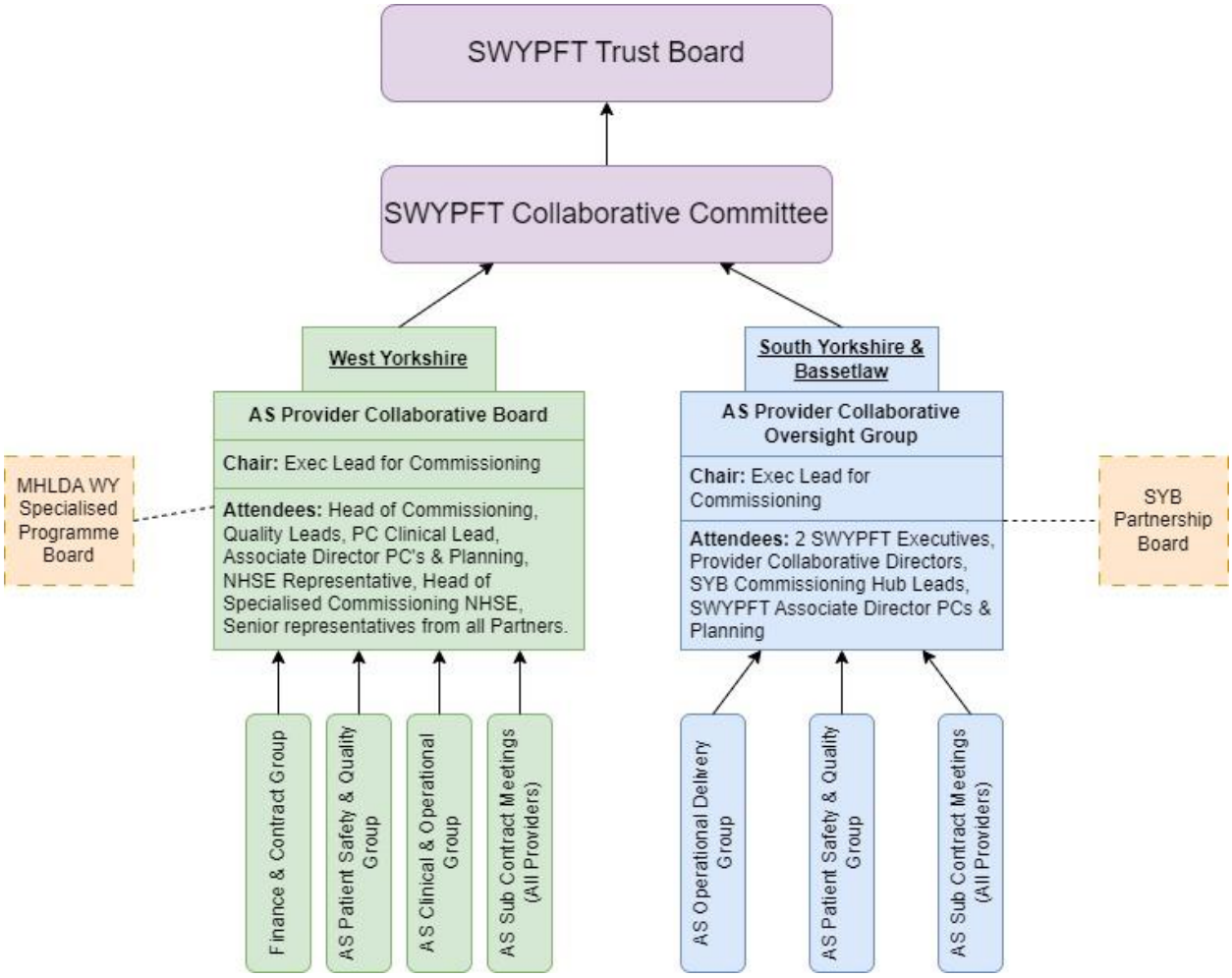
Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. Minutes will only being available to Private Board due to commercial sensitivity. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Next review due: April 2024

Appendix 1: Phase 1 Provider Collaborative Governance



South West Yorkshire Partnership NHS Foundation Trust

Collaborative Committee
Annual Work Programme
2023-24

Agenda item/issue	April	June	Aug	Oct	Dec	Feb
Section 1 - Standing items						
Declarations of Interest	X	X	X	X	X	X
Minutes of previous meeting and action log	X	X	X	X	X	X
Actions from Trust Board	X	X	X	X	X	X
Consideration of items from the corporate/organisational risk register allocated to the Committee	X	X	X	X	X	X
Section 2- West Yorkshire Adult Secure Provider Collaborative						
Minutes of West Yorkshire Adult Secure Provider Collaborative Board	X	X	X	X	X	X
Minutes of West Yorkshire Mental Health, Learning Disability and Autism Programme Board	X	X	X	X	X	X
Finance report (including Investment Fund)	X	X	X	X	X	X
Commissioning update	X	X	X	X	X	X
2023/24 Commissioning intentions					X	
Quality update report	X	X	X	X	X	X
Contracting update report	X	X	X	X	X	X
Phase 2 Provider Collaboratives including Forensic CAMHS	X	X	X	X	X	X
Update on West Yorkshire Provider Collaboratives where the Trust is a partner (Adult Eating Disorders and CYPMHS)		X		X		X
Section 3 – South Yorkshire and Bassetlaw Adult Secure Provider Collaborative						

Minutes of Provider Collaborative Oversight Group	X	X	X	X	X	X
Minutes of South Yorkshire and Bassetlaw Adult Secure Provider Collaborative Board	X	X	X	X	X	X
South Yorkshire and Bassetlaw Assurance Report (including finance and activity, commissioning, quality, contracting and risks)	X	X	X	X	X	X
2023/24 Commissioning intentions					X	
Finance report	X	X	X	X	X	X
Section 4 - Annual items						
Collaborative Committee Annual Report for Trust Board						X
Committee strategy session						X
Section 5- Governance						
Committee annual report						X
Revised Committee membership & ToR as necessary						X
Annual review of Committee effectiveness						X
Section 6 – Standard Closing Items						
Agreement of Committee meeting dates and work programme for following year						X
Items to bring to the attention of Trust Board	X	X	X	X	X	X
Review of risks	X	X	X	X	X	X
Work programme	X	X	X	X	X	X

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 12.3

Private/Public paper:	**Public**		
Title:	**Going Concern Basis**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	**Rob Adamson – Deputy Director of Finance**		
Mission/values:	Use of resources		
Purpose:	To enable the Board to make a decision that the 2022/23 accounts and financial statements are prepared on a going concern basis.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 3.1 - Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	By confirming the 2022/23 accounts and financial statements are prepared on a going concern basis the Trust Board ensures the organisations effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnership and Integrated Care Board, and place-based partnerships.		
Any background papers / previously considered by:	Regular finance report provided at each Board meeting. Detailed finance and planning reports provided at the monthly Finance, Investment & Performance Committee.		
Executive summary:	• International Accounting Standard (IAS) 1 - Presentation of financial statements – Part of IAS 1 sets out one of the minimum requirements for concepts as “going concern”. It requires organisations to disclose issues that would affect longevity, if any, and also set out their confidence with resources being able to sustain the business for the foreseeable future. • There is a requirement for the directors of an organisation to confirm whether or not it is appropriate for the accounts of that organisation to be prepared on a “going concern” basis. • The auditors of the Trust are required to evaluate the management’s adoption of the going concern basis and their assessment of any material uncertainties that may require disclosure.		

	• In 2020, the Public Audit Forum updated and simplified guidance on assessing going concern in its publication 'Practice note 10'. It was determined that 'Practice Note 10' applied to the NHS. This means that the anticipated continued provision of service is a sufficient basis for going concern. • This remains supported in the updated NHS foundation trust annual reporting manual (FT ARM) and the HM Treasury Financial Reporting Manual (FReM). • The impact of this change is that the usual financial assurance will not be included in this paper. Instead, the focus will be on the evidence of an annual plan. • Despite continued changes to the NHS financial regime, the Trust has developed plans for the next financial year, in collaboration with relevant NHS partners. It is therefore expecting to continue to provide services for the foreseeable future. • A separate paper has been provided on the financial plan for 2023/24 and Board members have had the opportunity to engage with the submission of the plan and ratify it. The final financial plan for 2023/24 is for a break-even position, which looks achievable based on the assumptions made and recent financial performance.
Recommendation:	**Trust Board is asked to APPROVE the preparation of the 2022/23 annual accounts and financial statements on a going concern basis by adopting the following statement:** ***'After making enquires, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.'***

South West Yorkshire Partnership NHS Foundation Trust

Going Concern Basis

Introduction

There is a requirement for the directors of an organisation to confirm whether it is appropriate for the accounts of an organisation to be prepared on a "going concern" basis. The auditors of the Trust are expected to evaluate the management's adoption of the going concern basis and their assessment of any material uncertainties that may require disclosure.

In 2021/22 The Public Audit Forum updated and simplified guidance on assessing going concern.

"The Public Audit Forum issues guidance to auditors on how auditing standards should be applied in the public sector. Its publication 'Practice Note 10'1 was revised in late 2020. This updated guidance to auditors, approved by the Financial Reporting Council, explains that where the applicable financial reporting framework provides that the anticipated continued provision of services is a sufficient basis for going concern, then this should determine the extent of the auditor's procedures on going concern.

This remains the case in the NHS, with the DHSC Group Accounting Manual (GAM) and NHS foundation trust annual reporting manual (FT ARM) both based on the HM Treasury Financial Reporting Manual (FReM) where this definition applies."

The NHS foundation trust annual reporting manual still reflects this change. The main point is captured in the quote below.

"An NHS foundation trust's assessment of whether the going concern basis is appropriate for its accounts should therefore only be based on whether it is anticipated that the service it provides will continue to be provided with the same assets in the public sector. This is expected to be the case for NHS foundation trusts unless exceptional circumstances indicate otherwise."

The (FT ARM) goes on to clarify that

"Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept."

For the reasons given above, the Trust no longer has to provide evidence regarding financial sustainability, as has been the case in previous years. This is covered in in risk disclosures and other performance reports. The section below, will instead, focus on the organisation's planning process.

The Trust has submitted a breakeven financial plan for 2023 / 24 as approved by Trust Board in March 2023 and shared with West Yorkshire Integrated Care Board.

This plan is based on the assumption that services provided by the Trust will continue for at least the next twelve months. This meets the condition, outlined above, that the organisation is expected to deliver services for the foreseeable future.

Directors should consider all available information about the future when concluding whether the company is a going concern at the date, they approve the financial statements. Their review

should usually cover a period of at least twelve months from the date of approval of annual and half-yearly financial statements.

Directors should make balanced, proportionate and clear disclosures about going concern for the financial statements to give a true and fair view.

Directors should disclose if the period that they have reviewed is less than twelve months from the date of approval of annual and half-yearly financial statements and explain their justification for limiting their review.

It should be noted that as per section 2.1*3* of the foundation trust annual reporting manual there is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

Section 2.14 of the annual reporting manual does state 'The anticipated continuation of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern.''

Recommendation

Given the above it is considered appropriate the Trust continues to report on a going concern basis. It is therefore recommended the Trust Board approves the following statement for inclusion in the 2022/23 annual report:

'***'After making enquires, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.'***

[1] https://www.public-audit-forum.org.uk with link to Practice Note 10 document at bottom of page

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 13.1

Private/Public paper:	**Public**		
Title:	**Strategic Objectives and Proposed Priorities 2023/24**		
Paper presented by:	Salma Yasmeen, Director of Strategy/Deputy Chief Executive		
Paper prepared by:	Salma Yasmeen, Director of Strategy/Deputy Chief Executive Sue Barton, Deputy Director of Strategy and Change		
Mission/values:	The proposals are in line with the Trust's values.		
Purpose:	• Set out the process which has been undertaken to develop the proposed priorities for 2023/24 and how this fits within the agreed Trust strategy and frameworks.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	1.1; 1.4; 2.2; 3.1; 3.3; 3.4; 4.1; 4.2; 4.3		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The paper sets out the process for developing the proposed priorities for 2023/24 which considers a full analysis of business and associated risks and a review of the Trust's role in local place-based integrated care partnerships. This analysis ensures that the priority areas of focus during 2023/24 will ensure effective, efficient and quality of care.		
Any background papers / previously considered by:	Strategic Objectives and Proposed Priorities 2022/23 presented to Trust Board in March 2022. Strategic overview of business and associated risks presented to Board in February 2023. Strategic Objectives and Proposed Priorities 2023/24 presented to private Trust Board in March 2023.		
Executive summary:	The **purpose** of this paper is to: • Set out the process which has been undertaken to develop the proposed priorities for 2023/24 and how this fits within the agreed Trust strategy and frameworks. • Reaffirm the rationale for describing an area of work as a priority. • Present the proposed priority areas, aligned to the four strategic objectives, for agreement by Trust Board.		

	• Describe the approach that we will take to enable successful delivery in line with the Trust's values. • Identify the next steps to develop this work. The priority areas are not discrete and separate pieces of work. They are interrelated and some are enablers for others. There are several priority areas which are golden threads which run through many of the other pieces of work. The Quality Priorities for 2023/24 relate directly to the Strategic Priorities. Each priority has an identified Senior Responsible Officer (SRO) and designated Priority Work areas. **Next steps** for this work include agreement of the detailed scope, articulation of the governance system, clarification of the expected outcomes and detailed work on metrics, measurement and reporting.
Recommendation:	**Trust Board is asked to AGREE the proposed priorities and areas of focus for 2023/24.**

Trust Board 25 April 2023
Strategic Objectives and Proposed Priorities 2023/24
Agenda item 13

1. Purpose

The purpose of this paper is to:

- Set out the process which has been undertaken to develop the proposed priorities for 2023/24 and how this fits within the agreed Trust strategy and frameworks.
- Reaffirm the rationale for describing an area of work as a priority.
- Present the proposed priority areas, aligned to the four strategic objectives, for agreement by Trust Board.
- Describe the approach that we will take to enable successful delivery in line with the Trust's values.
- Identify the next steps to develop this work.

