NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board (business and risk)
Tuesday 25 July 2023 at 9.30am
Room 3-4, Laura Mitchell Clinic, Halifax

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 27 June 2023**	Chair	**Paper**	2	To approve
9.40	**5. Matters arising from previous Trust Board meeting held 27 June 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 Corporate / organisational risk register	Director of Finance, Estates and Resources	**Paper**	15	To receive
10.30	9.3 Health and Safety Annual report	Director of Finance, Estates and Resources	**Paper**	5	To receive
10.35	9.4 Freedom to Speak up annual report	Director of Finance, Estates and Resources	**Paper**	5	To receive
10.40	9.5 Patient led assessments of the care environments (PLACE) scores	Director of Finance, Estates and Resources	**Paper**	5	To receive
10.45	9.6 Assurance and approved minutes from Trust Board committees - Audit Committee 11 July 2023 - Clinical Governance Clinical Safety Committee 24 July 2023	Chairs of committees	**Paper**	10	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	- People and Remuneration Committee 13 July 2023 - Finance, Investment and Performance Committee 17 April 2023				
10.55	*Break*			*15*	
11.10	**10. Performance**				
11.10	10.1 Integrated Performance Report (IPR) month 3 2023/24	Executive Directors	**Paper**	35	To receive
11.45	**11. Integrated Care Systems and Partnerships**				
11.45	11.1 South Yorkshire update including and South Yorkshire Integrated Care System (SYICS)	Chief Executive/ Interim Director of Strategy & Change	**Paper**	10	To receive
11.55	11.2 West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Interim Director of Strategy & Change /Director of Provider Development	**Paper**	10	To receive
12.05	11.3 Provider Collaboratives and Alliances	Director of Finance Estates and Resources/Director of Provider Development	**Paper**	10	To receive
12.15	**12. Governance**				
12.15	12.1 Assessment against NHS Constitution	Director of Finance, Estates and	**Paper**	5	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		Resources			
12.20	12.2 Barnsley Place Plan 2023-25	Interim Director of Strategy & Change/ Joe Minton	**Paper**	15	To receive
12.35	**13. Strategies and policies**				
12.35	13.1 Estates strategy	Director of Finance, Estates and Resources	**Paper**	15	To approve
12.50	**14. Trust Board work programme**	Chair	**Paper**	2	To receive
12.52	**15. Date of next meeting** The next Trust Board meeting held in public will be held on 26 September 2023	Chair	**Verbal item**	1	To note
12.53	**16. Any other business**	Chair	**Verbal item**	2	To discuss
12.55	*Close*				

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Minutes of Trust Board meeting held on 27 June 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)	Non-Executive Director
	Natalie McMillan (NM)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	David Webster (DW)	Non-Executive Director
	Mark Brooks (MBr)	Chief Executive
	Carol Harris (CH)	Chief Operating Officer
	Adrian Snarr (AS)	Director of Finance, Estates and Resources
	Prof.Subha Thiyagesh (ST)	Chief Medical Officer
	Darryl Thompson (DT)	Chief Nurse and Director of Quality and Professions
	Salma Yasmeen (SY)	Deputy Chief Executive/Director of Strategy and Change
Apologies:	Greg Moores (GM)	Chief People Officer
In attendance:	Lindsay Jensen (LJ)	Deputy Chief People Officer
	Dr.Rachel Lee (RL)	Associate Non-Executive Director
	Sean Rayner (SR)	Director of Provider Development
	Andy Lister (AL)	Company Secretary (author)
	Julie Williams (JW)	Deputy Director of Corporate Governance
Apologies:		
Observers:	Sue Barton	Deputy Director of Strategy and Change

TB/23/47 Welcome, introduction and apologies (agenda item 1)

The Chair, Marie Burnham (MBu) welcomed everyone to the meeting. Apologies were 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 welcomed Dr.Rachel Lee to her first Board meeting as an Associate Non-Executive Director.

MBu noted this is Salma Yasmeen's (SY) last board meeting and thanked SY for her dedication and service to the Trust over the last six and half years.

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/23/48 Declarations of interest (agenda item 2)

Darryl Thompson reported he has been appointed to the Council of the National Mental Health and Learning Disability Nurse Directors Forum. All members have been asked to declare an interest as they will be registered as directors on companies' house.

Action: Andy Lister

It was RESOLVED to NOTE the changes to Darryl Thompson's declarations of interest.

TB/23/49 Questions from the public (agenda item 3)

No questions were received from the public.

TB/23/50 Minutes from previous Trust Board meeting held 25 April 2023 (agenda item 4)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 25 April 2023 as a true and accurate record.

TB/23/51 Matters arising from previous Trust Board meeting held 25 April 2023 and board action log (agenda item 5)

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

TB/23/40a – Restraint incidents are increasing and reducing restrictive practice and interventions (RRPI) training numbers are below target – Lindsay Jensen reported there was no direct correlation between the number of incidents and the level of RRPI training, but a more detailed review is going to be undertaken and will report into the clinical governance clinical safety committee (CGCS) and will report back to Board through the triple A report. To close

TB/23/39g – Mike Ford (MF) to consider how to present assurance to the Board on quality issues raised at the Collaborative Committee through future triple A reports - MF reported he had used revised wording for this month's triple A report and the action could be closed if Board were satisfied with the updated report. (This was confirmed later in the meeting) To close.

TB/23/39g – Discussion to take place at the Finance Investment and Performance (FIP) committee about possible performance metrics to monitor waiting lists from a quality perspective – Adrian Snarr (AS) reported this was dealt with on the FIP agenda last week and so this action is complete. To close.

The Board accepted all other action updates for June 2023, 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/23/52 Service User/Staff Member/Carer story (agenda item 6)

Carol Harris (CH) introduced Carol Mason (CM) with her Individual Placement Support officer Neil Brannigan (NB).

CH reported the Individual Placement and Support (IPS) service is delivered across secondary care mental health services in Calderdale, Kirklees and Wakefield by the Trust, whilst provision in Barnsley is delivered in partnership with South Yorkshire Housing Association.

