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

With **all of us** in mind.

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 Trusts services are not designated within the commissioning contracts as CRS.
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 with NHSE.	The Trust submits monthly financial returns in line with all NHS providers. Given our good underlying 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	The Trust has sound and robust processes and systems in place to ensure it has the resources

Condition	Provision	Comments
	services (CRS).	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 27 June 2023

Corporate Governance Statement 2022/23

1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.
The Trust continues to implement, develop and improve its arrangements to ensure it meets the principles and standards of good corporate governance and to ensure it has the systems and processes in place to meet these as well as its statutory, legal and regulatory duties and requirements. As part of this continuous improvement process, Trust Board undertook a well-led governance review during 2015, which has been followed up by CQC well led reviews in each of 2017, 2018 and 2019. In 2022/23 the Trust commissioned an independent desktop well led review from Aqua to support a review of where it is currently performing in terms of "good" corporate governance, against the CQC well led assessment process. Overall, the report was positive, there was a small number of minor actions that have been completed, other recommendations were developmental in nature against the well led framework. The most recent CQC well led review (2019) provided a rating of **good**. Review and scrutiny of the Trust's governance arrangements took place as part of the well-led review, which included interviews with the Trust Board and staff. The review concluded that the Trust Board and leadership team had the appropriate range of skills, knowledge, and experience, and showed integrity on an ongoing basis. The report also highlighted that there was a robust and realistic strategy for achieving Trust priorities and effective internal governance structures, systems and processes in place to support delivery of the strategy. The 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. Overall, we are now 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.

However, the CQC did identify areas for improvement. Therefore, 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 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.

CQC inspection 2019: update 2022-23

Following the May-June 2019 core service visits and well-led review, the CQC issued the Trust with **12 MUST do and 37 SHOULD** do actions. These included 1 MUST do and 8 SHOULD do Trust wide actions.

12 of our 14 core services were rated as 'good.' Our overall rating changed to 'Good.' Our wards for adults of working age and PICU, and our specialist community services for children and young people (CAMHS) received a rating of 'requires improvement.'

To address these concerns The Trust developed an improvement plan. The plan was initially due to be complete in June 2020, however, due to the Covid-19 pandemic some elements of the plan, i.e. actions related to risk assessment and care planning, and suitable psychology provision on our older peoples' wards, were delayed. All other elements of the plan were completed.

In May 2023/24 the Trusts inpatient services were inspected by the CQC. The initial outcome letters were in public to Trust Board on 27 June 2023. On receipt of the full CQC report the Trust will continue to work with the CQC to respond to their report and formulate action plans to deal with any outcomes.

In 2022-23Clinical Governance Clinical Safety committee (CGCSC)

The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board on service quality and the application of controls and assurances in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice. The Committee met ten times in 2022/23. The Committee has terms of reference and is required to produce an annual report outlining achievements against objectives and compliance with the terms of reference. The annual report, work programme and updated terms of reference for the CGCSC were provided to the Audit Committee to provide assurance to Trust Board.

Quality initiatives in 2022/23

The quality initiatives prioritised for action in 2022/23 as part of the quality account process were as follows:

Patient Safety

Throughout 2022/23, we have continued to make good progress with our patient safety strategy work in line with national priorities and developments. We have:

- Reviewed our internal patient safety strategy and agreed that our ambitions remained current as it is structured around the NHS Patient Safety Strategy and reflects the ongoing national workstreams (described below). We will review our strategy at the end of 2023/24 to consider future arrangements in line with NHS Patient Safety Strategy developments
- Our patient safety specialists have joined a number of developing patient safety networks at all our places and with Integrated Care Boards (ICBs) and provider collaboratives colleagues along with regional and national level networks to support the patient safety priorities. Some key areas of work are outlined below:

Suicide prevention

- In 2022/23 we launched our suicide prevention strategy
- Relaunched the delivery of suicide alertness and suicide interventions training
- Commissioned additional professional training in the form of collaborative assessment and management of suicidality training for senior practitioners actively working with individuals where suicide is identified as a risk
- Continued promotion and awareness raising of basic suicide prevention training for all staff employed irrespective of professional qualification

Electronic prescribing medication administration (EPMA) roll-out

- The rollout included all 29 Mental Health Inpatient wards (444 beds) covering all localities. The initial go-lives took place in the first quarter of 2021 and, following a pause, concluded between February 2022 and March 2023.
- It has been a true multidisciplinary and multi-professional project from the start involving clinical and IM&T colleagues, from design to implementation to evaluation.
- A broad range of benefits were identified which are linked with the Trust's values, strategic objectives and priorities. A full project evaluation and benefits realisation is underway. However, some immediate benefits have been realised including:
  - Legible and complete prescriptions
  - Improved medicine administration (timely and appropriate)