2. Process undertaken to develop proposed priorities

2.1 Process

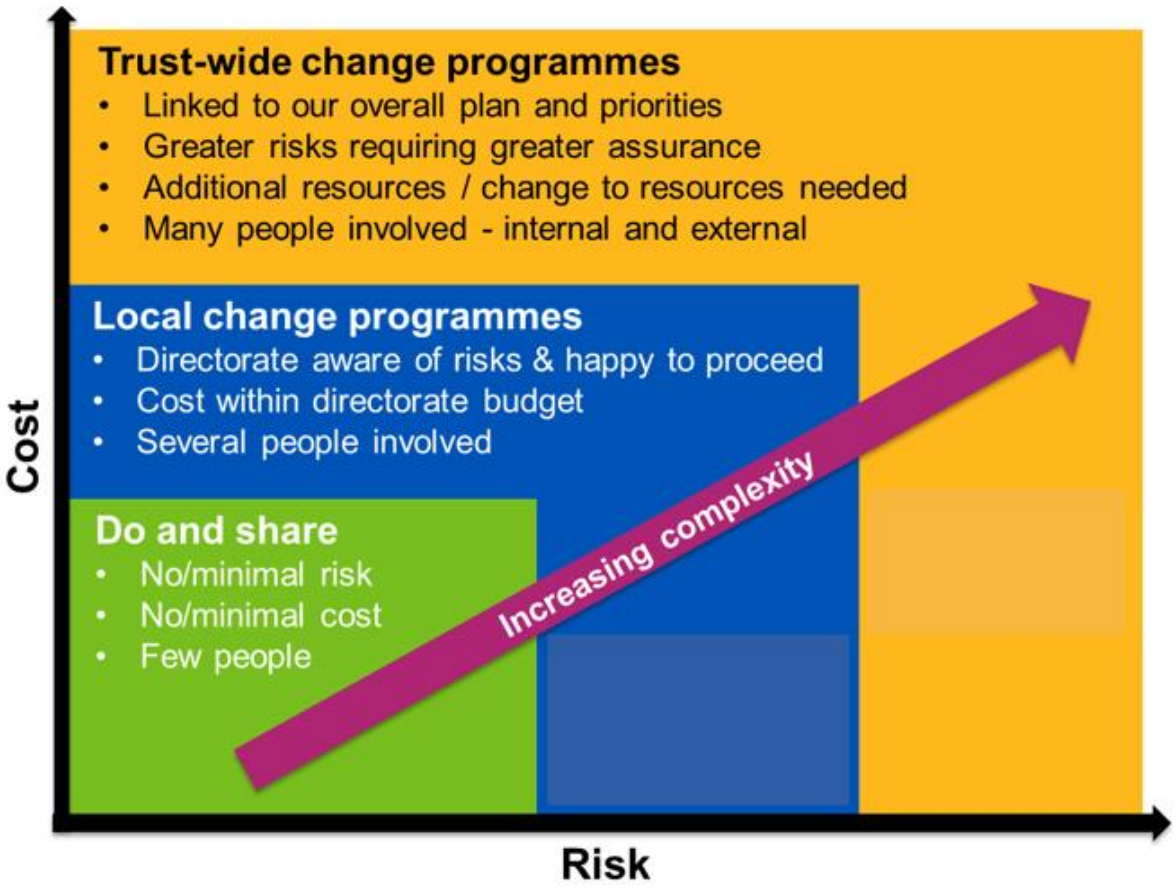
A comprehensive process has been undertaken to identify the proposed priorities for 2023/24 and to set these out as aligned programmes of work. This has included:

- Consideration of the Trust's mission, vision, values, objectives and ambitions.
- A review of the priorities for 22/23 to consider whether they are likely to continue.
- A full analysis of business and associated risks including a PESTLE and SWOT analysis. This was presented in a separate paper to the Board in February 2023 (the strategic overview of business and associated risks) and includes cross-referencing to the Organisational Risk Register and Board Assurance Framework.
- A review of the Trust's role in local place-based integrated care partnerships in Barnsley, Wakefield, Calderdale and Kirklees and South & West Yorkshire.
- Consideration of the operational planning guidance for 2023/24 and our annual plan development.
- Reference to the integrated change framework principles of risk/cost/complexity to assign work to different levels and clarify those which are the top-level priorities.
- Consideration of the relationships and alignment of the different areas of work and the best way of articulating these.
- Presentations and discussions with the Executive Management Team (EMT) on the proposals at various points during this process.
- Presentation of the proposed priorities to the private section of the Trust Board on 28 March 2023.

2.2 What is a priority?

Our agreed integrated change framework (see figure one below) sets out the three different levels of change that happen within the Trust.

Figure one Integrated Change Framework



So, our top-level priorities are the ones:

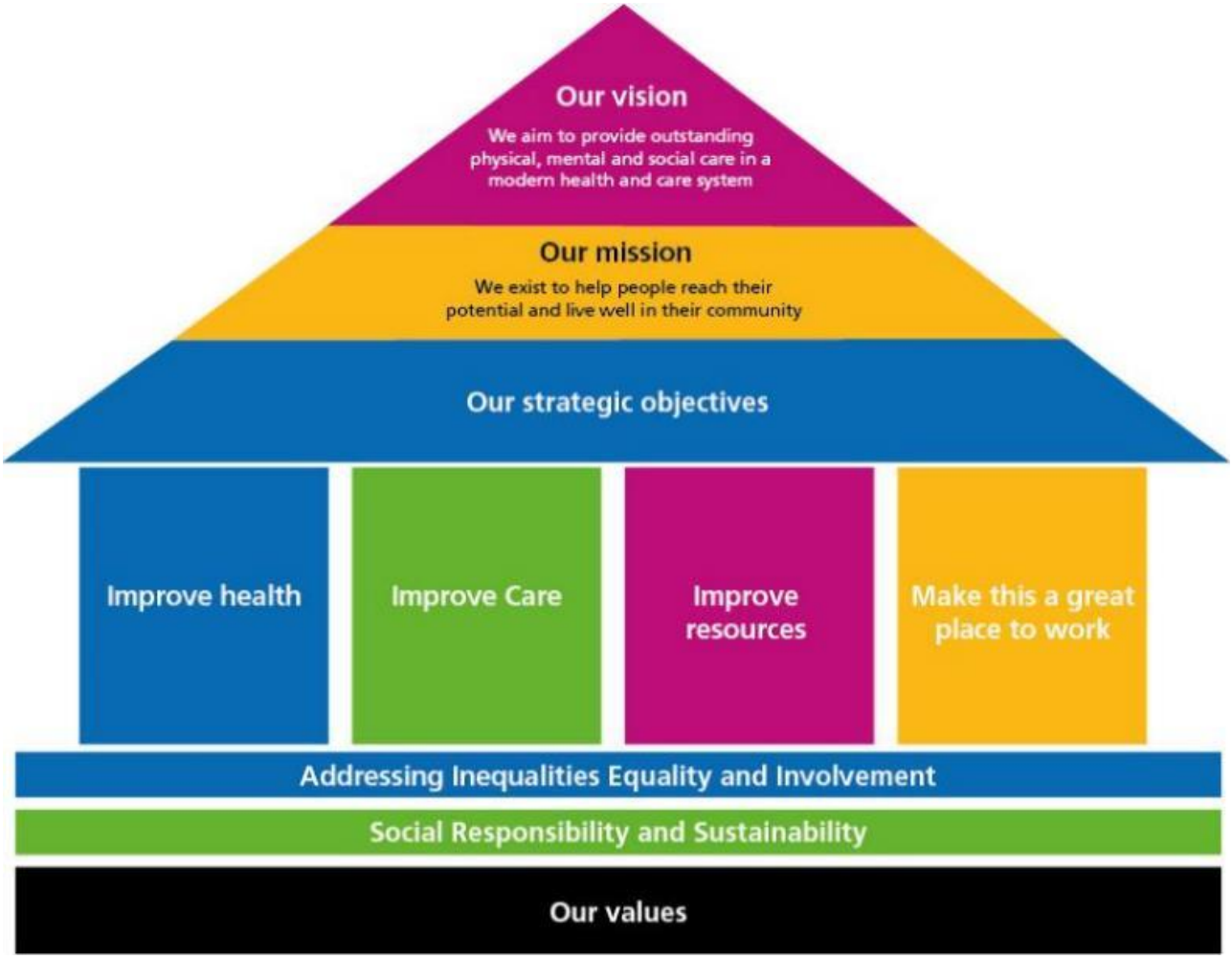
- which come out as priorities in our integrated change framework as they are high cost, high risk and/or high complexity.
- which we all agree are important areas for us to work on over the next year and where we must work collaboratively to achieve the improvements.
- which need strong integrated governance systems to ensure we deliver and manage any risks.
- which will need extra effort and resources from all services across the Trust.

3. Strategic Alignment

3.1 Strategy overview

An overview of the Trust's strategy is set out in the picture in figure two below.

Figure two Strategy overview



3.2 Strategic objectives

The Trust has four strategic objectives which have been identified against the quadruple aim. These are:

- Improve health
- Improve care
- Improve use of resources
- Make this a great place to work

The priorities are aligned to these objectives.

3.3 Strategic ambitions

The Trust has five strategic ambitions. The proposed priorities and related programmes will enable us to continue to work towards these ambitions which are set out below:

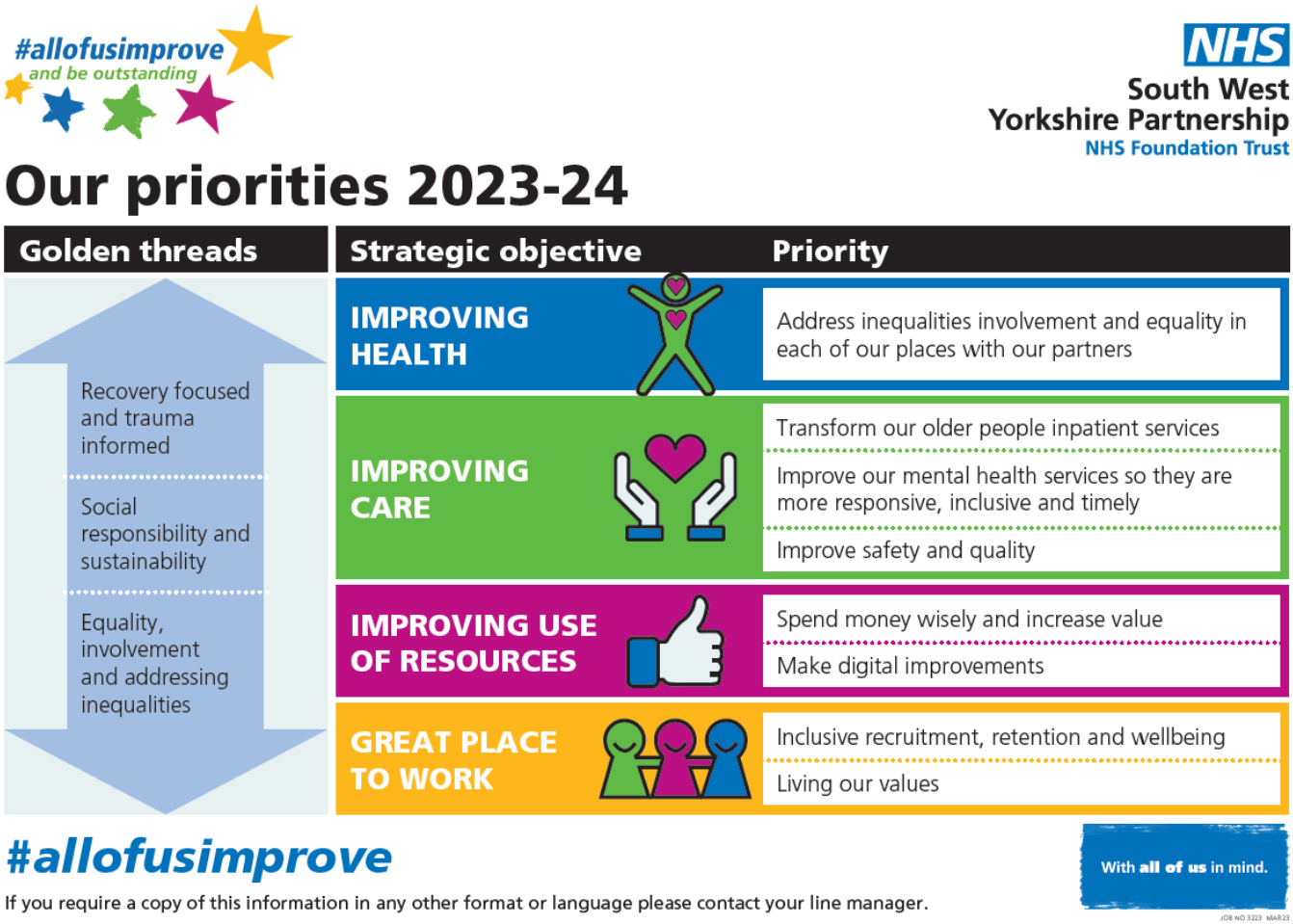
1. A **compassionate and innovative organisation** with **equality, co-production, recovery** and **creativity** at its heart
2. A **regional centre of excellence** for learning disability, specialist and forensic mental health services
3. A **trusted provider** of general community and wellbeing services delivering integrated care
4. A **strong partner in mental health and learning disability service** provision across South Yorkshire and West Yorkshire
5. A **trusted host or partner** in our four local **integrated care partnerships**

4. Proposed Strategic Priorities and Programmes

4.1 Overview of proposed priorities

The proposed Strategic Priorities for now up to the end of March 2024 are summarised in the table below, aligned to the strategic objectives. This is the poster, produced by the design team, which will be used to display the priorities across the organisation.