Using an evidence based “place then train” approach, IPS offers intensive, individually tailored support to help people to choose and find the right job, with ongoing support for the employer and employee to help ensure the person keeps their job. The IPS service believes anyone can work if the right kind of job and work environment can be found, and the right support is provided.

CM reported her mental health journey started in 2006 when she was admitted to Fieldhead hospital. She was readmitted due to a deterioration in her mental health in 2012, and at that point was discharged to the enhanced mental health community team. CM spoke to her care coordinator and asked about getting back into work and reported she wanted to help people with similar issues to herself. CM’s care coordinator put her in touch with NB. NB has helped CM develop a new curriculum vitae (CV) and in January 2023 CM has successfully gained employment as a mental health support worker.

CM reported given her life experience she understands what it is like to be going through mental health difficulties and wanted to give something back and help people. CM reported NB and the community enhanced mental health team have been impeccable and supported her immensely. CM reflected on her progression from October 2022 noting how incredibly well she has done and felt proud to be here today and telling her story.

NB spoke of how well CM has done in such a short time.

Mark Brooks (MBr) thanked CM for sharing her story. MBr firstly noted he would like the Trust to speak to CM about how our service can best support people who experience substance misuse and domestic abuse.

Action:Sue Barton

MBr continued, and asked CM what difference working is making to her life?

CM stated it has given her grounding which helps to manage her bi-polar disorder, and she also has a real sense of purpose In addition, she has financial stability. CM reported she loves her job because she knows she has so much to offer as a result of her own experiences.

Darryl Thompson (DT) thanked CM for speaking to the Board and noted it takes a lot of courage to achieve all that CM has, and asked what CM felt had given her the courage for her achievements?

CM reported the support from the enhanced team and NB has been a big part of this. CM added she lost her Mum, Dad and sister and wants to honour their memory and make them proud, so has also used their memory to move forward. CM reported she is going to write to a book called “Carol’s Courage”.

Prof.Subha Thiyagesh (ST) queried if work is having a positive effect on CM’s mental health?

CM stated it is because she can maintain relationships with work colleagues and patients. CM has also spoken to her employers about her experiences, which has been positive, and she has become an advocate for others.

Nat McMillan (NM) queried how easy it was to find out about the IPS service?

CM stated it was very easy, as her care coordinator referred her into the service straight away as soon as CM spoke about wanting to return to work.

Lindsay Jensen (LJ) noted the Trust is always looking at different recruitment options and asked CM what the Trust can learn from her experience through the IPS service.

CM stated the IPS and NB had helped her immensely with her job application, interview preparation and journey planning to enable her to get back to work.

MBr noted the IPS is a relatively new service having been operational for about two years.

NB reported the service started in Kirklees and Calderdale and the Wakefield service commenced more recently.

MBr noted approximately 150 people have benefitted from the service so far. MBr visited the service earlier in the year and spoke to two people who reported the service, and support, had been life changing for them. MBr thanked the IPS service for the work they are carrying out.

The Board thanked CM for her story and wished her well with her for the future.

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

TB/23/53 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
- Older People's Service Transformation
- Calderdale Talking Therapies Contract
- Annual report and accounts
- Quality Account

It is the 75th anniversary of the NHS this year and MBu and staff from the Trust will be going to London as part of a celebration event.

It was RESOLVED to NOTE the Chair's remarks.

TB/23/54 Chief Executive's report (agenda item 8)

Chief Executive's report

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

- A Care Quality Commission inspection has taken place in adult mental health, learning disability and forensic inpatient services. MBr thanked all staff who supported the inspection. The initial correspondence from the inspection is included in the board papers and include both positive comments and some areas of learning.
- MBr thanked everyone involved in managing service provision during the recent industrial action by junior doctors. A lot of effort and planning has taken place to maintain safe services. There is a further five consecutive days of industrial action planned by junior doctors in July.
- The Trust has been engaged in work taking place in with both integrated care systems on their new operating models to take account of the 30% running cost savings they are required to make.
- The national equality, diversity and inclusion improvement plan has been published. We very much welcome this plan. On initial review it has been identified the Trust's internal

plans are largely aligned to the national plan, noting there are also some areas where improvements can be made, and this will be followed up by the equality, inclusion and involvement committee (EIIC)
- Covid restrictions are now at their least restrictive level since March 2020
- It is Creative Minds 10-year anniversary, and this week a celebration event is being held at Huddersfield University
- "Right care, right person" is a national approach to how our services work with the police. We are working in partnership to manage any changes effectively and carefully. There will be more information coming out about this at future meetings.
- The latest successful bids to be included in the new hospital programme have been announced been released. The Trust did submit a bid which was not successful, and it is noted no mental health bids were included in this latest round of approvals.
- Salma Yasmeen (SY) is to leave the Trust after six and half years as the chief executive officer for Sheffield Health and Social Care NHS Foundation Trust. MBr thanked SY for all she had done for the Trust and wished her every success for the future.

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

TB/23/55 Performance (agenda item 9)

TB/23/55a Integrated performance report Month 2 2023/24 (agenda item 9.1)

AS introduced the summary dashboards and priority programmes section of the integrated performance report (IPR):

- Review and engagement sessions have been held with the executive management team (EMT) and the Board in relation to metrics required for the year ahead. The vast majority have been incorporated into the IPR for this month, with some metrics still to follow. Some others will be quarterly measures, so don't appear in this month's report.
- In general terms the Trust continues to perform well, although we acknowledge there are some hotspots and areas of challenge that will be discussed in more detail.
- There has been a focus on the collection of data in relation to protected characteristics. We are showing good performance in the collection of data and what it shows. We can then start to benchmark the protected characteristics data against service provision within the Trust and look at what this shows. This process has recently been used with waiting list reports. This information has been shared with the West Yorkshire ICS and its use will be promoted across the West Yorkshire system.

David Webster (DW) noted appraisal rates had been raised in CGCS and while in the main there had been improvement, there were a few wards where appraisal rates were quite poor. The finance, investment, and performance committee (FIP) have taken an action to look at how significant variance in appraisal rates can be addressed.
DW noted the metric in relation to ligature points and queried whether performance against this metric is within the Trust's control?