- Reduced medication incidents reported
- Providing a single and comprehensive view of a service user's current and historical medication
- Ability to view a service user's medication wherever a clinician or service user may be located

Clinical record keeping

- Following the CQC inspection 2019 where care plans and risk assessments were highlighted as requiring improvement to meet the expected standards of care, there has been an ongoing effort to improve. There have been internal and external factors which have impacted on the delivery of this work and therefore the work undertaken has not had the desired impact on improvement. Since the last quality account there has been a concerted focus on this priority piece of work adopting partnership approach to quality improvement methodology.
- There is a care plan and risk assessment improvement group which has been facilitated in partnership between the nursing, quality and professions directorate and the integrated change team. This approach has created an improvement group with high levels of engagement, motivation for change and commitment to delivery.

- The group meet every three weeks and work to date has included:
  - A deep dive into the problems/challenges and the development of a problem statement
  - The development of a driver diagram and change ideas identified to date
  - Initial 'quick win' changes to be implemented to improve data recording and reporting
  - A plan for task and finish groups to lead the work going forward
  - A look and see approach in clinical settings
  - Specific focus groups/targeted conversations
  - Keeping it on the agenda in meetings and forums to continue engagement and involvement at every level
  - A solution focused approach to the leadership style

Regular clinical record keeping audits, with improvement plans in response owned by CGs.

In addition, these actions are being monitored and mitigated by:

- Strategic, Trustwide improvement projects
- Local quality improvement projects and initiatives
- Local governance arrangements (ward manager and matron checks)

- Support from corporate services
- Clinical record keeping audits
- Quality monitoring visits
- Clinical audit
- Patient experience triangulation (surveys, complaints, staff surveys etc.)
- Ongoing dialogue with the CQC – being open, honest and transparent.

Overall, we are now 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.

Risks

The Trust does not apply or applies inconsistently good corporate governance. Mitigated by robust scrutiny through the Trust's governance and assurance processes.

There are a number of areas to provide assurance that the Trust applies the principles, systems and standards of good corporate governance.

- The Trust's Constitution, based on Monitor's model constitution, underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust seeks external advice on any changes, and ensures amendments are approved in line with the process set out in the Constitution.
- A review of the Trust's Constitution was undertaken in year to ensure compliance with the new code of governance which came into effect on the 1 April 2023. It was approved by Trust Board 31 January 2023 and ratified by Members Council on 24 February 2023
- The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where you are referred between services, and to include you in the relevant discussions". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this inappropriate. The annual self-assessment will be presented to Trust Board in July 2023.
- Each committee of the Trust Board is required to prepare an annual report, which is presented to the Audit Committee. The Audit Committee reviews overall effectiveness of committee structure. This provides assurance to Trust Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in April.

- Each group and committee of the Members' Council is required to prepare an annual report and review of the terms of reference, which is reported to the Member's Council annually in April / May and provides assurance that each group / committee is meeting its terms of reference and work programme.
- The Trust undertakes an annual assessment of compliance against NHS Improvement / Monitor's Code of Governance (still in effect during 2022/23) which is reported to Trust Board.
- The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually and both Directors and Governors are proactively asked to update their declarations. Directors and Governors are expected to declare any additions or changes to their declarations. The Chair of the Trust reviews the declarations and considers whether there are any conflicts of interest presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration.
- From April 2015, members of Trust Board have also been asked to make a declaration that they meet the fit and proper person requirement introduced in response to a recommendation made in the Francis Report. All members of Trust Board have made such a declaration and the Trust undertakes appropriate enquiries to ensure that newly appointed Directors meet the requirements as well as seeking an individual declaration. All members of Trust Board and the Executive Management Team have disclosure and barring (DBS) checks in place.
- All elections made to the Members' Council are held in accordance with the Model Election Rules in the Trust's Constitution.
- Elections are overseen by an external organisation (currently Civica Election Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties.
- The Trust was awarded a Licence on 1 April 2011. The Trust ensures it meets the conditions of its Licence through a process of self-assessment. There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence.
- The most recent Care Quality Commission (CQC) rating overall is good (which includes a rating of good for the well-led domain). During 2022/23, the Board continued its development programme which included amongst other items equality, diversity and inclusivity training, understanding and measuring the value of a board, and system governance structures.
- A new Board development programme is now in development for 23/24.

An assessment by internal audit found the Trust's arrangements around the overarching governance and risk management arrangements provided significant assurance and the Head of Internal Audit Opinion is one of significant assurance on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The Board Assurance Framework and Organisational Risk Register with mitigating actions are reported to Trust Board on a quarterly basis set in the context of the Board's risk appetite statement.