Figure three Summary chart of proposed priorities



4.2 Relationship and approach

It is important to note that priority areas set out in figure three above are not discrete and separate pieces of work. They are interrelated and some are enablers for others. There are several priority areas which are golden threads which run through many of the other pieces of work. These are part of both how we deliver the programmes of work and also what we do. They are essential for successful delivery in line with the

values of the Trust and to make sure we follow good practice in quality improvement and change management. They will be as part of the scoping and planning for each priority to make sure this happens.

Some of the areas which are golden threads are also priorities in their own right and therefore already included. These are improving value and digital innovations.

The ones which are not priorities in their own right or require highlighting are referenced in the overview slide for completeness. These are:

- Recovery approaches & becoming a Trauma informed organisation
- Equality, involvement and addressing inequalities
- Social responsibility and sustainability (SRS)

The accountability and responsibility for these is already assigned under director portfolios and accountabilities.

The Quality Priorities for 2023/24 are set out below. These relate directly to the strategic priorities as indicated.

Figure four Quality priority alignment to strategic priorities

Quality Priority	Strategic Priority
Safe and responsive care	**Improve safety and quality**
Equality, inclusion and equity	**Ensure equality, involvement & inclusion are central to all that we do so we reduce inequalities**
Health, wellbeing and experience of staff	**Great place to work**

4.3 Further detail on each of the priorities

Further detail is provided below on each of the proposed priorities. This includes:

- The proposed Senior Responsible Officer (SRO)
- The Priority Work areas

Table one Further detail on the priorities

Priority	SRO	Priority work areas
Address inequalities, involvement & equality in each of our places with our partners	Salma Yasmeen	• Focus on reducing inequalities
Transform our Older People inpatient services	Dr Subha Thiyagesh	• Older People Services consultation and planning
Priority	**SRO**	**Priority work areas**

Improve our mental health services so they are more responsive, inclusive and timely	Carol Harris	• Care Closer to Home and Patient flow • Mental Health Inpatient Improvement • Community Mental Health Transformation • Improving access & reducing waiting times
Improve safety and quality	Darryl Thompson	• Risk assessment and care planning • Care Programme Approach developments
Spend money wisely and increase value	Adrian Snarr	• Financial Improvement Plan
Make digital improvements	Salma Yasmeen	• Digital innovations
	Adrian Snarr	• Digital dictation

Improvements in inclusive recruitment, retention and wellbeing	Greg Moores	• Connecting and aligning our work on recruitment and retention including
		  ○ Developing new entry points to our workforce
		  ○ Headline initiative from the social responsibility and sustainability strategy
		  ○ Link to inpatient workforce plan
		  ○ Link to feeling safe and developing my potential

Living our values	Greg Moores	• Connecting and aligning work on 'how we do things around here' Our Organisational Development framework and plan

5. Next steps

A significant amount of work has been undertaken to get to this point, however, further work is required to ensure that the priority areas are addressed and impact monitored.

This includes:

- Agreement of the detailed scope for each of the priority areas with SROs. This will include ensuring we weave all the golden threads into the scoping and planning work.
- Articulation of the governance system to ensure that EMT can discharge its duties as the programme board for the priorities. This will include links to Director Objectives.
- Clarification of the expected outcomes for each priority area of work.
- Detailed work on metrics, measurement and reporting linked to the work on developing the IPR.
- Building on the process we used last year where each care group/directorate are asked to say how they achieve priorities – linked to their annual plan.

6. Recommendations

Trust Board is asked to:

- **Agree the proposed priorities and areas of focus for 2023/24.**
- **Note the continued work on developing the detailed scopes and specific metrics and measures.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 13.2

Private/Public paper:	**Public**		
Title:	**Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)**		
Paper presented by:	**Adrian Snarr - Director of Finance, Estates and Resources**		
Paper prepared by:	Julie Williams – Deputy Director of Corporate Governance		
Mission/values:	Policies and procedures covering core Trust systems and processes are a key part of the Trust's governance arrangements, supporting the Trust to achieve its mission and adhere to its values.		
Purpose:	To enable Trust Board to approve the Policy on Policies, a core policy for the Trust and reserved for Trust Board consideration and approval.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):	N/A		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Policies and procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust. A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that policies and procedures in use are current and reflect an organisational approach, including the Trust engagement with systems and partners.		
Any background papers / previously considered by:	The policy was previously approved by Trust Board on 31 March 2020 and is due for review from March 2023. Clinical leads, People Directorate, Staff side, staff network groups and Equality and Engagement leads were consulted to revise the policy. The revised policy has been reviewed and supported by the Executive Management Team on 20 April 2023 and is submitted for approval by Trust Board.		
Executive summary:	The purpose of the Policy on Policies is: • to describe the approach to development and approval of policies and procedural documents • to provide a standard template for policy documents		

	• to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure
	• to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance
	• to describe the process for version control to ensure people have access and are operating to the most current version
	• to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements.
	
	Following an extensive review, the following changes have been made:
	• A new Equality Impact Assessment has been completed and approved on 6 December 2022, see page 12.
	• References to Business Delivery Units (BDUs) changed to Care Groups.
	• Clarified governance process for clinical policies which should first go through the clinical policy group.
	• Clarified governance process for corporate policies which should go through the corporate policy, procedure and risk group.
	• A paragraph added following consultation with the Equality and Involvement Manager on Equality Impact Assessment and where staff can source resources from the Trust Intranet page, see page 7.
	• A paragraph added following consultation with the Equality and Involvement Manager on health inequalities and the Trust social responsibility and sustainability strategy, see page 8.
	• A paragraph added for authors to consider the principles of trauma informed care when drafting a document, see page 9.
	• There is now a separate paragraph explaining the approval and ratification process for policy and another paragraph for the approval and ratification process for procedures, see page 9 - 10
	• After consultation with the respective directorate service managers, paragraphs added for the governance process of the following documents (see page 10 - 11)
	  ○ Drugs and Therapeutic documents
	  ○ Barnsley care group documents
	  ○ People directorate documents
	• A paragraph has been added on the governance process for changing a policy to a procedure (see page 10) and a proforma drafted in consultation with the Chief Nurse and Director of Quality and Professions (Appendix H – page 47)
	• Acronym updated in Appendix I – page 48

Recommendation:	**Trust Board is asked to APPROVE the updates to the policy.**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Document name:	**Policy for the development, approval and dissemination of policy and procedural documents** **(Policy on Policies)**
Document type:	Policy
What does this policy replace?	Update of previous policy
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	April 2023
Next review:	April 2026
Approved by:	Executive Management Team Trust Board
Developed by:	Director of Finance, Estates and Resources Deputy Director of Corporate Governance, Performance and Risk
Director leads:	Director of Finance, Estates and Resources
Contact for advice:	Deputy Director of Corporate Governance, Performance and Risk Head of Corporate Governance (Company Secretary)

Table of Contents

Policy for the development, approval and dissemination of policy and procedural documents

1. Introduction

Policies and procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust.

A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that policies and procedures in use are current and reflect an organisational approach.

2. Purpose

The purpose of this document is:

- to describe the approach to development and approval of policies and procedural documents.
- to provide a standard format and content for policy and procedure documents.
- to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure.
- to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance.
- to describe the process for version control to ensure people have access to – and are operating to – the most current version.
- to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements.

3. Definitions

- A **POLICY** is a high level statement. Each policy should specify its purpose and may also include a procedure setting out how the policy will be achieved. A policy enables management and staff to make correct decisions, deal effectively and comply with legislation, Trust processes and good working practices.

- A **PROCEDURE** is often incorporated into a policy or can be a 'standalone' document. Procedures are the practical way in which a policy is translated into action. They explicitly outline how to accomplish a task or activity, giving detailed instructions. A procedure often allocates specific roles that specific individual must undertake.

4. Principles

The fundamental action points of this policy are to ensure all policies are developed and updated using a consistent approach, ensuring such documents are regularly reviewed to reflect current guidance, and following their approval that policies are disseminated so that staff are aware of their responsibilities.

5. Duties

It is the policy of the Trust that all policy documents and procedure documents will:

- have an identified Director lead
- have a designated contact for advice
- identify who is responsible for taking action

The following duties apply to this policy;

5.1 Trust Board
Trust Board is responsible for approving this policy for the approval, dissemination and implementation of policies and procedures as outlined in this document.

Policies that require Trust Board approval are outlined in the Trust's Scheme of Delegation. These include policies which are likely to be of major strategic or political significance, such as those relating to the appointment, remuneration and dismissal of staff, policies relating to the management of financial or clinical risk and policies for management of complaints and claims. Approval may also be delegated by the Trust Board for approval by a committee through their Terms of Reference and the Scheme of Delegation.

5.2 Executive Management Team (EMT)
The Executive Management Team (EMT) will approve all other policies (see 5.3 below). The EMT will be responsible for ensuring the policy document has been developed according to this policy.

5.3 Directors
Each policy will have an appointed Lead Director. This Lead Director is responsible for the development of new policies and timely review of current policies in accordance with this policy on policies.

The lead Director for each policy will be responsible for engaging relevant stakeholders in the development of the policy and ensuring appropriate arrangements are in place for managing any resource implications, including dissemination, training and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation.

It is the responsibility of the lead Director for a policy to ensure that the document is appropriately consulted on during the development process by key stakeholders (see section 6.2.3) and to agree the most appropriate way to undertake such consultation.

Multi agency policies will have a lead Director who will be responsible for ensuring the policy has gone through the necessary approval process.

Some policies are delegated to Committee for approval as detailed in the Trust's Scheme of Delegation.

In the case of policies relating to medicines management, with the exception of the overarching medicines management policy and the medicines code, approval is delegated to the Drugs and Therapeutics sub-committee of the Clinical Governance and Clinical Safety Committee, and it is the responsibility of the lead Director to ensure that these policies adhere to this policy.

Other policies that are specific or relevant to local clinical arrangements can be approved locally by appropriate mechanisms within Care Groups; however, where there are implications across the Trust or a policy will have an impact on resources, staffing, Trust strategy, reputation, etc., approval remains reserved for the EMT. Directors should seek the advice of the Company Secretary or the Corporate Governance Manager if in doubt.

Procedures and guidance notes may be developed and issued by the lead Director using the principles included in this document. The lead Director is responsible for engaging relevant stakeholders in developing the procedure or guidance note, communicating the procedure and ensuring its implementation.

5.4 Director of Finance, Estates and Resources

The Director of Finance, Estates and Resources supported by the Deputy Director of Corporate Governance will, on behalf of Trust Board, ensure this policy is implemented and that documents are controlled in accordance with non-clinical records management requirements.

5.5 Care Groups and Trust Action Groups (TAGs)

Directors may engage Care Groups (including the Operational Management Group (OMG) and TAGs in developing and implementing policies or procedural documents. They have no authority to approve policies.

5.6 Specialist staff

Specialist staff have a role in developing and implementing policies and procedures but have no authority to approve policies or procedures. Specialist staff include areas such as Safeguarding, Infection Prevention and Control, and Equality and Involvement Managers.

5.7 Service managers

Service managers have a role in developing and implementing policies and procedures but have no authority to approve policies or procedures.

5.8 Staff

All staff need to be aware of policies and how they impact on their practice. All new policies approved by Trust Board, its committees and / or EMT are communicated through the staff briefing and via the intranet and / or internet. Staff have an individual responsibility to seek out this information.

5.9. Duties for this policy

The Trust Board is responsible for approving this policy.

The lead Director is the Director of Finance, Estates and Resources.

All staff who write policies need to be aware of this policy.

The Deputy Director of Corporate Governance, supported by the Company secretary, is responsible for overseeing the administration of this policy. This includes ensuring policies for approval are included in the relevant Trust Board or EMT agenda in a timely way, maintaining a corporate record of all current and past policy and procedure documents, and notifying lead Directors when a policy or procedure is due for review.

6. Process of developing, approving and reviewing policies

6.1 Style and format

All policies and procedures should be written in a style that is clear, concise and unambiguous. Titles should be kept simple to assist easy identification of the document.

Policy and procedural documents should follow Trust branding guidance. The standard font is Arial 12 point. Uppercase and underlining should be avoided except in headings. Page numbers should be used.

A template showing the structure and mandatory sections to be included is provided in **Appendix D.**

Acronyms and technical language should be explained, or a glossary included.

A checklist, included at the end of the policy document, is to be completed and submitted to the EMT, committee or Trust Board at the time of final approval to ensure the policy includes all required contents.

6.2 Development process

6.2.1 Identification of need

The need for a new policy or procedure may be prompted by a change in national legislation, policy or guidance or it may be identified within the Trust either as a result of learning from experience, such as complaints or incidents, or as a result of a risk being identified by a specialist advisor or Task and Action Group (TAG). New policies may also be required as a result of the development of a new service or new way of working.