AS reported FIP and CH have discussed the reporting of appraisal rates, and noted there is the potential to lose detail when reporting takes place at a Trust level. CH has identified areas where there will be some focus on appraisal rates such as on inpatient wards, and this will be monitored through the FIP work programme and the operational management group (OMG).

In relation to ligature audits, AS reported there is a rolling programme of ligature audits and there is a work programme in place. There is a lead in time to some of this work as there have been some supply delays. The biggest challenge over the last year has been the door replacement programme, where there has been reduced supply of doors. AS pointed out that later in the finance section of IPR, it will be reported that the Trust is ahead of its capital programme, and this is directly related to the door programme that has caught up and doors are now being fitted.

DW queried if the 100% threshold is achievable?

MBr thanked DW for the question, noting this is new metric and DW's question demonstrates the reason for the metric being included. MBr noted if the Trust has a work programme it should be known if the programme is on track. From the information available this isn't currently clear. We need to establish if work is being completed within the stipulated time scales and added there is also a need to look at what risk assessment is in place to cover the risk until the work is completed.

Action: Adrian Snarr

NM noted the Board discussion and focus on waiting lists has brought positive results and this is good to see.

DT noted there is more information to share about ligature points in the CQC reports later in today's Board agenda.

Quality

DT gave the following highlights from the report:

- The Trust is holding steady on most of its quality indicators.
- We are above target on people where we have shared a copy of their care programme approach (CPA) care plan with.
- Completion of a timely risk assessment is up in community services to 94.6% but there has been a slight dip in inpatient services, and this is being reviewed to identify any learning.
- A new trajectory for risk assessments has been identified through the quality improvement approach.
- The number of restraint incidents is holding steady.
- Falls increased to 53 in the month and the falls coordinator is reviewing all incidents. Board members were asked to note that several incidents relate to one individual with complex needs.
- As MBr has already highlighted in his report, the Trust has stepped down universal mask wearing in line with national Covid-19 guidance.

MF noted it is good to see the improvement in care plans but queried why the year end forecast is red?

MBr suggested this in an error and needs to be checked.

Action: Adrian Snarr

Erfana Mahmood (EM) noted the Trust is still doing well given the operating context. EM queried if there had been any progress in identifying measures for acuity?

DT reported a task and finish group is working on this and will be reporting into CGCS. DT will establish what the timeline is on the outcome of this work being reported into CGCS.

Action: Darryl Thompson

NHSI national Indicators

AS reported in respect of out of area beds (OOA) the Trust is hitting the financial trajectory, but numbers remain high. The context of this is that the OOA packages are not as complex as assumed in the plan. The Trust is typically managing to look after complex cases within its own bed base.

The other area of note is national access targets, one of which is paediatric audiology. To give context, this service deals with small numbers of patients. The service has five people to see

in the month, four were seen within the timeline, and one declined an appointment offered, which brings the percentage to 80% which is red.

Locality report

CH reported continued pressures on neurodevelopmental assessments. In Kirklees, we have worked with commissioners to increase the capacity commissioned, but currently although there are 64 commissioned assessments available between the Trust and a third sector provider, demand is over 160 assessments a month. This is being discussed with commissioners and is a national issue.

SR commented that given this is a national issue, the West Yorkshire system has held a recent summit which involved all areas subject to this demand pressure, and there have been actions identified for all sectors, not just the health sector.

SR is writing a paper in relation to attention deficit and hyperactivity disorder (ADHD) wait times in Wakefield as an identified pressure, and what mitigating actions are being taken, noting there are issues beyond our control.

MBu queried if, hypothetically, money was no object, would the staff be available to meet the demand?

CH reported it would be a struggle due to it being a specialist service. There is different practice in relation to assessments, and the Trust maintains adherence to best practice guidelines. Other providers may perform a different, quicker, assessment but this may not meet the needs of a prescribing practitioner, as highlighted on the recent Panorama programme.

CH reported there are still pressures on beds for children in specialist placements, these are complex cases, and the Trust is working with partner colleagues to resolve the matter.

There is growing pressure in Wakefield core children and adolescent mental health services (CAMHS) with waits being over six months for children to be seen. This is a result of demand and capacity. This is monitored through the waiting list report and there are actions in place to address these issues.

Adult and Older People Services

- There have been improvements in collaborative care planning but as DT previously mentioned there has been a slight dip in the inpatients risk assessment metric.
- Challenges with appraisals are subject to targeted work which is now showing some improvement and the teams internally have committed to everybody having an appraisal by July 2023

EM queried the single point of access (SPA) team and if there is any improvement?

CH reported work is taking place to establish if there is higher demand or higher acuity, and what if any impact is being seen as a result of community mental health transformation.

EM queried if there is any way this can be built into figures in the IPR in the fullness of time?

CH agreed to look into this with AS and see what could be presented to the Board.

Action: Carol Harris/Adrian Snarr

MBu noted things seem to be improving from an operational perspective.

CH reported the performance figures demonstrate positive movement. The operational teams are keen to be involved in the development of services, despite the operational pressures.

The Trust will be contributing to a regional event about the development of services later this week.

MBr reminded the Board not to underestimate the challenges the Trust has. Staff are doing a fantastic job, but the pressure is still very apparent.

NM reflected on the importance of being clear what the priorities are, as this can help to drive positive solutions.

MBr agreed and commented that the Trust has a well-established process by which it identifies and communicates its priorities each year.

ST explained the trio leadership model helps this focus, as the challenges in community and inpatient services are very different.

DT noted in a recent visit to the rehabilitation service they had stated their shared ambition with inpatient services to assist early discharge and support inpatient services to deliver this.

Barnsley Community Services

- There are staffing challenges in Urban House and the paediatric epilepsy nursing service. There are plans in place to address,but it is causing pressure in relation to service delivery.
- Neighbourhood nursing teams – there have been previous issues in relation to this service, but we are now seeing positive recruitment in this area.
- AS has already, mentioned about six week waits for paediatric audiology. We hope to be on track for this service by October 2023 by recruiting into vacancies.