Risk

The outcome of the inspection required some areas that require improvement. Mitigated by an action plan to address areas for improvement.

The 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.

The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2022/23.

There has not been a CQC inspection completed during 2022/23

Risk
The Trust does not comply with the requirements of its Licence. Mitigated by ongoing review of Trust compliance and reporting to Trust Board as part of the NHS Improvement / Monitor requirements.

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The following also provide assurance to Trust Board that the Trust has good corporate governance arrangements in place and complies with its Licence:

Examples of corporate governance audits undertaken 2022/23and their ratings are:

Data protection & Security Toolkit – substantial assurance
System/partnership working: place governance - assurance
Care group risk management Care group risk management - significant assurance

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.

- The Head of Internal Audit Opinion for 2022/23provides significant assurance on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

- As Accounting Officer, the Chief Executive prepares an Annual Governance Statement. This document describes the risk and assurance processes for the Trust and meets the requirements set out in NHS Improvement's Foundation Trust Annual Reporting Manual 2023. The Statement for 2022/23 was assessed as fit for purpose and meeting guidance as part of the audit of the Trust's annual report and accounts.
- The Trust's Board assurance framework and risk register have been assessed as appropriate as part of an internal audit of the risk and governance in 2022/23 which received significant assurance.
- The Trust Board reviews compliance with the NHS Constitution annually, and was last reviewed in February 2023
- The Constitution was updated in January 2023 to align to the NHS England Code of Governance for NHS Provider Trusts and was approved by Trust Board on 31 January 2023 and ratified by the Members Council on 24 February 2023
- The Trust Board receives annual self-certifications of compliance with the NHS Provider Licence (April) and corporate governance statement (June).

Risk

The Trust does not continue to have good corporate governance arrangements in place. Mitigated by submission of financial and performance metric data on a monthly basis, through ongoing review of internal governance processes and through internal audit processes.

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.

In addition to measuring performance against our quality priorities we monitor our performance against a range of other key performance indicators (KPIs). A number of these are reported to our Trust Board and others are reported and acted upon internally. A range of performance data is also shared with our commissioners.

During 2022/23 the impact of the Covid-19 pandemic meant that contractual arrangements and national priorities around reporting shifted. Despite this, the Trust continued to report and monitor its performance against our strategic objectives using metrics that were already in existence. Additional operational data was identified in 2020/21 to assist with monitoring the impact and effect of Covid-19. This continued to be reported on during 2022/23.

For 2022/23, the Trust identified those metrics that would best demonstrate performance against achievement of its agreed objectives. These are reported to the Trust Board as part of the Integrated Performance Report (IPR) every month. The KPIs represent a mix of nationally and locally set targets. A review of the integrated performance report content and format commended in year.

Trust Board receives an Integrated Performance Report (IPR) on a monthly basis. This enables Trust Board to satisfy itself that the Trust is meeting its financial and quality performance targets. Other reports to Trust Board and its committees provide further assurance that the Trust is fulfilling its purpose in an effective and efficient manner.

In addition, actions identified from each of the internal audits are allocated a lead within the organisation and tracked through an online web portal 'Pentana'. Progress updates and supporting information is be uploaded to the tracker which are reviewed by auditors and action leads, and once complete they are closed by the auditor. The audit actions are tracked through updates to the Audit Committee.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time-to-time.

Risk
Trust does not have regard to guidance. Mitigated by the Company Secretary having oversight of the systems and processes in place to ensure guidance is identified, captured, assessed and implemented.

The Accounting Officer, Deputy Director and Company Secretary ensure that Trust Board is made aware of guidance on good corporate governance from NHS Improvement, an assessment of the Trust's immediate position is undertaken and any action or development required to ensure compliance is initiated.

3. The Board is satisfied that the Trust implements:
- **a) effective board and committee structures**
- **b) clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees**
- **c) clear reporting lines and accountabilities throughout its organisation.**

Risk
The Trust does not have effective structures at Trust Board level. Mitigated by annual committee review process, independent review by internal audit of effectiveness, clear view of roles and responsibilities, and clear approach to leadership and management throughout the Trust.

Trust Board is clear that its role is to set the strategic direction and associated priorities for the organisation, ensure effective governance for all services and provide a focal point for public accountability. The general duty of Trust Board, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for members of the Trust as a whole and the public. Trust Board is clear of its accountability and responsibility.