The first step should be to establish whether a new policy or procedure is required or whether the requirement can be met by amending an existing policy or procedure.

The aim should be to keep the number of policies to a minimum. The lead Director should be able to provide a clear justification for the development of any new policy.

This policy has been developed to minimise risks associated with policies and procedures being written without appropriate authority or consideration of the impact of the policy and to prevent inconsistent application of policies as a result of failure to effectively communicate or disseminate a policy or procedure. No other document already in existence in the Trust covers this subject.

6.2.2. Undertaking Equality Impact Assessments

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer.

An Equality Impact Assessment (EIA) must be completed prior to the revision of an existing Trust Policy or writing of a new Trust Policy. A toolkit to support this process is included in **Appendix Di** to this document and guidance can also be found at:

An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

As part of stakeholder involvement, Equality and Engagement Managers should be involved in the development or review of the EIA to ensure all equality and diversity requirements are included, prior to the review of the policy. If any negative impact is identified, the policy should be amended or (if this is not possible) an action plan to mitigate the negative impact must be included.

6.2.3 Stakeholder involvement

Consultation with relevant stakeholders secures ‘buy in’ and provides an opportunity to identify and eliminate potential barriers to implementation.

Policy authors may wish to consider the Core20PLUS5. This is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement. Further information is available on NHS England website;

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Policy holders may also consider the Trust social responsibility and sustainability strategy (2022 – 2027) to reduce disadvantage and inequalities, improving our environmental impact and achieving the Trust's mission of helping people to reach their potential and live well in their communities.

https://www.southwestyorkshire.nhs.uk/wp-content/uploads/2022/01/2688-Social-responsibilty-and-sustainability-strategy.pdf

The lead Director is responsible for ensuring relevant stakeholders have been consulted during the development of the policy. The following identifies some of the individuals or groups who might be consulted with. This is not an exhaustive list. Consideration should be given to digitally enabled care.

Stakeholder	**Level of involvement**
Executive Management Team (EMT)	Approval – (may also be involved at the outset in confirming the requirement for a new policy or agreeing the development process)
Directors	Initiation, lead, development, receipt, circulation
Care Service Groups (Including the Operational Management Group (OMG)	Development, consultation, dissemination, implementation, monitoring
Specialist advisors	Development (including EIA), consultation, dissemination, implementation
Service user and carers	Development, consultation
Professional groups and leaders	Development, consultation, dissemination, implementation
Trust Action Groups (TAGs)	Development, consultation, dissemination, implementation
Staff side	Development, consultation, dissemination
Trust learning networks	Consultation
Local Authorities	Development, consultation
Police	Development, consultation
Other NHS Trusts	Development, consultation
University	Consultation

For this document, the clinical leads, People Directorate, staff side, and the EMT were consulted. The Trust Board agreed when developing the Scheme of Delegation that responsibility for determining policy approval arrangements should be a decision reserved for the Trust Board.

6.2.4. Trauma informed organisation

All documents should be written in a way that ensures they are underpinned by the key principles of Trauma-Informed Care in line with the Trust becoming a Trauma-Informed organisation. Further information can be found on the following link;

https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice

This guidance provides a definition of trauma-informed practice, its key principles and how it can be built into services and systems.

6.3. Process for review, approval and ratification

6.3.1 Policies

The EMT receive the Policy Register monthly for the lead Director to note when policies are due for review.

The Corporate Governance Team (for corporate policies) and Quality Improvement and Assurance Team (QIAT) (for clinical policies) are responsible for notifying policy authors and the lead director when policies are due for review.

On receipt of notification, policy authors should first update the EIA for the relevant policy **(Appendix Di).** On completion of the EIA, it should be sent to the Equality and Involvement team (InvolvingPeople@swyt.nhs.uk) to ensure sign off is complete prior to submission to the EMT with the appropriate policy.

An EIA must be completed for all policies that have not previously been subject to EIA. For revised policies an update of the EIA needs to be undertaken. Guidance can be found on the Trust intranet – An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

The policy author will review the policy. If no amendment is required, this should be reported to the EMT (or Trust Board) for ratification including the updated EIA by the policy review date. Policies should be submitted to EMT with a completed proforma for approval of policies; for clinical policies please contact the Quality Improvement & Assurance Team (QIAT) on qiat@swyt.nhs.uk and for corporate policies the Corporate Governance Team on; corporategovernanceteam@swyt.nhs.uk

If the policy requires amendment, this should be done in consultation with the updated EIA prior to presenting the revised policy to the relevant sub-group; Corporate Policy, Procedure and Risk Group (corporate policies) or Clinical Policy, Procedure and Risk Group (clinical policies) for review.

The Corporate Governance Team (for corporate policies) and Quality Improvement and Assurance Team (QIAT) (for clinical policies) will then send the policy for peer review to the Executive Director prior to submission to EMT.

For submission to EMT the policy and signed off EIA need a completed proforma for approval **(Appendix F).**

It should be noted that, for services that came to the Trust as part of transformation, there may be a number of policies that, over time, will need to be aligned. Existing policies will continue to be followed until this work takes place.

Each appointed lead Director for a policy will need to ensure that reviews include all existing policies that have been produced by previous organisations and that new / updated polices are clear which policies they replace.

Should the review of a policy be delayed, a request for extension should be presented to EMT by submitting a completed proforma (**Appendix G**). At the time of approval, all policies should have a clearly defined review date (maximum of three years). This may be brought forward if earlier review is required, for example because of an identified risk or change in national policy.

Policies requiring approval by Trust Board will be subject to review at EMT prior to submission to Trust Board for sign off.

The Company Secretary will notify and track Trust Policies for approval by Trust Board.

Policies requiring approval by EMT should be presented by the lead Director.

6.3.2 Procedures

Procedures and guidance notes, due to their operational nature, are likely to require more regular updates.

Where a procedure requires update / review, the completion of an EIA is not mandatory, but is seen as good practice. Where a procedure already has an EIA, this should be reviewed prior to revision. Procedures should be submitted to the Operational Management Group (OMG) for approval, with oversight from the operational lead.

The checklist at **Appendix Eii** (Template - Checklist for review and approval of a document) should be completed by the reviewer.

6.3.3 Changing a policy to a procedure

It is the responsibility of the policy lead to identify and discuss with their Lead Director and appropriate professional advisors as to whether a policy can be changed to a procedure.

It should be noted that this CAN ONLY be applied if the policy is not required for compliance with legislation or regulatory standards.

Once a procedure has been agreed as a replacement the policy lead must contact the Corporate Governance Team for corporate policies or the Quality Improvement and Assurance Team (QIAT) for clinical policies.

The policy lead will be required to submit their proposal by completing the policy proforma (**Appendix H**), and the proposal will then be submitted to EMT for approval.

6.3.4 Drugs and Therapeutic Documents

Drugs and Therapeutic (D&T) documents are approved at the Drug and Therapeutic group.

6.3.5 Barnsley Care Group documents

Barnsley Care Group clinical working instructions and local working instructions are approved by Barnsley governance group.

6.3.6 People directorate documents

All people directorate documents are subject to consultation with staff side at the employment policy group. Documents then proceed to the Trust partnership forum for final ratification (including staff side) before progressing to EMT for final approval.

6.4 Version control

All policies and procedures must have the version number, date of issue and the review date clearly marked on the front cover and as a footnote.

Draft policies should be marked v1 draft, v2 draft etc during the consultation phase. Once approved the document becomes Version 1. Each time the policy or procedure is updated the version number must be changed.

The introduction to the policy should make it clear whether a document replaces or supersedes a previous document, including the title(s) of any superseded or replaced documents.

6.5 Dissemination and implementation arrangements (including training)

Once approved, the Corporate Governance Team (for corporate policies) and Quality Improvement and Assurance Team (QIAT) (for clinical policies) will be responsible for ensuring the updated version is added to the document store on the intranet and is included in the weekly communication to staff.

Some Trust policies are required to be published on the external facing internet and these can be found at South West Yorkshire Partnership NHS Foundation Trust. The Corporate Governance and QIAT Team will inform the Trust Communications Team.

The Corporate Governance Team (for corporate policies) and Quality Improvement and Assurance Team (QIAT) (for clinical policies) will also be responsible for ensuring previous documents are archived prior to the new version being uploaded.

Directors are responsible for ensuring that staff within their area of responsibility are aware of new or amended policies and procedures related to their work.

If local teams download and keep a paper version of procedural documents, the responsible manager must identify someone within the team who is responsible for updating the paper version when a policy change is communicated via the staff brief.

All policies and procedures must identify the arrangements for implementation, including:

- Any training requirements, including which staff groups this affects and the arrangements and timescale for delivering training.
- Any resource requirements, including staff, and how these will be met.
- Support available to assist implementation.
- Arrangements for ensuring the policy or procedure is being followed.
- Monitoring and audit arrangements.

6.6 Document control and archiving

Current policies and procedures will be available on the intranet in read only format.

For historic policies and procedures, a central electronic read only version will be kept as a corporate record (archive) in a designated shared folder to which all staff can request access.

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

6.7 Monitoring compliance with the policy

All policies and procedure must identify the arrangements that are in place for ensuring and monitoring compliance. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission (CQC) standards, NHS Resolution frameworks and Monitor (or successor organisation) compliance.

Methods may include:

- Monitoring and analysis of incidents, performance reports and training records
- Audit
- Checklists
- Monitoring of delivery of actions plans through TAGS or Care Service Groups

The document should identify the methods that will be used to ensure timely and efficient implementation.

For this policy implementation:

- is the responsibility of the lead Director for individual policies to ensure that this policy is followed in the development and presentation of individual policies
- is monitored through presentation to EMT and / or Trust Board, evidenced by the minutes of meetings where policies are approved, or the appropriate ratifying body, again evidenced by the minutes of meetings where policies are approved
- is monitored by the ratifying body through the policies checklist
- is assured through occasional audit by the Trust's internal auditors (currently 360 Assurance).

7. Equality Impact Assessment (EIA)

An EIA has been completed for this policy with no negative impact identified (**Appendix A**).

8. Dissemination and implementation arrangements (including training)

The dissemination and implementation of this policy will be conducted in accordance with the processes outlined under section 6.5.

Support to assist the development of other policies is available by contacting the Corporate Governance Team (for corporate policies) and Quality Improvement and Assurance Team (QIAT) (for clinical policies).

9. Process for monitoring compliance and effectiveness

Compliance and effectiveness of this policy is reviewed through the approval of all other policies to ensure they comply with the requirements of this policy. Other methods may include review as part of Care Quality Commission (CQC) inspections and audit by the Trust's internal auditors.

10. Review and revision arrangements

A review and revision of this policy should take place at least every three years or if required earlier due to national guidance.

11. References associated documents and supporting references

This document has been developed in line with guidance issued by the NHS Resolution and with reference to model documents used in other trusts.

Appendix A

Equality Impact Assessment
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)

Date of EIA: November 2022 (final approval April 2023) Review Date: April 2026

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 Policy for the development, approval and dissemination of policy and procedural documents approved on February 2020.
2	**Description of the document** Prompt: What is the aim of this document	This purpose of this policy is to guide staff of South West Yorkshire Partnership NHS Foundation Trust on the development and approval of policies and procedural documents. It aims to; - to provide a standard format and content for policy and procedure documents. - to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure. - to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance. - to describe the process for version control to ensure people have access to – and are operating to – the most current version. - to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements.
3	**Lead contact person for the Equality Impact Assessment**	**Asma Sacha** **Corporate Governance Manager**
4	**Who else is involved in undertaking this Equality Impact Assessment**	**Advice sought from Equality and Involvement 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 2022 Workforce Monitoring Report.** The fundamental aim of this policy is to ensure all policies are developed and updated using a consistent approach, ensuring such documents are regularly reviewed to reflect current guidance, and following their approval that policies are disseminated so that staff are aware of their responsibilities. The Trust currently employs approx.4,530 staff delivering a range of services including mental health, learning disability, forensic, some physical health and an extensive range of community services.

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 policy (use of technology) • The area reporting high numbers of staff with disabilities is Barnsley care group • The data shows 8.4% of staff consider themselves to have a disability, this is an increase from the 2020 figure of 6.4% • Staff can access this policy using the accessibility mode where the policy 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 policy has been sent to the staff Disability Network for consultation. • Policy holder to ensure staff disabilities and accessibility is considered during the writing of the policy or procedure/guidance.

Disability (March 2022)

Area	Yes	No or Unknown	Grand Total
Barnsley	91 *7.8%*	1,082 *92.2%*	1,173
Calderdale and Kirklees	84 *10.0%*	760 *90.0%*	844
Wakefield	31 *8.5%*	334 *91.5%*	365
Forensic Services	70 *11.2%*	557 *88.8%*	627
CAMHS	28 *8.6%*	299 *91.4%*	327
Inpatient Services	33 *9.8%*	304 *90.2%*	337
Support Services	38 *5.0%*	715 *95.0%*	753
Sub-total	**375** ***8.5%***	**4,051** ***91.5%***	**4,426**
Medical Staff	9 *5.4%*	159 *94.6%*	168
Grand Total	**384** ***8.4%***	**4,210** ***91.6%***	**4,594**

	QUESTIONS	**ANSWERS AND ACTIONS**
5b	**Gender:** Prompt: Female & Male issues should be considered.	This policy applies equally to all members of staff • Gender split of staff is 21% male 79% female – this is indicative of all NHS bodies. • No barrier identified by gender in accessing the policy

		• Gender neutral pronouns to be considered when forming a policy/procedure/guidance to avoid distinguishing roles according to people's sex or gender.