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

- Adult ADHD continues to experience high demand, this is being monitored through FIP.
- The Trust is working through the “any qualified provider” contract which is new in Calderdale. We are working through some issues in the implementation to this contract before signing.
- We have now received the invited review report form the Royal College of Psychiatry. We are working through this and will provide the royal college with a response, and this will come through the Trust governance process to CGCS.
- It was learning disability week last and there were celebrations across the Trust. The Horizon improvement work is continuing, and the executive trio have seen visible improvements.
- There is positive progress in relation to annual health checks in learning disability services across all areas in which we work.
- Forensic service metrics continue to hold steady; sickness continues to be an issue but the team are working hard to address this
- Trauma informed care continues to be rolled out across the forensic service and is being well received by staff.

NM reported the Horizon work is a standing item at CGCS that is being consistently reviewed until the executive trio are satisfied the changes are embedded.

CH reported the executive trio carried out an unannounced visit to Horizon after the last board meeting and it felt very positive, with notable changes.

Kate Quail (KQ) reported the Mental Health Act committee (MHA) had received a report about the improvement work and this demonstrated good triangulation and assurance between CGCS, MHA and the executive trio.

CH added there have been some freedom to speak up (FTSU) issues raised and we continue to look into concerns despite the positive improvements that have been seen.

MBr reminded the Board they have opportunities to promote reducing health inequalities for all of our service users. Today's Board story has reminded MBr there is work taking place to help those with a learning disability gain employment. Colleagues at Mid Yorkshire Trust have done some excellent work in this regard, and we can promote this work as a Board.

Finance and Contracts

AS highlighted the following points:

- There is still a good degree of confidence the Trust will achieve its plan for 2023/24 but when we look at the drivers behind expenditure, pressures are building.
- We will get additional funding for the pay award, but there will be a gap of about £2m,
- so there are recurrent pay cost pressures starting to develop.
- Inflationary pressures are coming through on estates and premises costs as well as travel budgets.
- Efficiency programme robustness is being developed and monitored through FIP.
- Whilst AS is confident the Trust can achieve this year's plan some of the measures are not recurrent, therefore medium-term planning will show some pressures.
- In this report we have made a separation between core SWYPT business and provider collaboratives.
- Agency spend – there is no move, and the Trust is starting to look like an outlier in the system. CH and AS have agreed to support the agency working group. In inpatients there is still a level of stress around staffing. If we don't act, we may be under external scrutiny.
- The agency working group is led by people directorate, and reports into EMT, and into the people and remuneration committee (PRC).
- The capital programme is ahead of plan but is shown as red which is misleading. This is largely due the door replacement scheme.

NM asked how the Board are going to see the trajectory around agency.

MBr reported the agency working group had been in place prior to the pandemic and has been re-established. In more recent times, during the pandemic, the focus was getting staff into the Trust, rather than the cost. There is a lot of detail available in relation to agency, but the Board needs to consider if this goes to the finance committee, the people committee, or Board.

SY reported it is part of the priority programme to improve use of resources and therefore the highlights could come through the priority programme section of the IPR to Board and the detail can be presented to one of the Board committees.

Action: Adrian Snarr

The Board agreed it should become a standing item at PRC.

Action: Greg Moores/Lindsay Jensen

MBr noted the pay increase gap will cost the Trust £2m recurrently. Last year's pay increase gap was approximately the same in value, and so the Trust's pay bill has come under pressure by approximately £4m over the last two years due to the way the funding works.

People

LJ highlighted the following points:

- Continuing trend of more starters than leavers this month
- The Trust continues to work on international nurse recruitment, there are now 64 nurses in place.

- There has been a recent successful assessment centre, with over 60 people through for support worker roles.
- The Trust is working with Touchtone in Leeds to prioritise recruitment from diverse groups.
- The people directorate have met with Richard Bates from the individual placement support service IPS service (today's board story) to see what the Trust can offer to people engaged with this service.
- Turnover has come down and the Trust benchmarks well against trusts of a similar type.
- Sickness absence is reduced this month.
- Appraisals, there has been a slight increase, and we know there is challenge. There is a weekly appraisal report going to OMG to identify hotspots and assist managers to tackle this issue. There is also a review of the appraisal system taking place as the contract expires in March 2024.
- Mandatory training – in the main positive but there are some areas for improvement – CPR training is a current area of focus. Mandatory training is monitored through OMG.
- LJ noted the Trust has achieved its 95% compliance on information governance (IG) training to support the submission of the annual data security and protection toolkit (DSPT) and the Trust is now green on food safety training which has been a recent area of focus.

Mandy Rayner (MR) noted the good progress and highlighted the reduction in absence especially given national issues. MR challenged the reducing restrictive practice and interventions (RRPI) and cardiopulmonary resuscitation (CPR) mandatory training figures and asked for assurance that that training rates will improve given their importance.

MBr stated EMT received a paper last week for RRPI training and they have agreed to recruit two new members of staff and ensure there are suitable training facilities.

CH reported for RRPI training, some of the bigger challenges are in community services rather than inpatients. Forensics are green and inpatients are amber.

DT reported the RRPI team are also looking at options with partners across the system.

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

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

TB/23/55b 2022 NHS Staff Survey update (agenda item 9.2)
LJ introduced the item and highlighted the following points:

- There has been a 50% response rate this year, up 7% from last year.
- The paper has addressed the" so what" questions.
- An engagement plan has been formulated and the people directorate has spoken to a number of teams across the Trust about their results, including where we need to improve.
- The plan is based on the Trust's people promises as part of the great place to work strategy.
- The people directorate have helped teams to focus on the improvement of their own issues, empowering them to make changes.
- Staff health and wellbeing is a focus.
- A review at Q2 23/24 will come back through to PRC to ensure assurance is received on progress.

MBr noted feedback on what the Trust has done about the staff survey results is important so that staff know the Trust has listened and changes have been made.