Trust Board and committee structures in place are effective and meet the requirements of the Trust's Constitution. Committees are supported by terms of reference and annual work plans and have clear reporting mechanisms to Trust Board. The Trust Board has a work programme and agenda is drawn up with reference to the board assurance framework, and cycle of meetings. The Trust has eight committees:

- Audit Committee
- Clinical Governance and Clinical Safety Committee
- Equality, Inclusion and Involvement Committee
- Finance, Investment and Performance Committee
- Mental Health Act Committee
- People and Remuneration Committee
- West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Committees-in-Common
- Charitable Funds Committee (Committee of the Corporate Trustee)
- Collaborative Committee

The Committees are chaired by a Non-Executive Director and, with the exception of the Audit Committee, have Non-Executive and Executive Director membership. The Audit Committee membership comprises exclusively of Non-Executive Directors. Agendas, which are risk-based, are compiled and agreed by the chair of the committee in conjunction with the lead Director. Each committee has an annual work programme, which is incorporated into agendas as appropriate. Lead Directors are responsible for ensuring, with the Company Secretary and lead PA for each meeting, that papers are commissioned to meet the Terms of Reference of the Committee, to provide assurance that risk is mitigated within the Trust and to provide assurance that the Trust is working to deliver and continuously improve the services it provides whilst achieving value for money and best use of resources.

The membership of committees is reviewed regularly by the Chair of the Trust in terms of Non-Executive Directors. The committee structure is reviewed for appropriateness from time-to-time by the Chair, with support from the Chief Executive and Company Secretary. An update to the internal meeting governance framework was agreed by Trust Board in December 2022.

Each committee is required to prepare an annual report, which is presented to the Audit Committee. The Audit Committee reviews overall effectiveness of committee structure. This provides assurance to Trust Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in April.

The Executive Management Team's (EMT) role is to ensure that resources are deployed to support the delivery of the Trust's plan, to ensure that the Chief Executive can discharge their accountability to best effect through effective delegation and prioritisation of work, to support each other to find appropriate linkages and synergies, to ensure performance is scrutinised and challenged, both Trust-wide and by Care Groups (CGs), and to ensure the work of the EMT is aligned with that of Trust Board.

Trust Board is supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. The Members' Council is clear that its role is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the members of the Trust as a whole and the interests of the public. The Members' Council continues to develop its skills and experience in its ability to challenge and hold Directors to account for the Trust's performance. The Members' Council holds an annual session specific to holding the Non-Executive Directors to account. This is supported by a training session to enable the governors to develop their skills to run the session successfully.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation through robust service delivery arrangements. There are clear structures with clear responsibility and accountability below Director level. Within CGs, deputy directors provide operational leadership and management allowing CG Directors to focus on building and managing strategic and partner relationships and to lead the transformation agenda. CGs are supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to ensure excellence in service delivery and quality and to enact the service change required to achieve transformation.

CGs are supported by corporate directorates, which provide co-ordinated support services linked to the accountabilities of executive directors. There are six domains comprising financial management, information and performance management, people management, estates management, compliance, governance and public involvement and engagement, and service improvement and development.

4. The Board is satisfied that the Trust effectively implements systems and / or processes:

a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively

b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations

c) to ensure compliance with healthcare standards binding on the Licence holder, including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions

d) for effective financial decision-making, management and control (including, but not restricted to, appropriate systems and / or processes to ensure the Licence holder's ability to continue as a going concern)

e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Trust Board and Committee decision-making

f) to identify and manage (including, but not restricted to, manage through forward plans) material risks to compliance with the conditions of its Licence

g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and, where appropriate, external assurance on such plans and their delivery **h) to ensure compliance with all applicable legal requirements.**
Risk *The Trust does not have the systems and processes to ensure compliance with its Licence. Mitigated by performance reporting arrangements to Trust Board, including exception reports on areas of risk or concern, quarterly exception reports, robust committee arrangements in place providing assurance that the systems and processes in place are effective.* As part of its annual audit, the Trust's external auditor, Deloitte, will determine they are satisfied that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources in 2022/23. This work will be completed by the end of August 2023. The Trust's internal audit plan is risk-based to enable the Trust to identify areas where improvement is sought and to learn from best practice. The Audit Committee approved the internal audit plan for 2022/23. The plan included core reviews to inform the Head of Internal Audit Opinion relating to core financial controls, governance, and risk management, which included a focus on Board committee arrangements, policy monitoring and data security and protection toolkit. This was supported by a number of cyclical and risk reviews covering cost improvement process and reporting. 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, 7 internal audit reviews have been conducted and presented to the Audit Committee Have been completed and presented to the Committee. Of these, there were: - 4 'significant assurance' reports - 1 'substantial' assurance report - 2 'limited assurance' report In addition, two further reports were received in year, carried over from 21/22, which received significant assurance. 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 there is a first follow up implementation rate of 86% and an overall implementation rate of 94%.

The Head of Internal Audit's overall opinion for 202223 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.

The conclusions and recommendations from all internal audit reports are reported into EMT and the Audit Committee and if deemed appropriate the Audit Committee will seek further assurance and updates on actions being taken.