Staff in post by gender and area March 2022

Gender/Area	Barnsley	Calderdale and Kirklees	Wakefield	Forensic Services	CAMHS BDU	Inpatient Services	Support Services	Medical Staff
Female	1,020 87.0%	689 81.6%	303 83.0%	464 74.0%	288 88.1%	261 77.4%	541 71.8%	68 40.5%
Male	153 13.0%	155 18.4%	62 17.0%	163 26.0%	39 11.9%	76 22.6%	212 28.2%	100 59.5%
Grand Total	1,173	844	365	627	327	337	753	168

5c	**Age:** Prompt: Older people & Young People issues should be considered	This policy applies equally to all members of staff • The highest number of Trust staff fall in the age bands 40 – 49 and 50 – 59 with just under 53% of total staff being between 40 and 59. • Potential barrier with access to the policy (use of technology) • 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. • Policy holder to consider use of technology and appropriate training when forming new policies/procedures/guidance.

Age by area (March 2022)

Area	19 & Under	20-29	30-39	40-49	50-59	60-69	70+	Grand Total
Barnsley		118 *10.1%*	286 *24.4%*	291 *24.8%*	345 *29.4%*	124 *10.6%*	9 *0.8%*	1,173
Calderdale and Kirklees	1 *0.1%*	110 *13.0%*	205 *24.3%*	216 *25.6%*	231 *27.4%*	78 *9.2%*	3 *0.4%*	844
Wakefield	1 *0.3%*	32 *8.8%*	86 *23.6%*	83 *22.7%*	115 *31.5%*	45 *12.3%*	3 *0.8%*	365
Forensic Services	6 *1.0%*	145 *23.1%*	157 *25.0%*	141 *22.5%*	140 *22.3%*	34 *5.4%*	4 *0.6%*	627
CAMHS		57 *17.4%*	101 *30.9%*	77 *23.5%*	74 *22.6%*	18 *5.5%*		327
Inpatient Services	1 *0.3%*	94 *27.9%*	84 *24.9%*	57 *16.9%*	80 *23.7%*	20 *5.9%*	1 *0.3%*	337
Support Services		51 *6.8%*	120 *15.9%*	183 *24.3%*	277 *36.8%*	119 *15.8%*	3 *0.4%*	753
Sub-total	**9** ***0.2%***	**607** ***13.7%***	**1,039** ***23.5%***	**1,048** ***23.7%***	**1,262** ***28.5%***	**438** ***9.9%***	**23** ***0.5%***	**4,426**
Medical Staff		9	38	58	50	12	1	168

	5.4%	*22.6%*	*34.5%*	*29.8%*	*7.1%*	*0.6%*	
Grand Total	**9** ***0.2%***	**616** ***13.4%***	**1,077** ***23.4%***	**1,106** ***24.1%***	**1,312** ***28.6%***	**450** ***9.8%***	**24** ***0.5%***	**4,594**

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

Sexual Orientation (March 2022)

Area	Heterosexual	Gay or Lesbian	Bisexual	Unknown	Grand Total
Barnsley	1,005 *85.7%*	19 *1.6%*	8 *0.7%*	141 *12.0%*	1,173
Calderdale and Kirklees	701 *83.1%*	24 *2.8%*	11 *1.3%*	108 *12.8%*	844
Wakefield	300 *82.2%*	12 *3.3%*	3 *0.8%*	50 *13.7%*	365
Forensic Services	513 *81.8%*	24 *3.8%*	13 *2.1%*	77 *12.3%*	627
CAMHS BDU	291 *89.0%*	5 *1.5%*	10 *3.1%*	21 *6.4%*	327
Inpatient Services	271 *80.4%*	9 *2.7%*	6 *1.8%*	51 *15.1%*	337
Support Services	586 *77.8%*	10 *1.3%*	5 *0.7%*	152 *20.2%*	753
Sub-total	**3,667** ***82.9%***	**103** ***2.3%***	**56** ***1.3%***	**600** ***13.6%***	**4,426**
Medical Staff	138 *82.1%*	5 *3.0%*	1 *0.6%*	24 *14.3%*	168
Grand Total	**3,805** ***82.8%***	**108** ***2.4%***	**57** ***1.2%***	**624** ***13.6%***	**4,594**

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

Religious belief (March 2022)

Area	Atheism	Christianity	Islam	Other*	Unknown	Grand Total
Barnsley	193	649	10	118	203	1,173

	16.5%	*55.3%*	*0.9%*	*10.1%*	*17.3%*	
Calderdale and Kirklees	187 *22.2%*	353 *41.8%*	48 *5.7%*	95 *11.3%*	161 *19.1%*	844
Wakefield	65 *17.8%*	181 *49.6%*	5 *1.4%*	48 *13.2%*	66 *18.1%*	365
Forensic Services	159 *25.4%*	271 *43.2%*	24 *3.8%*	64 *10.2%*	109 *17.4%*	627
CAMHS BDU	94 *28.7%*	148 *45.3%*	5 *1.5%*	49 *15.0%*	31 *9.5%*	327
Inpatient Services	64 *19.0%*	143 *42.4%*	19 *5.6%*	44 *13.1%*	67 *19.9%*	337
Support Services	117 *15.5%*	364 *48.3%*	22 *2.9%*	82 *10.9%*	168 *22.3%*	753
Sub-total	**879** ***19.9%***	**2,109** ***47.7%***	**133** ***3.0%***	**500** ***11.3%***	**805** ***18.2%***	**4,426**
Medical Staff	20 *11.9%*	44 *26.2%*	36 *21.4%*	47 *28.0%*	21 *12.5%*	168
Grand Total	**899** ***19.6%***	**2,153** ***46.9%***	**169** ***3.7%***	**547** ***11.9%***	**826** ***18.0%***	**4,594**

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

Marital Status (March 2022)

Area	Civil Partnership	Divorced/Legally Separated	Married	Single	Widowed	Unknown	Grand Total
Barnsley	11 *0.9%*	125 *10.7%*	651 *55.5%*	366 *31.2%*	15 *1.3%*	5 *0.4%*	1,173
Calderdale and Kirklees	15 *1.8%*	85 *10.1%*	385 *45.6%*	337 *39.9%*	9 *1.1%*	13 *1.5%*	844
Wakefield	6 *1.8%*	38 *10.1%*	195 *45.6%*	120 *39.9%*	4 *1.1%*	2 *1.5%*	365
Forensic Services	9 *1.4%*	45 *7.2%*	245 *39.1%*	318 *50.7%*	4 *0.6%*	6 *1.0%*	627
CAMHS		36 *11.0%*	155 *47.4%*	132 *40.4%*		4 *1.2%*	327
Inpatient Services	3 *0.9%*	31 *9.2%*	122 *36.2%*	178 *52.8%*	2 *0.6%*	1 *0.3%*	337
Support Services	8 *1.1%*	77 *10.2%*	422 *56.0%*	233 *30.9%*	7 *0.9%*	6 *0.8%*	753
Sub-total	**52** ***1.2%***	**437** ***9.9%***	**2,175** ***49.1%***	**1,684** ***38.0%***	**41** ***0.9%***	**37** ***0.8%***	**4,426**
Medical Staff	2 *1.2%*	3 *1.8%*	127 *75.6%*	34 *20.2%*	1 *0.6%*	1 *0.6%*	168
Grand Total	**54** ***1.2%***	**440** ***9.6%***	**2,302** ***50.1%***	**1,718** ***37.4%***	**42** ***0.9%***	**38** ***0.8%***	**4,594**

5g	**Pregnancy and Maternity** Prompt: Currently pregnant or have been pregnant in the last 12 months should be considered	This policy applies equally to all members of staff
5h	**Gender Re-assignment** Prompt: Transgender issues should be considered	This policy applies equally to all members of staff
5i	**Carers** Prompt: Caring responsibilities paid or unpaid, hours this is done should be considered	This policy applies equally to all members of staff • The policy 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 shows just under 89% consider themselves white. Of the remaining 11.3%, the largest group (5.1%) consider themselves of Asian origin. • Staff can request the policy is interpreted into a different language • The policy has been sent to the REACH (Race, Equality and Cultural Heritage) staff network for consultation

Workforce ethnicity

Area	Asian	Black	Chinese or Other	Mixed	White	Unknown	Grand Total
Barnsley	13 *1.1%*	12 *1.0%*	7 *0.6%*	9 *0.8%*	1,131 *96.4%*	1 *0.1%*	1,173
Calderdale and Kirklees	52 *6.2%*	34 *4.0%*	6 *0.7%*	14 *1.7%*	737 *87.3%*	1 *0.1%*	844
Wakefield	7 *1.9%*	6 *1.6%*	3 *0.8%*	7 *1.9%*	342 *93.7%*		365
Forensic Services	25 *4.0%*	44 *7.0%*	7 *1.1%*	11 *1.8%*	538 *85.8%*	2 *0.3%*	627
CAMHS BDU	9 *2.8%*	12 *3.7%*	2 *0.6%*	5 *1.5%*	299 *91.4%*		327
Inpatient Services	21 *6.2%*	31 *9.2%*		5 *1.5%*	280 *83.1%*		337
Support Services	27 *3.6%*	11 *1.5%*	13 *1.7%*	10 *1.3%*	688 *91.4%*	4 *0.5%*	753
Sub-total	**154** ***3.5%***	**150** ***3.4%***	**38** ***0.9%***	**61** ***1.4%***	**4,015** ***90.7%***	**8** ***0.2%***	**4,426**
Medical Staff	79 *47.0%*	9 *5.4%*	17 *10.1%*	5 *3.0%*	58 *34.5%*		168
Grand Total	**233** ***5.1%***	**159** ***3.5%***	**55** ***1.2%***	**66** ***1.4%***	**4,073** ***88.7%***	**8** ***0.2%***	**4,594**

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.

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	x	The Trust will ensure that staff of all backgrounds, identities and ages in their present circumstance will receive information to provide direction to develop policy, procedure and guidance documentation.	Corporate Governance Team	March 2026 (every 2 years)	Involve the staff networks (LGBT, REACH (formerly BAME), carers network and Disability)	Achieving
Disability	X					
Gender reassignment	X					
Marriage and civil partnership	X					
Race	X					
Religion or belief	X					
Sex	X					
Sexual Orientation	X					
Pregnancy maternity	X					
Carers	X					

Who will benefit from this action? (tick all that apply)		Action 2: This is what we are going to do	Lead/s	By when	Update -outcome	RAG
Age	x	There is a statutory duty to carry out Equality Impact Assessments and policy authors to ensure they are considering the impact on those with protected characteristics throughout the policy/procedure or guidance development.	Policy authors	Ongoing	To ensure the most up to date national data is available to compare to our Trust workforce data.	**Developing**
Disability	X					
Gender reassignment	X					
Marriage and civil partnership	X					
Race	X					
Religion or belief	X					
Sex	X					
Sexual Orientation	X					
Pregnancy maternity	X					
Carers	X					

Grading the EIA
Undertaken by: Aboobaker Bhana, Equality and Involvement Manager

Date: 6 December 2022

Rating: Developing
EIAs are now reviewed using a grading approach which is in line with our Equality Delivery System (EDS). The team have reviewed and rated the EIA using the following:

- **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

Comments:
Overall a good EIA
Needed some specific examples in the involvement section- You Said -We Did
Would have been good to include the description of CPRG group and its function
In the action plan -The new census 2021 demographic data for ALL areas needs to be added as soon as available
Include examples any other related work programmes led by the Corporate Governance team to support this policy
Include any SI/SUI's/complaints or concerns related to CQC Guidelines, that may have had an impact one of the equality groups, that led to learning lessons and positive outcomes

7. Involvement & Insight: New or Previous (please include any evidence of activity undertaken in the box below)

An integral element of the policy to write and develop policies, procedures and guidance is to involve the various groups and support networks, i.e., LGBT+, Race, Equality and Cultural Heritage (REACH) staff network group (formerly BAME), carers and Disability networks to ensure there continues to be no unintended consequences to individuals.

Policy authors need to ensure key consideration is given to external stakeholders and those who use our services; service users and carers when developing policies, procedures and guidance. The policy authors can take insight from the Friends and Family Test, Complaints, Compliments and Carers Groups.

8. Publishing the Equality Impact Assessment

This is available on the Trust intranet and via Freedom of Information request.

9. Methods of Monitoring progress on Actions

The policy will be reviewed by the Corporate Policy, Procedure and Risk Group (Chair, Head of Corporate Governance/ Company Secretary)

10. Signing off Equality Impact Assessment:

Adrian Snarr, Director of Finance, Estates and Resources – Approved 16/12/2022

Julie Williams, Deputy Director of Corporate Governance, Performance and Risk – Peer review – Approved 16/12/2022

Asma Sacha, Corporate Governance Manager – Approved 06/12/2022

Andrew Lister, Head of Corporate Governance/ Company Secretary – Approved 06/12/2022

Aboobaker Bhana – Equality and Involvement Manager – Approved 06/12/2022

Once approved, you must forward a copy of this Assessment/Action Plan by email to:

InvolvingPeople@swyt.nhs.uk

If you have identified a potential discriminatory impact of this policy, please refer it to the Equality & Engagement Development Managers together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Equality & Engagement Development Managers.