It was RESOLVED to NOTE and SUPPORT the updates provided in this paper.

TB/23/56 Risk and Assurance (agenda item 10)

TB/23/56a Incident Management Annual report (agenda item 10.1)

DT introduced the item and highlighted the following points:

- The Trust continues to have a robust incident management process.
- Data quality remains an area of focus and incidents include the capture of protected characteristics.
- Work around sexual safety has been increased.
- There has been a 12% increase in reporting in year, the percentage of no harm or low harm is at 97%, which shows a positive reporting culture.
- Serious Incidents has reduced to 16.
- Self-harm incidents have increased from 770 (21-22) to 1067 which appears to be a significant increase. A group has been established to review the Trust's learning from these incidents. For context Board should also note in 2020-21 the number of self -harm incidents was 994. The 21-22 year was therefore comparably low in number.
- There were no never events in year
- There has been an increase in pressure ulcers, this has been noted throughout the year by CGCS and update reports have been presented to committee, including the executive trio report. There is a further report to be submitted to committee demonstrating the learning taken from these incidents. DT assured the Board that a significant number of the pressure ulcers reported were service users admitted to Trust services with the pressure ulcer already present.
- The report referenced the Trust's learning from patient safety events and the patient safety incident review framework (PSIRF) is also referenced.
- This annual report includes learning from healthcare deaths.
- The appendix shows examples of learning that the Trust has taken in year.
- Our learning journey used to be an independent report but is now included in this report and will now form part of the quarterly report.

NM informed the Board that CGCS has held detailed discussions on key issues raised in this report throughout the year, including a focus on pressure ulcers.

KQ noted the Board had discussed earlier waiting lists broken down by protected characteristics and queried if there is any progression towards carrying out this analysis for incidents.

DT reported this is in the planning stage, the data is now available, and we are working through this, with the aim that this information will start to come through in quarterly reports.

MBr noted sexual safety is subject to increased focus nationally and is likely to become part of the care quality commission (CQC) well led process and so this may need to be monitored in more depth by CGCS.

ST reported sexual safety incidents are being monitored through the clinical risk panel. ST noted the only incident category in the top ten that has reduced is the administration/supply of medication from a clinical area. These incidents have steadily decreased quarter on quarter over the last 18 months, likely due to the implementation of electronic prescribing and medicines administration (EPMA) which has been rolled out in the Trust over the last 18 months.

It was RESOLVED to RECEIVE and APPROVE the annual report on incident management and to NOTE the next steps identified.

TB/23/56b CQC inspection reports update (agenda item 10.2)

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

- The letters received from the CQC are the initial outcomes of the two inspections that took place, one in the psychiatric intensive care unit (PICU) and mental health inpatient wards, the other for forensic services.
- Nine wards were visited during the inspection.
- The letters reference how welcome staff were and open to engagement with the CQC and their inspection process.
- The mental health and PICU wards were noted for their positive and caring interactions with service users.
- Patients told inspectors they were treated with kindness and respect.
- Wards were safe, clean and free from avoidable hazards.
- Medicines were well managed and there was further positive feedback in relation to electronic prescribing and medicines administration (EPMA).
- Staff felt valued.
- The CQC felt there were some aspects of care that weren't met, access to personal psychological support and cultural needs.
- There was use of a non-bedroom area in Kendray hospital where someone was being treated in an "extra" care area due to national bed shortages.
- It was noted that all wards were impacted by staffing pressures which impacted on activities and the support of service user leave from the ward.
- Inspectors did not identify any concerns in relation to culture on the wards, which is positive, given the current operating context.
- In forensic services, the CQC observed not all wards had an up-to-date ligature risk assessment and staff were not always aware of ligature risks on the wards or how they were locally managed. The Trust has responded to this with a folder being placed on all units containing the ligature risk assessments and a summary sheet at the front of the folder to highlight the specific risks for that unit.
- Oversight of ligature risk assessment actions and sign off is now under review along with where new learning can be highlighted. This oversight is through the clinical environmental safety group and will feed through to CGCS as an update report.
- There was a noted lack of activities across some of the forensic wards, especially in the aftermath of the pandemic.
- Inspectors observed some positive interactions between staff and patients.
- Patients told inspectors that some staff really cared about them.
- EPMA was seen as an effective tool.
- Clinic rooms were generally well maintained, but some out of date and un-checked equipment was found by inspectors.
- Inspectors were unclear about the kind of security checks [of the environment of the ward] that were being undertaken.
- Staff were positive about some of the training being offered.
- Fridge temperatures (where medication is stored) were not always checked on some wards. This has now been reviewed by the pharmacy team and renewed guidance has been circulated.
- 120 data submissions were requested after the visit and the full outcome of the CQC visit is expected to be received by the end of July 2023.
- Staff have reported they felt it was a very positive experience.

EM praised the operational staff on the initial outcome of this report. EM noted the fridge temperatures had been raised in a previous visit which was resolved, but it has appeared again.

CH reported the fridge temperatures had been recorded but some had been noted to be below temperature and there is an action plan in place to address this. This was fed back to the CQC as part of their data requests and follow up information.

MF noted there was reference to blind spots in the forensic services.

DT reported this was in relation to the ward environment and is being built into the environmental review as part of the learning.

It was RESOLVED to RECEIVE this executive summary and the CQC response letters.

TB/23/56c Premises Assurance Model annual report (agenda item 10.3)

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

- The premises assurance model annual report is a mandatory annual return.
- There are a comprehensive set of questions with an evidence and peer review process.
- There are six categories of scoring, and all Trust scores are "good" to "outstanding."
- It demonstrates we have good functional estate with good effective services that manage our estate.

MR noted the move from good to outstanding in categories is positive.

MF noted this paper will be added to the Audit Committee work programme to be reviewed by Audit Committee prior to Board submission in future.

Action: Adrian Snarr

It was RESOLVED to NOTE the content of the report, **NOTE that the overall score is "good", NOTE the improvement to "outstanding" in some areas across the submission and AGREE that the submission of the formal PAM return to NHS England.**

TB/23/56d Data Security and Protection Toolkit (DSPT) (agenda item 10.4)

AS introduced the item and highlighted the following points:

- This is the required annual return.
- The Trust started from a position of strength.
- The mandatory training target was a challenge but has been achieved.