The Trust continues to develop and implement service line reporting, which is monitored and scrutinised by the Audit Committee on behalf of Trust Board. Further work will be undertaken in the coming year to use the information to benchmark internally and learn from best practice.

Trust Board receives an Integrated Performance Report (IPR) on a monthly basis. This enables Trust Board to satisfy itself that the Trust is meeting its financial and quality performance targets. Other reports to Trust Board and its committees provide further assurance that the Trust is fulfilling its purpose in an effective and efficient manner.

The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions. The Trust has a robust process in place to ensure that it meets the requirements of its registration. Action plans were developed in response to recommendations included in the most recent inspection reports published in 2019.

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.

The following steps have been put in place to assure the Trust Board that appropriate controls are in place to ensure the accuracy of data, these are described below and demonstrate that there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

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 CGs 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 Account and associated detailed reports.
- Corporate leadership of data quality through the Director of Finance and Resources, supported by the Chief Nurse/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 Director of Nursing, Quality, and Professions (Caldicott Guardian) and Director of Finance 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.

The CQC 'Monitoring the Mental Health Act in 2019/20' looked at how services nationally responded to the pandemic.

The Trust implemented a range of actions to ensure that service users' rights continued to be upheld during the pandemic period. The Mental Health Act teams, clinical staff and associate hospital managers successfully developed virtual and 'paper' hearings, supported virtual tribunals and established access to advocacy through virtual means. Face-to-face visits with Independent mental health advocates and independent mental capacity advocates resumed in September 2020. The pandemic led to restricted visiting in all Trust inpatient areas and a Virtual Visitor scheme was developed.

A quarterly briefing is also provided to the Trust Mental Health Act Committee.

The Trust accounts are prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual which defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. This was confirmed by the Trust Board in April 2023.

The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services

Risk
The Trust is unable to meet the requirements of its operational and financial plans. Mitigated by regular review at finance, investment and performance committee to ensure its plans provide sufficient investment in services and to consider the planned end-of-year outturn position.

The Board Assurance Framework and Organisational Risk Register with mitigating actions are reported to Trust Board on a quarterly basis set in the context of the Board's risk appetite statement. Other key issues are identified through the biennial Board investment appraisal reports along with PESTLE (Political, Economic, Sociological, Technological, Legal, Environmental) and SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis and are set out below. In addition to the key risks identified above we identified and acted upon a number of other issues as set out below.

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.

During 2022/23 we have undertaken a significant amount of work in integrated care partnerships in each of our four local areas. We have also worked with partners in each of our places to develop the governance structures and approach in response to the new Health and Social Care Bill which has been given royal assent and becomes law as of 1 July 2022.

In Barnsley the Trust continues to be 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 to monitor system performance.

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 with those of the acute hospital to ensure that people have been discharged quickly with the right level of support. We have received external recognition for our integrated discharge to assess processes.

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.

We have further developed an alliance agreement with the Barnsley Healthcare Federation with joint leadership arrangements to enable closer alignment between primary and community care for the people of Barnsley. We have also developed a joint operational plan that prioritises learning disabilities (LD) and severe mental illness (SMI) annual health checks to address inequalities. Frailty and dementia are also a shared priority.

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.

In **Calderdale** we have contributed to a place-based plan which focuses on addressing health inequalities in the Calderdale population. We have continued to work with the system leadership to implement the single plan for Calderdale, Calderdale Cares, that sets out the vision to

improve, health, social and economic outcomes for local residents. This has included 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 are part of a collaborative in Calderdale with a focus on tackling climate change, increasing social value and supporting new ways of integrated working in the Upper Calder Valley

This year we have continued to support creativity and health within Calderdale with positive feedback. This has been recognised as exemplary practice by the National Centre for Creative Health. We have also continued to integrate physical activity into systems and processes as part of the Active Calderdale Programme, which through its strategy aims to ensure Calderdale is the most active borough in the north by 2024.

In Kirklees we have contributed to a place-based plan which focusses on addressing health inequalities in the Kirklees population. We have continued work on the development of an alliance of partners to deliver mental health and wellbeing service improvements for the people of Kirklees, through the Kirklees Mental Health Alliance. We have been a pro-active partner in the development of Kirklees Place-based partnership arrangements as part of the establishment of the statutory West Yorkshire Integrated Care System during 2022. We are working with partners to develop the Kirklees Health and Care Plan.

Across Kirklees, Calderdale, and Wakefield:
- We continue to work closely with colleagues in the Mid Yorkshire Hospitals and Calderdale and Huddersfield Trusts at a strategic and operational level to improve care and pathways for people with a mental health problems who access their emergency and inpatient services.