Appendix B

Checklist for review and approval

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	YES	Staff networks, corporate policy, procedure and risk group and EMT
	Is there evidence that a trauma-informed 'lens' has been applied? e.g. through use of language etc.	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?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint People Directorate /staff side committee (or equivalent) approved the document?	YES	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	Trust Communications Team
	Does the plan include the necessary training/support to ensure compliance?	N/A	Equality Impact Assessment training available
8.	**Document Control**		
	Does the document identify where it will be held?	YES	Intranet document store
	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?	N/A	
	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 C

Version control sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	June 2008	Director of Corporate Development	Final	Final version approved by Trust Board
2	March 2009	Director of Corporate Development		Changes made to ensure clarity on superseded or replaced documents and to reflect change in guidance for 2009/10
3	March 2010	Integrated Governance Manager	Final draft	Changes made following review and subsequent recommendations made during NHS LARMS review
4	December 2010	Integrated Governance Manager	Final	Inclusion of Equality Impact Assessment
5	July 2011	Integrated Governance Manager	Final	Changes made to accommodate comments made during NHS LARMS review and transfer of services from NHS Barnsley
6	October 2012	Integrated Governance Manager	Final draft	Changes made to meet requirements of NHS LARMS
7	October 2013	Integrated Governance Manager	Final	Revised equality impact assessment added (approved by lead Director 3 October 2013)
8	July 2014	Integrated Governance Manager	Final	Review by Lead Director; agreed no changes required. Approval of review date extension for further two years
9	January 2017	Integrated Governance Manager	Final	Reviewed with minor amendments and approved by Trust Board.
10	January 2019	Company Secretary Corporate Governance Manager	Final	Reviewed with minor amendments. Approved by EMT and Trust Board.
11	January 2020	Company Secretary	Draft	Reviewed with minor amendments. To be approved by EMT and Trust Board.
12	March 2020	Corporate Governance Manager	Final	Approved by EMT and Trust Board.
13	April 2023	Director of Finance, Estates and Resources, Deputy Director of Corporate Governance Head of Corporate Governance and Corporate Governance Manager	Final	Full review undertaken and completion of the new Equality Impact Assessment proforma. Approved by EMT and Trust Board.

Appendix D
Policy Template - style and format

Document name:	**Name of the policy**
Document type:	Policy
What does this policy replace?	New policy / Updated version
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet and / or Internet
Issue date:	Month Year
Next review:	Month Year
Approved by:	Executive Management Team on (date) Trust Board on (date)
Developed by:	Job title
Director leads:	Job title
Contact for advice:	Job title

Contents

1. Introduction

This section should include a brief explanation of the reason for the policy.

2. Purpose and scope of the policy

This section should include why the policy needed, the rationale for development, what will it cover and an outline of the objectives and intended outcomes.

3. Definitions

This section should include a list and / or description of the meaning of terms used in the context of the policy or procedure.

4. Principles

This section should include the fundamental action points of the policy or procedure to be adopted.

5. Duties

This section should include the following:

- who is responsible for developing and implementing the policy
- who in the organisation is required to do what
- who is responsible for communicating the policy
- who is responsible for consultation with stakeholders
- who is responsible for approving the policy/procedure

6. Equality Impact Assessment

This section should include a new or updated Equality Impact Assessment to be completed.

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer.

An Equality Impact Assessment (EIA) must be completed prior to the revision of an existing Trust Policy or writing of a new Trust Policy. A toolkit to support this process is included in the appendices to this document and guidance can also be found at:

An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

As part of stakeholder involvement, Equality and Engagement Managers should be involved in the development or review of the EIA to ensure all equality and diversity requirements are included, prior to the review of the policy. If any negative impact is identified, the policy should be amended or (if this is not possible) an action plan to mitigate the negative impact must be included.

7. Dissemination and implementation arrangements (including training)

This section should describe the methods that will be used to ensure timely and efficient dissemination and implementation arrangements including training. This should include:

- any training requirements, including which staff groups this affects and the arrangements and timescale for delivering training;
- any resource requirements, including staff, and how these will be met; and
- support available to assist implementation;

Directors are responsible for ensuring that staff within their area of responsibility are aware of new or amended policies and procedures related to their work and the change is communicated in The Headlines. If local teams download and keep a paper version of documents, the responsible manager must identify someone within the team who is responsible for updating the paper version.

8. Process for monitoring compliance and effectiveness

This section should identify the arrangements for compliance and effectiveness, responsibility for conducting any audit, review or monitoring, the methodology to be used for audit, review or monitoring, its frequency, the process for reviewing the results and monitoring of key performance indicators. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission (CQC) standards, and Monitor / NHS Improvement compliance. Methods may include:

- monitoring and analysis of incidents, performance reports and training records
- audit by the Trust's internal auditors
- checklists
- monitoring of delivery of actions plans through TAGs or Care Groups.

9. Review and revision arrangements

This section should identify the arrangements for the review and revision of the policy. If an update to a policy has taken place it should describe the process undertaken.

10. References

This section should list any other documents referenced within the policy.

11. Associated documents

This section should list any other documents to be read in association with the policy. This could include other policies, procedures and guidance documents.

12. Appendices

Appendix A: Equality Impact Assessment (EIA)
Appendix B: Checklist for the review and approval of policy document
Appendix C: Version control sheet

TEMPLATE Di
Appendix A - Equality Impact Assessment (EIA) Toolkit

To be completed and attached to any policy document when submitted to the Executive Management Team and / or Trust Board for consideration and approval.

Document author to download the most up to date form from the Trust intranet (sharepoint)

Guidance
An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

EIA form
EIA Policy template July21 v2.doc (sharepoint.com)

TEMPLATE Dii
Appendix B - Checklist for the review and approval of policy document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
	Is it clear in the introduction whether this document replaces or supersedes a previous document?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Is the method described in brief?		
	Are people involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
	Is there evidence that a trauma-informed 'lens' has been applied? e.g. through use of language etc.		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		

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

TEMPLATE Diii
Appendix C - Version control sheet for policy document

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes

Appendix E

Procedure Template - Style and format

Document name:	**Name of the procedure / document**
Document type:	Procedure guidance/ Guidance/ Standard Operating Procedure? (please choose)
What does this procedure replace?	Update of previous procedure New procedure / Updated version
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet and / or Internet
Issue date:	Month Year
Next review:	Month Year
Approved by:	Operational Management Group on (date)
Developed by:	(name and job title)
Director lead:	(name and job title)
Contact for advice:	(name and job title)

Contents

Procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust.

A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that procedures in use are current and reflect an organisational approach.

Equality Impact Assessment (s) for procedures are not mandatory, but guidance should be sought from the Equality and Inclusion team if in doubt. If there is an EIA in place for the procedure you are writing, this may require an update including equality data for staff, and people who use our services or population data. Please contact the Equality and Involvement Team **before you develop the procedure.**

1. **Introduction**
Set out the context for the procedure, why is it required and background information. Refer to polices that staff may need to make reference to with respect to this procedure.

2. **Purpose and scope**
What is the aim of the procedure and which groups of people does it apply to.

3. **Definitions**
Define any terms that are required, i.e. in a care plan SOP we may want to define what we mean by a ‘care plan’.

4. **Principles**
Outline the key principles that underpin the procedure.

5. **Procedure / Process**
Outline the procedure in sufficient detail for staff to follow.
Include flowcharts where applicable.

6. **Duties**
Outline key duties of staff who will be using the procedure.

7. **Dissemination and implementation arrangements**
Identify how the implementation and effectiveness of the procedure will be monitored.

8. Training needs

Identify any training needs relevant to the procedure.

9. Process for monitoring compliance and effectiveness

This section should identify the arrangements for compliance and effectiveness, responsibility for conducting any audit, review or monitoring, the methodology to be used for audit, review or monitoring, its frequency, the process for reviewing the results and monitoring of key performance indicators.

10. Review and revision arrangements (to include document control and archiving)

This section should identify the arrangements for the review and revision of the procedure. If an update to a procedure has taken place it should describe the process undertaken.

11. References

This section should list any other documents referenced within the procedure.

12. Associated documents (if applicable)

Appendix A Equality Impact Assessment (EIA) (If applicable, not mandatory)
Appendix B Checklist for review and approval
Appendix C Version control sheet

Template Ei

Appendix A - Equality Impact Assessment (EIA)
If applicable, document author to consult the Equality and Involvement Team.

Document author to download the most up to date form from the Trust intranet (sharepoint).

Guidance
An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

EIA form
EIA Policy template July21 v2.doc (sharepoint.com)

Template Eii

Appendix B - Checklist for the review and approval of a procedure

To complete and attach to the document

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, procedure, protocol or standard?		
	Is it clear in the introduction whether this document replaces or supersedes a previous document?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Is the method described in brief?		
	Are people involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
	Is there evidence that a trauma-informed 'lens' has been applied? e.g. through use of language etc.		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		

	Are key references cited?		
	Are the references cited in full?		
	Are supporting documents referenced?		
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint People Directorate Human Resources/staff side committee (or equivalent) approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8.	**Document Control**		
	Does the document identify where it will be held?		
	Have archiving arrangements for superseded documents been addressed?		
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?		
	Is there a plan to review or audit compliance with the document?		
10.	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so is it acceptable?		
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?		

Template Eiii

Appendix C - Version control sheet for a document

This control sheet should provide a history of previous versions of the procedure and changes made

Version	Date	Author	Status	Comment / changes

Appendix F

PROFORMA FOR APPROVAL OF POLICIES BY THE EXECUTIVE MANAGEMENT TEAM (EMT)

This form should be completed to support submission of policies for approval to EMT.

Policy name and reference number	
EMT date *(Corporate Governance Officer to complete)*	
Review deadline *(month/year)*	
Proposed date of next review *(month/year)*	
Purpose of the policy	
Note what has changed and why *(highlight any changes in the policy document)*	
Policy / policies it replaces or updates, if any *(please state version)*	
Confirm that the policy has been developed / updated in accordance with the 'Policy for the development, approval and dissemination of policy and procedural documents' (Policy on Policies).	
Provide evidence of consultation with appropriate stakeholders - (who, how and when). For clinical documents this must include the Clinical Policies and Procedures Group. For corporate documents this must include the Corporate Policy, Procedure and Risk Group.	

Provide the <u>date</u> that the Equality Impact Assessment (EIA) was completed / updated in consultation with an Equality and Involvement Manager.	
Identify any risks:	
Note any implications for: • **Finance** • **Governance** • **Training** • **Other**	

Appendix G

PROFORMA FOR EXTENSION OF POLICIES BY THE EXECUTIVE MANAGEMENT TEAM (EMT)

This form should be completed to support submission of policies for extension to EMT.

Policy name and reference number	
EMT date *(Corporate Governance Officer to complete)*	
Review deadline *(month/year)*	
Length of extension required	
Purpose of the Policy	
Details of any previous extension requests	
Reason for extension	
Identify any risks (including safeguarding children and adult)	
How will the risk be managed	

Appendix H

PROFORMA FOR APPROVAL OF CHANGING A POLICY TO A PROCEDURE BY THE EXECUTIVE MANAGEMENT TEAM (EMT)

This form should be completed by the policy lead.

Policy name and reference number	
EMT date *(Corporate Governance Officer to complete)*	
Purpose of the Policy	
Reason for changing a policy to a procedure	
Confirm that the policy Lead Director has been consulted (Name of Lead Director and date consulted)	
Identify any risks (including safeguarding children and adult)	
How will the risk be managed	

Appendix I

Acronym buster

Text	Acronym
Executive Management Team	EMT
Care Groups	CGs
Trust Action Groups	TAGs
Equality Impact Assessment	EIA
Operational Management Group	OMG
Quality Improvement & Assurance Team	QIAT
Care Quality Commission	CQC

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 April 2023
Agenda item 13.3

Private/Public paper:	**Public**		
Title:	**Standards of Conduct in Public Service Policy (conflicts of interest)**		
Paper presented by:	**Adrian Snarr - Director of Finance, Estates and Resources**		
Paper prepared by:	**Organisation Development and Wellbeing Lead**		
Mission/values:	The NHS as a whole spends a large amount of public money and therefore it is vital that this is done in the best interest of the population served. The Trust's Standards of Conduct in Public Service Policy, which is supported by NHS England's guidance, is designed to ensure that all staff are clear about the importance that decisions are seen to be arrived at without undue influence. This policy supports all the Trust's values but in particular the commitment to be honest, open and transparent.		
Purpose:	To inform the Trust Board of updates to the Trust's standards of conduct in public service policy and to gain approval for it.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	N/A		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The standard of business conduct policy is designed to ensure that all staff are clear about the importance that decisions are seen to be arrived at without undue influence, and supports the Trusts values of being honest, open and transparent.		
Any background papers / previously considered by:	Update to the previous Standards of Business Conduct policy which forms part of all staff contracts of employment. The update was reviewed by the Executive Management Team on 12 January 2023.		
Executive summary:	The Trust's Standards of Conduct in Public Service Policy sets outs clear expectations and responsibilities of staff whilst at work and in summary these are: Staff of the Trust are expected to:		

	• Ensure that the interest of patients remains paramount at all times. • Be impartial and honest in the conduct of their official business. • Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money. Staff have a responsibility not to: • Abuse their official position for personal gain or to benefit their family or friends. • Accept bribes. • Seek to advantage or further private business or other interests, in the course of their official duties. NHS England guidance on managing conflict of interests: • Introduced common principles and rules for managing conflicts of interest. • Provided simple advice to staff and organisations about what to do in common situations. • Supported good judgement about how interests should be approached and managed. A full review of the policy has taken place and includes the following changes after review by the Counter Fraud Specialist: • Minor updates following name change to Counter Fraud, Bribery and Corruption Policy • Clarification of referral process for suspected fraud • Changes to NHS Protect, to NHS Counter Fraud Authority • Removal of reference to NHS Improvement • Update reference to Data Protection Act 1998 to 2018. The updated policy is recommended to Trust Board for approval by EMT.
Recommendation:	**Trust Board is asked to APPROVE the updated to the policy.**

South West Yorkshire Partnership NHS Foundation Trust

Document name:	Standards of Conduct in Public Service Policy (including managing conflicts of interest)
Document type:	Policy
What does this Policy replace?	Update of previous version
Staff group to whom it applies:	All staff
Distribution:	Trust Wide
How to access:	Intranet
Issue date:	Version 6 January 2023
Next review:	January 2026
Approved by:	EMT on 12 January 2023
Developed by:	HR Business Manager Deputy Director of Finance Corporate Governance Manager
Director leads:	Director of Finance and Resources Chief People Officer
Contact for advice:	Corporate Governance Team

Contents

1 Policy Summary

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our service users / patients for the decisions we take.