MR acknowledged of the work that has taken place in achieving this standard.

It was RESOLVED to APPROVE the Trust's submission of the final assessment of the DSPT with "standards exceeded".

TB/23/56e Guardian of Safe Working hours report (agenda item 10.5)

ST introduced the item and highlighted the following points:

- There is an annual return – Dr Marriot is the guardian of safe working hours.
- It ensures safe working practices for junior doctors.
- All rota patterns are compliant with the required terms and conditions.
- There are very few exception reports, and where issues arise, these have been directed to appropriate managers to address the difficulties.
- Access to training experience in assessing self-harm and other acute presentations - we are held to account by NHS England (formerly Health Education England).
- EPMA has been very helpful and had a positive impact on workload.
- The Board are to note the Trust spends very little on junior doctor agency spend due to a junior doctor bank scheme now being in place.
- Rota administration has been well supported and has assisted the Trust during times of industrial action, with the support of operational colleagues.

EM noted the format of the report is easy to understand. EM queried if the skills mix is right across the Trust.

LJ reported a new roles group has been established which looks at potential new roles and what can be implemented within the Trust. LJ stated the Trust now has two physician associate roles within the Trust. They are not able to prescribe, which is a limitation to the role. It takes years to train for a role such as this. This work is being reviewed through PRC and the Trust recruitment plan.

MBr reported at an EMT time out earlier in the year, there was an agreement to re-visit the Trust's workforce plan to consider realistic assumptions on recruitment, finances available and new roles and ways of working. MBr noted further the publication of the long-term NHS people plan is imminent.

MF noted the rota gap trends and queried if this will be a pressure going forward?

ST reported this is a possibility, but it is difficult to predict but, the filling of gaps is supported by the medical bank.

It was RESOLVED to RECEIVE and CONFIRM the Board are assured that the Trust has met its statutory duties.

TB/23/56f Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 10.6)

Audit Committee (AC) 26 June 2023

- The head of internal audit opinion is significant assurance.
- Update received from Deloitte on the Trust accounts and no adjustments have been requested.

Collaborative Committee (CC) 5 June 2023

- The report includes additional detail following a previous board action.
- The committee received its first report on where the Trust is a partner in a provider collaborative (not the lead provider)
- Received a paper on plans for a community pathway for the West Yorkshire adult secure provider collaborative. The committee has asked for clinical input into the review of the proposal of the proposal prior to coming to committee.
- Phase 2 collaborative reporting will now start to come to committee.

Clinical Governance & Clinical Safety Committee (CGCS) 16 May 2023

Nat McMillan (NM) reported the following:

- The committee is assured about the process being utlised for the improvement work in the Horizon centre.
- The committee is focusing on complaints and how improvements can be made.
- The "support to carers" by Gillian Cowell was presented to the committee and this is a positive piece of work.
- Reducing restrictive practice and interventions (RRPI) the committee has asked for the quarterly report to include mechanical restraint.
- Out of area (OOA) beds will now be part of the clinical audit programme to provide assurance, but noted there are no concerns in this area at present.
- Falls prevention work continues to come through the committee.

MBr queried the backlog of complaints being 26 and queried if this is the number of complaints, or the numbers of complaints awaiting allocation for investigation?

DT reported this is the number of complaints awaiting an investigator being allocated.

Equality, Inclusion and Involvement Committee (EIIC) 14 June 2023

EM highlighted the following:

- There was a focus on forensic services, learning disabilities, attention deficit and hyperactivity disorder (ADHD), and autistic spectrum disorder (ASD).
- There was also a presentation from the race, ethnicity, and cultural heritage (REACH) network. Good progress is being made, with some aspects of improvement required in relation to training programmes.
- Trust workforce data is being used to help inform decisions.
- The social responsibility and sustainability internal audit resulted in significant assurance, with 2 proposed and agreed medium risk actions identified (impact and likelihood 3x3). The report provided assurance to the committee with the report and content noted.

Finance, Investment & Performance (FIP) Committee 19 June 2023
DW highlighted the following from the June meeting:

- Capital training for the Board is now to take place in September 2023

Mental Health Act Committee (MHAC) 16 May 2023
KQ asked to take the report as read and highlighted the following:

- Strike action was noted along with the impact on MHA implementation. The committee agreed that nurse associates will now be able to receive section papers if there are no registered staff on duty.
- The committee is looking at service user experience and is going to do some work on the experience of children detained in adult beds.
- The committee received an update on the improvement work on Horizon.
- There was good assurance of performance against and compliance for Mental Health Act training.
- Assurance was received on the progress against the CQC action plan.

Members' Council 9 May 2023
MBu asked for the paper to be taken as read.

People and Remuneration Committee 23 May 2023
MR highlighted the following:

- The committee looked at challenges regarding appraisal compliance, agency spend, industrial action and some mandatory training issues.
- A highlight report was received on recruitment and the metrics are showing some positive movement.
- Assurance was received regarding the staff survey.

WYMHLDA Committees in Common 26 April 2023
MBu asked to take the paper as read.

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

TB/23/57 Integrated Care Systems and Partnerships (agenda item 11)

TB/23/57a 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:

- A review of the governance structure in the integrated care board (ICB) is taking place to look at whether the board and committee structure is best enabling the ICB to meet its objectives.
- There was a focus on industrial action.
- There was a deep dive on mental health indicators, there are six national mental health indicators for this year.

- There was a focus on actions in place to address health inequalities.
- There was a development session on digitisation, what the ICB role is in this, and where the digital agenda is going in the future.
- In relation to the Mental health, learning disability and autism provider collaborative, there was a focus on inpatient quality transformation programme, the specialist provider collaborative hub and agreement of our funding arrangements.

EM queried how influential are we in terms of digitisation?