In **Wakefield** we have contributed to a place-based plan which focuses on addressing health inequalities in the Wakefield population. We have played a strong role in the Wakefield District Health and Care Partnership, which has continued to progress the integration agenda underpinned by a *System partnership principles of ways of working together.* We are the 'host' of the Wakefield Mental Health Alliance, which is accountable to the Wakefield Provider Collaborative. The Alliance provides a framework for all partners to be involved in service transformation, improvement, and investment prioritisation. This work is led by the Trust through our Director of Provider Development.

Work with partners in Wakefield to increase uptake of annual health checks (AHC) for people with learning disabilities has continued. At end March 2023, our AHC figure for people aged 14+ with a learning disability in Wakefield was 77.4%, exceeding the target for the year (75%). This work has included providing training to GP practices, working with the ICB and Healthwatch Wakefield to audit GP practices for accessibility of AHCs, and proactive engagement with those experiencing barriers to attending for an AHC.
The community learning disabilities team have developed much more joined up partnership relationships with other providers, such as care homes, to support reduction of health inequalities for people with learning disabilities in care homes and other provider settings.

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.

In **South Yorkshire Integrated Care System,** we have worked to connect and align our work on addressing health inequalities. we have worked with provider partners within the mental health learning disabilities and autism provider collaborative across the ICS and have connected the work of the partnership group for Barnsley. We have participated in the development of a population health management approach. Our work on social responsibility and sustainability is aligned to the work across the ICS.

The Trust achieved 'go live' for the South Yorkshire and Bassetlaw (SYB) Adult Secure Provider Collaborative on 1 May 2022, for which the Trust leads the Provider Collaborative. 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 (see 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 provider for the West Yorkshire Adult Secure Lead Provider Collaborative, working with NHS and independent sector providers in West Yorkshire. In May 2022 the Trust constituted a new committee (Collaborative Committee) the purpose of which is to ensure delineation between provision and commissioning responsibilities (finance, contracting, planning and quality assurance) of the West Yorkshire Adult Secure Provider Collaborative and other specialised mental health provider collaboratives as appropriate and to provide oversight and assurance of the Trust's commissioning responsibilities as Lead Provider.

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 continues to develop and create capacity in the communities we serve through innovative models of delivery and support for service users and carers. We have developed a recovery approach with recovery colleges across our districts. Alongside this we host Altogether Better, a national initiative which supports development of community champions. This is all complemented by our charity EyUp! and linked charities Creative Minds, Spirit in Mind and the Mental Health Museum. Creative Minds is a partnership with over 100 third sector organisations, delivering sport, leisure and creative activities that build resilience and wellbeing. Spirit in Mind delivers faith-based support.

5. The Board is satisfied that:

a) there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided **b) Trust Board's planning and decision-making processes take timely and appropriate account of quality of care considerations** **c) the collection of accurate, comprehensive, timely and up-to-date information on quality of care** **d) Trust Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care** **e) the Trust, including Trust Board, actively engages on quality of care, with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources** **f) there is clear accountability for quality of care throughout the Trust, including, but not restricted to, systems and/or processes for escalating and resolving quality issues, including escalating them to Trust Board where appropriate.**
Risk *The Trust does not have the capacity and capability at Trust Board level. Mitigated by quality performance reporting to Trust Board, annual quality report, customer services processes and ongoing engagement with stakeholders, service users / carers and staff, clear process in place for whistleblowing and raising concerns, and processes in place for recruitment and selection of Trust Board members.* The Trust continues to regularly review processes against governance best practice, including: • policies developed, reviewed and in place • governance systems • the assurance framework and risk register presented to Trust Board quarterly • Integrated performance report submitted monthly to Trust Board • audits undertaken both internally and externally • a programme of unannounced visits • reports submitted to Trust Board and its Committees, as well as the Members' Council, detailing our performance against mandatory, contractual, quality & safety metrics and action plans as required. The Trust's Quality Account publication for 2022/23 will provide a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The report will not be externally audited as this is not currently a requirement and will be submitted to NHS England in June 2023. The process introduced by the Chief Nurse/Director Quality, and Professions to assess risk to and impact on quality and safety of the cost improvement and efficiency savings proposed by CGs continued to be applied in 2022/23. The Quality Impact Assessment process, led by the Director of Nursing, Quality, and Professions undertaken in conjunction with clinical and general management within CGs, provides assurance throughout the process to the Executive Management Team (EMT) and, through regular reports, to the Clinical Governance and Clinical Safety Committee and Trust Board that cost improvements do not have an adverse effect on Trust services.

Quality impact assessments are carried out on all Trust cost improvement plans with Medical Director and Director of Nursing, 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. It is being reintroduced for 23/24.