As a member of staff you should…	As an organisation we will…

• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf.
 	
• Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent.
 	
• Regularly consider what interests you have and declare these as they arise. If in doubt, declare.
 	
• **NOT** misuse your position to further your own interests or those close to you.
 	
• **NOT** be influenced, or give the impression that you have been influenced by outside interests.
 	
• **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money.
	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do.
	
	• Identify a team or individual with responsibility for:
	  ○ Keeping this policy under review to ensure they are in line with the guidance.
	  ○ Providing advice, training and support for staff on how interests should be managed.
	  ○ Maintaining register(s) of interests.
	  ○ Auditing this policy and its associated processes and procedures at least once every three years.
	
	• **NOT** avoid managing conflicts of interest.
	
	• **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

2 Introduction

South West Yorkshire Partnership NHS Foundation Trust (the 'Trust'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our service users / patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise. (See Section 4 for the definition of conflict of interests)

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As a Trust and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

In terms of standards of integrity the Trust, and this policy, follow the Nolan principles of public office.

- Selflessness – act solely in terms of the public interest.
- Integrity – avoid placing in situations where decisions could be inappropriately influenced.
- Objectivity – make decisions impartially, fairly and using the best evidence without discrimination or bias.
- Accountability – be open to public scrutiny.
- Openness – decisions taken in an open and transparent manner.
- Honesty.
- Leadership – everyone should exhibit these principles in their own behaviour, promote and support the principle and challenge poor behaviour wherever it occurs.

This policy replaces Standards of Conduct in Public Service Policy (October 2017). The structure follows the national model policy and incorporates Trust specific elements. All staff (See section 6) must follow the principles set out in the policy.

All staff are responsible for ensuring that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

3 Purpose

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules.
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests.

The core principles underpinned by this policy include that staff are expected to:

- Ensure the interest of patients remains paramount at all times.
- Be impartial and honest in the conduct of their official business.
- Use public funds entrusted to them to the best advantage of the services, always ensuring value for money.

It is the responsibility of staff to ensure that they do NOT:

- Abuse their official position for personal gain or to benefit their family or friends.
- Accept bribes.
- Seek to advantage or further private business or other interests in the course of their official duties.

This policy should be considered alongside these other Trust policies:

- Standing Financial Instructions (SFIs).
- Counter-Fraud, Bribery and Corruption Policy.
- Whistleblowing Policy.

4 Key terms

A ‘conflict of interest’ is:

> “A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.”

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests.
- Potential – there is the possibility of a material conflict between one or more interests in the future.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

5 Interests

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.

- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- **Indirect interests:**
  Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

6 Staff

At the Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees.
- All prospective employees – who are part-way through recruitment.
- Non-Executive Directors.
- Bank staff.
- Contractors and sub-contractors.
- Agency staff.
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the Trust).
- Volunteers.
- Governors (Governors are also required to sign the 'code of conduct for governors' on appointment to the Members' Council which requires all governors to adhere to Trust policies and procedures).

[1] This may be a financial gain, or avoidance of a loss.
[2] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

This policy applies to all staff, and it is the responsibility of all staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. Staff need to be aware that it is both a serious criminal offence (Bribery Act 2010, the Theft Act 1968 and the Fraud Act 2006) and disciplinary matter to corruptly receive or give any fee, loan, gift, reward or other advantage in return for doing (or not doing) anything or showing favour (or disfavour) to any person or organisation.

It is the responsibility of managers within the Trust to ensure that the policy is brought to the attention of all staff.

Staff need to ensure that they consider any potential conflict of interests arising from the development of the Integrated Care Systems and the different organisations which operate within them. In each case the policies and procedures of the host organisation will take precedent, but declarations should be made to all parties.

Staff on secondment will also need to comply with the policy of their host organisation and make declarations to both the Trust and their host organisation.

7 Decision Making Staff

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'

Decision making staff in this Trust are:

- Trust Directors.
- Trust Board members.
- Senior Managers with responsibility for commissioning of services and /or the purchasing of goods and services.

The Trust is required to publish declarations of interest for decision making staff annually. This report is available on the Trust website:

https://www.southwestyorkshire.nhs.uk/contact-us/freedom-of-information/registers-and-documents/

Note, there are separate Declaration of Interest policies for the Trust Directors, Trust Board members, and governors of the Members' Council.

8 Identification, declaration and review of interests

8.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the Trust.
- When staff move to a new role, or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

A declaration of interest(s) form is available at Appendix D.

Declarations should be made to the Trust Company Secretary.

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

8.2 Proactive review of interests

We will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return.

9 Records and publication

9.1 Maintenance

The Trust will maintain a single Register of Interest.

All declared interests will be promptly transferred to the register by the Company Secretary, at least monthly.

9.2 Wider transparency initiatives

The Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These “transfers of value” include payments relating to:

- Speaking at and chairing meetings.
- Training services.
- Advisory board meetings.
- Fees and expenses paid to healthcare professionals.
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK.
- Donations, grants and benefits in kind provided to healthcare organisations.

Further information about the scheme can be found on the ABPI website:

http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

10 Management of interests – general

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making.
- removing staff from the whole decision making process.
- removing staff responsibility for an entire area of work.
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

11 Management of interests – common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

11.1 Gifts

- Staff should not accept gifts. These should be politely but firmly declined.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be politely but firmly declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6[3] in total and need not be declared.
- If gifts of low value are received by a team e.g., chocolates, these should be distributed equally. The Trust and its staff must not promote a business/company in any way. Refer to the Trust's guidance on social media if required Use social media (sharepoint.com).

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts of a low intrinsic value such as chocolates or flowers can be accepted but must be declared.
- If a gift is accepted a Declaration of Interest form (Appendix D) should be completed.
- Any gift accepted should be accepted on behalf of the Trust and other related Charities.

[3] The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

11.1.1 What should be declared

- Staff name and their role with the Trust.
- A description of the nature and value of the gift, including its source.
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.2 Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason, and it is proportionate to the nature and purpose of the event. (It would be normal and reasonable for hospitality to be provided).
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval, by a General Manager or equivalent, must be obtained.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75[4] - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the Trust's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest or are of a type that the Trust itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the Trust's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  - offers of business class or first class travel and accommodation (including domestic travel).
  - offers of foreign travel and accommodation.

11.2.1 What should be declared

- Staff name and their role with the Trust.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

[4] The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

11.3 Outside Employment

Employees of the Trust are advised not to engage in outside employment, which may conflict with their NHS work, or be detrimental to it.

Outside employment could include working in a private clinic / hospital, registered nursing or residential care home. Other areas may include consultancy work, or involvement in running of a voluntary sector organisation (even in a voluntary capacity).

- Staff must declare any existing outside employment on appointment and any new outside employment when it arises.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff are required to seek prior approval from the Trust to engage in outside employment.

11.3.1 What should be declared

- Staff name and their role with the Trust.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.4 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the Trust.
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

11.4.1 What should be declared

- Staff name and their role with the Trust.
- Nature of the shareholdings / other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the Trust.
- Staff should seek prior permission from the Trust before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the Trust's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

11.5.1 What should be declared

- Staff name and their role with the Trust.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their Trust does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

11.6.1 What should be declared

- Staff name and their role with the Trust.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.7 Donations

- Donations made by suppliers or bodies seeking to do business with the Trust should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear

reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the Trust or is being pursued on behalf of the Trust's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the Trust if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the Trust's own. Approval must be received from the Director of Finance and the Director of Human Resources.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

11.7.1 What should be declared

- The Trust will maintain records in line with the above principles and rules and relevant obligations under charity law.

11.8 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in a clear benefit to the organisations and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the Trust's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the Trust involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the Trust through the Declaration of Interest form.

11.8.1 What should be declared

- The Trust will maintain records regarding sponsored events in line with the above principles and rules. This must include:
    - Purpose of Sponsorship.
    - Names of companies involved.
    - Sponsorship value.

11.9 Sponsored research

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the Trust, and / or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the Trust through the Declaration of Interest form.

11.9.1 What should be declared

- The Trust will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
    - Their name and their role with the Trust.
    - Nature of their involvement in the sponsored research.
    - Relevant dates.
    - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.10 Sponsored posts

- External sponsorship of a post requires prior approval from the Trust.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

11.10.1 What should be declared

- The Trust will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

11.11 Clinical private practice

Clinical staff should declare all private practice on appointment, and / or any new private practice when it arises[5] including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions / time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their Trust before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[6]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

11.11.1 What should be declared

- Staff name and their role with the Trust.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

12 Management of interests – advice in specific contexts

12.1 Strategic decision making groups

In common with other NHS bodies the Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

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[5] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

[6] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the Trust's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute Counter-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the Trust should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

By participating in tendering exercises prospective suppliers should also be in agreement with, and adhere to, the Trust's Supplier Code of Conduct. A copy of which is included within the tender documentation. Any supplier not wishing to comply with this term should provide details of their objections which will be duly noted and considered within the contract award process.

13 Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

13.1 Identifying and reporting breaches

In cases of suspected fraud, bribery or corruption, concerns must only be reported to the Trust's Local Counter Fraud Specialist or the Director of Finance.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the Trust's Whistleblowing Policy available on the Intranet document store: (http://nww.swyt.nhs.uk/docs/Documents/Forms/AZ.aspx)

The organisation will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so what severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

13.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR / employment law / contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England, or the CQC), and / or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
  - Informal action (such as reprimand or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

13.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Trust Executive Management Team (EMT) and reported, at least annually, to the Trust Audit Committee.

14 Bribery

Bribery is defined as “an inducement or reward offered, promised or provided to gain personal, commercial, regulatory or contractual advantage”. Bribery can also be described as corruption, the offering or acceptance of inducements, gifts, favours, payment or benefit-in-kind which may influence the action of a person.

All employees have a personal responsibility to protect the Trust from bribery and corruption and not engage in any form of bribery, in the UK or abroad.

Please refer to the Trust’s Counter-Fraud, Bribery and Corruption Policy.

15 Counter Fraud measures

As noted in section 3, staff are expected not to use their position to gain advantage. The organisation will take all steps necessary to prevent fraud and encourages staff with concerns or reasonably held suspicions about potentially fraudulent activity or practice, to report these. In accordance with the Trust’s Counter-Fraud, Bribery and Corruption Policy and also the Trust’s Whistleblowing Policy, staff should inform the nominated Local Counter Fraud Specialist (LCFS) or the Trust’s Director of Finance, unless the Director of Finance or LCFS is implicated. If that is the case, they should report it to the Chair, Chief Executive or Chair of the Audit committee, who will decide on the action to be taken.

Employees can also call the NHS Fraud and Corruption Reporting Line on free phone 0800 028 40 60. This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt

with by experienced trained staff and any caller who wishes to remain anonymous may do so.

16 Review

This policy will be reviewed bi-annually unless an earlier review is required. This will be led by the Company Secretary/Deputy Director of Governance supported by the People Directorate and Finance.

17 Associated documentation

Trust's Counter-Fraud, Bribery and Corruption Policy
Bribery Act 2010
Theft Act 1968
Fraud Act 2006
Freedom of Information Act 2000
ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
ABHI Code of Business Practice
NHS Code of Conduct and Accountability (July 2004)

Equality Impact Assessment

Date of EIA: 16th June 2022
Review Date: October 2025
Completed By: HR Business Manager

	QUESTIONS	ANSWERS AND ACTIONS
1	**What is being assessed?** Prompt: what is the function of this document (new or revised)	Standards of Conduct in Public Service Policy
2	**Description of the document** Prompt: What is the aim of this document	To ensure that employees adhere to the expected standards of business conduct required of NHS staff and that there is an appropriate means of declaring legitimate interests.
3	**Lead contact person for the Equality Impact Assessment**	Ashley Hambling, HR Business Manager
4	**Who else is involved in undertaking this Equality Impact Assessment**	**Deputy Director of Finance** **HR Business Manager** **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?**	**The Trusts Equality Workforce Monitoring Annual Report 2021.** Workforce equality information - South West Yorkshire Partnership NHS Foundation Trust
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	Whilst this policy is applicable to all Trust staff, we need to make sure this is easily accessible, available and understandable to all staff including those with long term conditions/disabilities. Advice is available to staff from line managers as well as the support service colleagues. The 2022 workforce equality monitoring report states 8.4% of Trust report as disabled.