MBr reported one of the benefits of integrated care boards and partnerships is having people present from all health sectors including mental health, primary care, acute, voluntary and community, and HealthWatch. We have a good level of influence. There was good discussion about digitisation and what can be done to influence best practice and inclusion.

SY reported the health and care partnership in Barnsley continues to mature, and it is now conducting positive work against the significant financial challenge that is being faced. The meeting started with a powerful story from someone of no fixed abode which demonstrated the positives of partnership working.

The health and care plan has been agreed and work continues to implement this.

The Barnsley health and care alliance has made progress against all three priorities from last year and has held a workshop to establish priorities for this year.

It was RESOLVED to NOTE the SYB ICS update.

TB/23/57b 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:

- The recruitment for an independent chair of the Wakefield District Health and Care partnership has not been successful.
- Place committees in all areas are thematically focusing on financial recovery plans.

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/23/57c Provider Collaboratives and Alliances (agenda item 11.3)

AS presented the item and asked to take the report as read:

- West Yorkshire is a full collaborative and there is a full risk and benefit share across all of the workstreams.
- Other collaboratives that the Trust partners in are experiencing issues regarding staffing and out of area placements, which is having some financial impacts.
- The adult secure collaborative, which the Trust leads, is in a better financial position but this can be subject to change.
- As we move into the second-year, governance is embedded we can now focus on pathways, and this work is progressing well. There is some variance in pathways, and we are looking at what the optimum model is moving forward.
- In the South Yorkshire adult secure provider collaborative there is no confirmed risk and benefits share, although it is recognised there should be one. There are some contractual challenges to be worked through.

- There is ambition to develop a forensic community pathway in South Yorkshire.

MF noted that Deloitte advised the Trust needs to move forward on getting contracts signed.

MBu asked for a meeting with AS and SR to look at the current situation in respect of provider collaboratives across both systems. Dr.Rachel Lee also asked to attend.

Action: Adrian Snarr/Sean Rayner

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/23/58 Governance matters (agenda item 12)

TB/23/58a Compliance with NHS provider licence conditions and code of governance - self-certifications (agenda item 12.1)

AS introduced the item and highlighted the following points:

- This is an annual return and a self-assessment.
- There are some clearly defined standards for the Trust to meet.

MF noted the internal audit report stated the reported states that we received seven internal audits but there were two that carried over from last year. It also needs to reflect that the value for money work will be completed by the end of August 2023.

Action: Adrian Snarr

It was RESOLVED to NOTE the comments made and 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:

- **the Corporate Governance Statement 2022/23**
- **the training for Governors 2022/23**

TB/23/58b Trust Seal (agenda item 12.2)

AS reported the Trust seal has not been used since the Board meeting of 28 March 2023.

It was RESOLVED to NOTE the Trust Seal has not been used since the last report in March 2023.

TB/23/59 Trust Board work programme 2023/24 (agenda item 13)

It was RESOLVED to NOTE the work programme.

TB/23/60 Any other business (agenda item 14)

TB/23/61 Date of next meeting (agenda item 15)

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

Signature: Date:

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TRUST BOARD 27 June 2023 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 27 June 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/48	Darryl Thompson reported he has been appointed to the Council of the National Mental Health and Learning Disability Nurse Directors Forum. All members have been asked to declare an interest as they will be registered as directors on companies' house.	Andy Lister	July 2023	Declarations updated
TB/23/52	Mark Brooks (MBr) thanked CM for sharing her story. MBr firstly noted he would like the Trust to speak to CM about how our service can best support people who experience substance misuse and domestic abuse.	Sue Barton	September 2023	
TB/23/55	MBr noted if the Trust has a ligature work programme it should be known, if the programme is on track. From the information available in the IPR this isn't currently clear. We need to establish if work is being completed within the stipulated time scales but there is also a need to look at what risk assessment is in place to cover the risk until the work is completed.	Adrian Snarr	July 2023	The door programme which was the main part of the works in 2023/24 has been completed ahead of schedule. The other main component for this year is renewal of windows at the Dales unit which is on track. Individual patient risk assessments continue to be implemented during delivery of the works programme. An SBAR (situation, background, assessment, recommendation) is also in place for the Dales unit as a whole.

TB/23/55	MF noted it is good to see the improvement in care plans but queried why the year end forecast is red? MBr suggested this in an error and needs to be checked.	Adrian Snarr	July 2023	IPR reviewed and identified as an error and updated.
TB/23/55	EM queried if there had been any progress in identifying measures for acuity? DT reported a task and finish group is working on this and will be reporting into CGCS. DT will establish what the timeline is on the outcome of this work being reported into CGCS.	Darryl Thompson	July 2023	Acuity for the trust (including indices and measures) as a strand of work is now incorporated into the inpatient priority programme workstream. This will be reported back to the Clinical Governance Group by the end of Quarter 3 and escalated to Committee as necessary.
TB/23/55	EM queried if there is any way SPA demand and acuity can be built into figures in the IPR in the fullness of time? CH agreed to look into this with AS and see what could be presented to the Board.	Adrian Snarr/Carol Harris	September 2023	
TB/23/55	NM asked how the Board are going to see the trajectory around agency. SY suggested agency can become part of the priority programme section of the IPR through improving the use of resources. Highlights could come through the priority programme section of the IPR to Board and the detail can be presented to one of the Board committees.	Adrian Snarr	September 2023	
TB/23/55	Agency to be monitored through PRC	Greg Moores/Lindsay Jensen	September 2023	
TB/23/56c	Premises Assurance Model to be added to Audit Committee work plan	Adrian Snarr	July 2023	Audit Committee workplan updated

TB/23/57c	MBu asked for a meeting with AS and SR to look at the current situation in respect of provider collaboratives across both counties. Dr.Rachel Lee also asked to attend.	Adrian Snarr/Sean Rayner	September 2023	
TB/23/58a	In relation to the Compliance with NHS provider licence conditions and code of governance - self-certifications MF noted the internal audit report stated the reported states that we received seven internal audits but there were two that carried over from last year. It also needs to reflect that the value for money work will be completed by the end of August 2023.	Adrian Snarr	July 2023	Document updated. Action complete.