The Trust's approach to quality improvement is clear that quality is the responsibility of all staff from 'ward to board'. Reporting processes and mechanisms through Trust Board, its committees, EMT and through to CGs and their governance processes reflects this approach. Accountability for quality is also clear through the leadership and management arrangements within the Trust. CGs continue to enable better and more rapid decision-making, as close as possible to the point of care delivery, which, in turn, enables more effective clinical engagement and leadership in service development and delivery as well as providing service users with greater access to decision-making.

The Trust's approach to clinical quality improvement is based on continuous service improvement, working in innovative ways to meet local priorities, to ensure compliance with national standards and external regulation, adoption of lean systems thinking, and making the most of shared learning opportunities across the healthcare system, using quality to deliver best value. The Trust's strategic priorities and combined support service offer aligns clinical services and support functions to deliver the best care possible to those who use Trust services.

Trust Board receives regular reports, directly and through the Clinical Governance and Clinical Safety Committee, on all aspects of clinical quality and safety including management of incidents and complaints, equality and diversity, service user experience, control of infection and research and development. The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board that issues and risks identified in a number of portfolio areas, such as managing aggression and violence, safeguarding adults and children, infection prevention and control, reducing restrictive practice, and information governance, are being addressed. Where the Clinical Governance and Clinical Safety Committee identify an area of concern which has been raised at a particular time, it is scrutinised on behalf of the board by receiving regular reports for a period.

Performance reports to Trust Board provide assurance against a range of Key Performance Indicators (KPIs) relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board. This was continued for priority indicators during 2022/23.

The Trust has a range of arrangements in place for monitoring service user experience as an indicator of service quality.

The Trust has in place an Equality, Involvement, Communication and Membership Strategy 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 and communities

The Equality, Inclusion and Involvement 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 is compliant with the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infection (Hygiene Code). The Trust has an Infection Control Strategy in place and the infection control annual plan and annual report are considered by the Clinical Governance and Clinical Safety Committee on behalf of Trust Board. Trust Board monitors infection control through the monthly performance reports and the quarterly compliance report. Hygiene and quality of environment are maintained through cleaning schedules and through service level agreements and regular visits to clinical areas by the Director of Nursing and Quality, include checks for cleanliness.

The Trust publishes information in relation to the Friends and Family test for service users and staff.

The Trust actively engages with its service users, their carers, staff and stakeholders on the quality of its services through the development of its Quality Account and in the development of its services.

The Trust has a whistleblowing policy in place, which sets out clearly staff responsibility to raise concerns and how they can do this. The policy is clear on the escalation process and who concerns should be reported to. The policy is supported by information on the Trust's intranet and in associated documentation, such as the fraud and bribery act policy, safeguarding policies, and serious incident reporting and management policy. Arrangements are scrutinised by the Audit Committee. The Trust has also appointed Freedom to Speak Up Guardians (FTSUG), rather than one individual due of the diverse nature of services and large geographical spread of the Trust, the FTSUG provide staff with another way to raise concerns at work. Trust Board has also identified the Deputy Chair as the Senior Independent Director. All Executive Directors have regular one to one meetings with the Chief Executive to ensure that any incidents/concerns are discussed at a senior level in the Trust.

6. Trust Board effectively implements systems to ensure that it has in place personnel on Trust Board, reporting to Trust Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the Trust's NHS provider licence.

Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

The Chair and Non-Executive Directors have a broad base of skills and experience, including financial, commercial, legal, community engagement, and health and social care. It is the role of the Nominations Committee to assess the mix of skills and experience across Trust Board annually and when appointing Non-Executive Directors to the Board and to ensure a balance is maintained with skills complementing those of Executive Directors. To inform this process and to ensure Trust Board retains a balance of skills and experience to operate effectively as a unitary board, a review of Trust Board skills and experience will be undertaken as part of the Trust Board development plan. The recruitment process for new members of the Trust Board incorporates testing against the values of the organisation and discussion panel including staff (with representation from staff equality networks), governors and service users / carers.

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by the Members' Council, led by the Senior Independent Director, and involving Non-Executive Directors, Executive Directors, Governors and stakeholders. Trust Board undertakes ongoing Board development, using external expertise where required. During 2022/23 a structured development programme was followed using the NHS Improvement framework.

The Chief Executive is subject to formal annual appraisal by the Chair. Executive Directors are subject to annual appraisals by the Chief Executive, and Non-Executive Directors are subject to annual appraisal by the Chair, both of which inform individual development plans for all Board members. The outcome of the Non-Executive Director appraisals is reported to the Members' Council.

Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation requirements. This process of assessing the organisation's readiness for medical and nursing re-validation has been scrutinised both by Trust Board and by the Clinical Governance and Clinical Safety Committee.