	QUESTIONS	ANSWERS AND ACTIONS
5b	**Gender:** Prompt: Female & Male issues should be considered	This policy is applicable to all staff, no issues identified. The Trust split of female to male employees is approx. 80/20 79% female to 21% male.
5c	**Age:** Prompt: Older people & Young People issues should be considered	This policy is applicable to all staff, no issues identified. We would need to ensure that any colleagues are not subject to bribery with the purpose of sexual exploitation. Bribery is covered in section 14 of the Policy. The equality workforce monitoring report 2022 provides the age range of staff within Trust. As in previous years the highest number of Trust staff fall in the age bands 40-49 and 50-59 with 52.7% of the total staff being between 40 and 59.
5d	**Sexual Orientation:** Prompt: Heterosexual, Bisexual, Gay, Lesbian groups are included in this Category	This policy is applicable to all staff, no issues identified. The equality workforce monitoring report 2022 provides the sexual orientation of Trust staff which is 83% heterosexual, 2.4% gay/lesbian, 1.2% bisexual and 13.6% unknown.
5e	**Religion & Belief:** Prompt: Main faith groups and people with no belief or philosophical belief issues should be considered	This policy is applicable to all staff, no issues identified. The equality monitoring report 2022 states staff reported as 46.9% Christianity, 3.7% Islam, 11.9% other and 19.6% Atheism.
5f	**Marriage and Civil Partnership** Prompt: Single, Married, Co-habiting, Widowed, Civil Partnership status are included in this category	This policy is applicable to all staff, no issues identified. The equality workforce monitoring report 2022 provides the marital status of Trust staff which is 1.2% civil partnership, divorced/legally separated 9.6%, married 50.1%, single 37.4%, widowed 0.9%, and unknown 0.8%.
5g	**Pregnancy and Maternity** Prompt: Currently pregnant or have been pregnant in the last 12 months should be considered	This policy is applicable to all staff, no issues identified.
5h	**Gender Re-assignment** Prompt: Transgender issues should be considered	This policy is applicable to all staff, no issues identified.
5l	**Carers** Prompt: Caring responsibilities paid or unpaid, hours this is done should be considered	This policy is applicable to all staff, no issues identified.
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.)	This policy is applicable to all staff, no issues identified. The equality workforce monitoring report 2022 provides the ethnicity of Trust staff. Asian 5.1%, Black 3.5%, Chinese or Other 1.2%, Mixed 1.4%, White 88.7%, unknown 0.2%.

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.

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	X	Review any declaration of interests received to see if they are being received by certain demographic groups. Consider any potential impacts on these groups.	Ashley Hambling Andy Lister Rob Adamson	October 2023.		
Disability	X					
Gender reassignment	X					
Marriage and civil partnership	X					
Race	X					
Religion or belief	X					
Sex	X					
Sexual Orientation	X					
Pregnancy maternity	X					
Carers	X					

Who will benefit from this action? (tick all that apply)		Action 2: This is what we are going to do	Lead/s	By when	Update -outcome	RAG
Age		Review any data for staff from protected groups that have been subject to breach of the policy and have undergone a disciplinary process this policy.	Ashley Hambling Andy Lister Rob Adamson	October 2023		
Disability						
Gender reassignment						
Marriage and civil partnership						
Race						
Religion or belief						
Sex						
Sexual Orientation						
Pregnancy maternity						
Carers						

Grading EIA assessment by equality and involvement manager

Name: Aboobaker Bhana

Date: 11/07/22

Rating: *Developing*

EIAs are now reviewed using a grading approach which is in line with our Equality Delivery System (EDS). The team have reviewed and rated the EIA using the following:

- **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

Comments:

No examples in the involvement section
No examples of past learning shared
The new census demographic data needs to be added as soon as available in the Autumn of 2022 in the action plan

6. Involvement & Insight: New or Previous (please include any evidence of activity undertaken in the box below)

Review of interest declarations made.

7 Methods of Monitoring progress on Actions Review in Corporate Governance and Risk Group.
8 **Publishing the Equality Impact Assessment**
9 Signing off Equality Impact Assessment:    Greg Moores, Chief People Officer Date: 27 September 2022

Once approved, you must forward a copy of this Assessment/Action Plan by email to:
InvolvingPeople@swyt.nhs.uk

Please note that the EIA is a public document and will be published on the web.

Failing to complete an EIA could expose the Trust to future legal challenge.

Appendix B - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	Clear policy which enables management and staff to make correct decisions, deal effectively and comply with legislation, Trust processes and good working practices.
	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?	No	
	Are people involved in the development identified?	Yes	Utilise national policy framework but HR, finance and governance involved prior to Staff side and Members review
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	Applies to all staff
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Are supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes	Will be subject to discussion and agreement with staff side
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 C - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1.0	Aug 03	James Corson	Superseded	
2.0	May 12	James Corson	Superseded	An extensive rewrite and change of title. It incorporates elements of the Barnsley PCT policy and reference to the Bribery Act and the revised CIPS professional Code. It also now makes reference to the Code of conduct for NHS Managers. This single procedure now replaces all the previous disciplinary documents for the forerunner organisations: Barnsley, Calderdale and Wakefield PCT's
2.0a	Apr 13	James Corson	Superseded	Links embedded in the document updated
2.0b	Dec 13	James Corson	Superseded	Addition of further information on Fraud/bribery/corruption following a Focussed Quality Assessment
2.0c	Feb 15	James Corson	Superseded	Further clarification of when staff can engage in outside employment. See para 5.8
3	3/10/17	HR Business Manager / Deputy Director of Finance	Superseded	Updated in accordance with national guidance.
	25/07/18	Company Secretary	Superseded	Reference added to bribery and counter fraud.
4	Sept 19	Company Secretary Deputy Director of Finance HR Business Manager	Superseded	Minor updating. Reference to staff working across Integrated Care Systems/secondments.
5.	May 2022	Corporate Governance Manager, Deputy Director of Finance, HR Business Manager	Current	Minor updating

South West Yorkshire Partnership NHS Foundation Trust

Appendix D - Declaration Form

IN STRICT CONFIDENCE - INTERESTS DECLARATION FORM		
Name and Base		
Job Title		
Description of Interest		
Relevant dates	From:	To:
The information submitted will be held by South West Yorkshire NHS Foundation Trust ('the Trust') for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that South West Yorkshire NHS Foundation Trust holds. I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to South West Yorkshire NHS Foundation Trust as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result. I **do / do not** give my consent for this information to published on registers that South West Yorkshire NHS Foundation Trust holds. If consent is not given please give reasons.		
Signed:	**Date:**	
Comments of Line Manager and/or Head of Service (as appropriate)		
Signed:	**Date:**	
Action required, if any:		
• **Copy to Personal File**	• **Original to Register of Interests File**	

PLEASE RETURN THIS FORM TO: Company Secretary, Block 8, Fieldhead, Wakefield

GUIDANCE NOTES FOR COMPLETION OF INTERESTS DECLARATION FORM

Name and Base	Insert your name and location
Job Title	Insert your position/role in relation to the Trust
Description of Interest:	Provide a description of the interest that is being declared. This should contain enough information to be meaningful (e.g., detailing the supplier of any gifts, hospitality, sponsorship, etc.) That is, the information provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest. Types of interest: **Financial interests** - This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making **Non-financial professional interests** - This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career **Non-financial personal interests** - This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career **Indirect interests** - This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making. A benefit may arise from both a gain or avoidance of a loss. Further comments: Detail any action taken to manage an actual or potential conflict of interest. It might also detail any approvals or permissions to adopt certain course of action.
Relevant Dates:	Detail here when the interest arose and, if relevant, when it ceased.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2023-24

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✘	Item deferred

Note that some items may be verbal

Agenda item / issue	25 Apr	30 May	27 June	25 July	22 Aug	26 Sept	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	26 Mar
Standing Items												
Welcome, Introduction and Apologies	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Declarations of Interest	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Minutes from the previous meeting	✘		✘	✘		✘	✘	✘		✘		✘
Action log and matters arising from previous meeting	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Service User/Staff Member/Carer Story	✘		✘	✘		✘	✘	✘		✘		✘
Chair's remarks	✘		✘	✘		✘	✘	✘		✘		✘

Agenda item / issue	25 Apr	30 May	27 June	25 July	22 Aug	26 Sept	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	26 Mar
Chief Executive's Report	✘		✘	✘		✘	✘	✘		✘		✘
Questions from the public (item 3)	✘		✘	✘		✘	✘	✘		✘		✘
Any other business (public and private)	✘		✘	✘		✘	✘	✘		✘		✘
Risk and Assurance												
Board Assurance Framework	✘			✘			✘			✘		
Corporate / organisational risk register	✘			✘			✘			✘		
Strategic overview of business and associated risk											✘	✘
Review of Risk Appetite statement							✘					
Complex Incidents update (private session)	✘		✘	✘		✘	✘	✘		✘		✘
Serious Incidents quarterly report (public)			✘			✘		✘				✘
Risk assessment of performance targets, CQUINS and System Oversight Framework and agreement of KPIs (when published)			✘									
Assurance from Trust Board committees and Members' Council	✘		✘	✘		✘	✘	✘		✘		✘
Guardian of safe working hours annual report			✘									
Workforce Equality Standards						✘						
Medical appraisal / revalidation annual report						✘						
Ligature Annual Report								✘				
Freedom to Speak Up Annual report (July Annual report and January 6 monthly update)				✘						✘		
Medical Education Annual Board report								✘				

Agenda item / issue	25 Apr	30 May	27 June	25 July	22 Aug	26 Sept	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	26 Mar
Data Security and Protection toolkit	✘ (update)		✘									
Annual report and accounts (including Quality Account for 2022)		✘										
Annual Governance Statement	✘											
Equality and diversity annual report							✘					
Serious incidents annual report			✘									
Health and safety annual report			✘									
Patient Experience annual report			✘									
Sustainability annual report						✘						
Premises Assurance Model (new annual report 2021)			✘									
EPRR Compliance report						✘						
IPC BAF												✘
Integrated Care Systems and Partnerships												
South Yorkshire update including the South Yorkshire Integrated Care System (SY ICS)	✘		✘	✘		✘	✘	✘		✘		✘
West Yorkshire update including the West Yorkshire & Health & Care Partnership (WYHCP)	✘		✘	✘		✘	✘	✘		✘		✘
Provider Collaboratives and Alliances	✘		✘	✘		✘	✘	✘		✘		✘
Performance reports												
Integrated Performance Report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
Safer Staffing report	✘							✘				
System Oversight Framework (when released)			✘									

Agenda item / issue	25 Apr	30 May	27 June	25 July	22 Aug	26 Sept	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	26 Mar
Service Line Performance report (private – under review)	✘		✘	✘		✘	✘	✘		✘		✘
Strategic Direction												
Board Development		✘			✘				✘		✘	
Covid-19 Reflections		✘			✘				✘		✘	
Horizon Scanning – Focus On		✘			✘				✘		✘	
Investment Appraisal Framework (private)	✘						✘					
Strategic Objectives												✘
Trust Board Annual Work Programme											✘ (draft)	✘
Operational Plan (private)										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
Five-year plan (for review November 2023)								✘				
Governance												
Constitution (including Standing Orders) and Scheme of Delegation (if required)							✘					
Compliance with NHS provider licence conditions and code of governance (now changed due to new corporate governance code – to be confirmed)												
Going Concern Statement	✘											
Assessment against NHS Constitution				✘								
Audit Committee annual report including committee annual reports and terms of reference	✘											
Use of Trust Seal			✘			✘		✘				✘
Strategies and Policies												
Digital strategy (including IMT) **update**							✘					

Agenda item / issue	25 Apr	30 May	27 June	25 July	22 Aug	26 Sept	31 Oct	28 Nov	19 Dec	30 Jan	27 Feb	26 Mar
Estates strategy **update**										✘		
Policy on Policies *(April 2023)*	✘											
Standards of Conduct in Public Service Policy (conflicts of interest)	✘											
Customer Services policy *(June 2023)*			✘									
Equality, Involvement, Communication and Membership Strategy *(October 2023)*							✘					
Estates strategy (full)				✘								
Learning from Healthcare Deaths Policy *(January 2024)*										✘		
Workforce strategy *(March 2024)*												✘
Digital Strategy (full) *(March 2024)*												✘
Trust Board declaration and register of fit and proper persons, interests and independence policy *(March 2024)*												✘

Policy / strategy review dates:

- Trust Strategy *(reviewed as required)*
- Standing Financial Instructions *(delegated approval authority to Audit Committee, reviewed as required)*
- Treasury management strategy and policy (delegated approval authority to Audit Committee, reviewed as required)
- Constitution (October 2023) (if required)
- Equality, Involvement, Communication and Membership Strategy (October 2023)
- Emergency Preparedness Resilience and Response Policy (November 2025)
- Customer Services Policy *(to be confirmed)*
- Digital Strategy *(next due for review in March 2024)*
- Estates Strategy *(July 2023)*
- Learning from Healthcare Deaths Policy *(next due for review in January 2024)*
- Organisational Development Strategy *(deferred)*
- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(April 2023)*
- Procurement Strategy
- Quality Strategy *(March 2026)*

- Risk management governance framework *(next due for review in April 2025)*
- Standards of Conduct in Public Service Policy (conflicts of interest) *(next due for review in September 2025)*
- Sustainability and Social Responsibility Strategy *(July 2025)*
- Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in March 2024)*
- Workforce Strategy *(next due for review in March 2024)*
- Research and Development Strategy *(October 2025)*