Trust Board satisfies itself that the management team has the necessary skills and competencies to deliver the Trust's strategic objectives. Where gaps are perceived, the Chief Executive will seek to address Trust Board concerns, supported by the Workforce and Remuneration Committee.

All appointments to senior management positions are subject to rigorous and transparent recruitment processes. Senior managers have objectives linked to the delivery of the strategic objectives and operational plan. The Chair and Chief Executive continue to review the capacity of senior managers within the Trust to ensure there is the required and necessary balance to deliver and maintain high quality and safe services during a time of unprecedented transformational change within the organisation and wider NHS and succession planning. Professional and clinical leadership is devolved into the organisation under the leadership of the Chief Nurse/ Director of Quality and Professions, and the Chief Medical Officer.

Through our leadership and management development framework, we have continued to support our leaders and managers in their needs-led development on a limited basis during the year. We have provided continuing access to:

- Institute of Leadership and Management (ILM) qualification & non-qualification programmes and CPD activities
- Executive coaching, 1:1 & peer coaching, mentoring, and reciprocal mentoring.
- Building Leadership for Inclusion (BLFI) programmes to support the development of colleagues from under-represented communities or with protected characteristics
- Talent pool and talent programmes in partnership with the Wakefield District Health and Care Partnership and the West Yorkshire Mental Health Collaborative.
- Hosting of both a Fellow and an NHS Graduate Trainee.

We are closing 202/23with a review and reset of our leadership and management framework to reflect our post pandemic needs and role as a leader in place and system from 2023-24onwards.

The planned roll out of the Great Place to Work Leadership Forum was paused due to a pausing of non-essential learning &and development activity and service pressures. The programme has been co-designed with colleagues working in ward manager &and team leader roles, with input from senior managers. The programme re-started in April 2022.

Risk
The Trust does not have suitably qualified individuals at all levels of the organisation. Mitigated by recruitment and selection processes for Trust Board, Director-level appointments and staff at all levels.

For non-medical professional qualifications, all nursing, allied health professionals and psychology registered professional staff are subject to revalidation arrangements through their professional bodies. The Trust provide a monitoring and reminder system to all registered professional staff to ensure that registration is maintained. The revalidation process is also monitored by nominated professional leads with routine reporting into Clinical Governance and Clinical Safety Committee around compliance.

The Nursing and Midwifery Council (NMC) have remained clear that if a nurse is able to revalidate within the allocated timeframe, then they should so, however, during the Covid-19 pandemic, the NMC helped to support the process of revalidation by providing extensions where required. For those due to revalidate between July and December 2020 who required more time to send their application, a request for a 12-week extension was available through the NMC Online account.

For nurses due to revalidate from January 2021, if more time is required to complete an application, an 8-week extension can be sought through the NMC Online account. The NMC require a reason for the extension and each request is considered on a case by case basis.

For the recruitment of medical staff, doctors are assessed during the application and interview process to ensure they have the relevant qualifications and experience to fulfil the post. Medical HR will meet with the doctors to verify their ID and complete the Disclosure and Barring Service (DBS) check. The Medical Directorate request information relating to the doctor's last appraisal date, whether there are any concerns about the doctor's practice, conduct or health and if there are any outstanding investigations. The information received is checked by the Trust's Responsible Officer (RO), prior to final offer being made. Where this information is not received prior to the final offer being made, the offer remains subject to satisfactory RO information or satisfactory Annual Review of Competence Progression (ARCP) outcome for those doctors joining the Trust straight from a training programme.

Once a doctor joins the organisation, they are connected to the Trust on the General Medical Council (GMC) connect and added to the appraisal system, L2P. They have an induction meeting with the Associate Medical Director (AMD) of Appraisal and Revalidation and after this are appraised in line with their dates. All appraisals are reviewed by the AMD and Responsible Officer (RO), before being passed or returned to the individual. There are regular meetings between AMD,RO and business manager and any issues are raised in these meetings. In addition, there is a Responding to Concerns Action group (RtCAG), whose membership comprises of RO, AMD, Medical Director, Director of Nursing & Quality and Chief people Officer, where any issues about a doctors fitness to practice are raised, including reviewing any complaints with a named medic.

From the 2021/22 appraisal report to the trust Board, 137 doctors had a prescribed connection with the Trust as of 31st March 2022.

- 96.4% of the doctors that were due to have their appraisal have successfully completed the appraisal process during 2021/22, which is a vast increase on last year, back to pre-covid levels.
- 13.8% of the doctors had late meetings or late submissions. 4 of these late submissions were not approved. The rest were approved by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate. Post-Covid-19, medical appraisal and revalidation has reverted back to pre-pandemic processes and timescales following a period of paused appraisals.