Actions from 25 April 2023

TB/23/36	Dr.Subha Thiyagesh (ST) thanked P and C for their story and informed them that the Trust is in the process of older people's services transformation and asked if P and C would be willing to share their experiences to help improve the service for others? P and C agreed.	Subha Thiyagesh	September 2023	
TB/23/39c	Average Risk Score on the Heat map to be checked for accuracy for the Q1 report 2023/24	Adrian Snarr	July 2023	Heat map scoring matrix checked prior to submission to Board
TB/23/39f	KQ reported it would be useful to have regular updates to CGCS about progress in relation to the role of Learning Disabilities champion and it will be good to also look at the over use of medication for people with a learning disability which is a national programme.	Subha Thiyagesh	July 2023	Plans in place to hold a specific session at a face to face extended EMT session in September. There are ongoing pieces of work in relation to consistently manage overuse medication (STOMP pathway). Feedback will be taken to CGCSC through the Care group quality and safety report (trio report).
TB/23/39g	The Tees Esk and Wear Valley report to come to Board once it has been presented to CGCS to identify any learning	Darryl Thompson	September 2023	

TB/23/40a	NM noted the learning in respect of the reduction in falls should come to CGCS to be discussed in more detail.	Darryl Thompson	July 2023	This has been added to the CGCS workplan
TB/22/40a	DT reported an update on pressure ulcers will go to CGCS through the chief nurse report. DT and NM to discuss if a further detailed pressure ulcer report is required.	Darryl Thompson	July 2023	This has been added to the CGCS workplan
TB/23/40c	Safer staffing report - MF noted the IPR monitors unfilled shifts and this measure does not feature in this report. MF suggested unfilled shifts should feature in future reports	Darryl Thompson	November 2023	
TB/23/40c	EM reported she was pleased to see the community safer staffing information in the report but would like to see more analysis of this in the next report.	Darryl Thompson	November 2023	

Actions from 28 March 2023

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	September 2023	
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	This has been added to the CGCS workplan.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 July 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.		
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:	**The much anticipated and awaited NHS long-term workforce plan was published on June 30th.** The detail of the plan, what it means for the Trust, and how we engage with its implementation are being assessed and will be overseen by the People and Remuneration Committee. The plan centres on the key themes of train, retain, and reform. £2.4bn will be invested in the plan in the coming years. It aims to increase training places and could mean that there are an extra 60,000 doctors, 170,000 more nurses and 71,000 more allied health professionals in place by 2036/37. More specifically, there are plans to increase training places for both mental health and learning disability nursing, although the plan recognises growth will be limited over the next couple of years. Over the course of the 15 years of the plan, growth in the mental health workforce is targeted at 4.4% per annum. There are also plans to increase training places for clinical psychologists and child and adolescent psychotherapists, as well as an aim to increase other roles such as peer support workers. **A 'rapid review' into data on mental health inpatient units chaired by Dr Geraldine Strathdee has been published.** This rapid review sets out 13 recommendations aimed at integrated care systems, provider trusts, and provider collaboratives. The report has five themes: measuring what matters; including the patient, carer and staff voice; freeing up time to care; getting the most out of what we have; and data on its own is not enough. An initial review of this report has taken place with the Executive Management Team and further assessment will take place before Trust Board is briefed any further.		

	This report is being prepared during the latest round of industrial action by junior doctors, with consultant action due to follow shortly after. The five days of consecutive action by junior doctors is the longest period of action to date. Plans have again been put in place to ensure we can continue to provide safe care and thanks are again offered to our staff who have supported this by planning and providing cover. Whilst the impact of industrial action continues to be well planned and managed, the cumulative effect cannot be under-estimated. The results of the ballot by the Royal College of Nursing have been published and no further industrial action will take place by its members. Two further days of action by consultants have been announced for August unless the dispute is settled before then. **The focus of this Board meeting is on risk and business**. Our risks continue to be closely managed and the Board agenda includes annual reports for freedom to speak up and health & safety. These are key reports that provide assurance of how some of our key risks are managed Our updated Board Assurance Framework and Organisational Risk Register are included in the papers. **Operationally, demands on our services continue to be high**. This is reflected in the number of referrals in some services, along with high levels of acuity and complexity. Out of area bed placements remain stubbornly high despite intensive focus and work on bed management and flow. **The financial environment continues to tighten**. The pay increases for staff were not fully funded in our Trust, which adds pressure to our position, and the impact of cost inflation is being experienced in many areas of our non-pay spend. Whilst expenditure on out of area bed placements is in line with our plan for this year it is high by historical standards and much higher than the funding we receive for it. The West Yorkshire integrated care system is reporting a position that is adverse to plan and this is likely to trigger reviews across the patch. **In October the Health Services Safety Investigations Body (HSSIB) will carry out a national investigation into mental health inpatient care settings.** This work is being scoped out and at this stage it is understood the investigation will cover how young people are cared for in inpatient services, how providers learn from deaths in their care, how out of area placements are handled, and how staffing models can be improved. **We have engaged with the development of joint forward plans for both the South and West Yorkshire systems. These are due to be published in between the date of writing this report and the Trust Board meeting. A link will be provided to all Board members separately to the joint forward plans. In addition, both systems are developing revised operating models in response to the requirement to make significant savings to running costs**. Proposals are likely to be available in the coming weeks and these will be communicated with Board members when available. There will inevitably be some changes to ways of working and how some functions are provided that will have an impact on the Trust. We continue to offer our support to our colleagues across all places and systems in what is a very unsettling time for many staff.

	The NHS 75th anniversary was celebrated and enjoyed in the Trust. A number of events and promotions took place which included attendance at a celebratory service at Westminster Abbey by the Chair along with four members of staff, we had several local celebration events, and on social media 75 achievements and milestones for the Trust were highlighted. **My service visits recently included the CAMHS leadership team in Kirklees and Calderdale**. As always, an open and transparent discussion took place, and some examples of positive work and feedback were provided. Two quotes from the many received bring home the life changing impact our services can have on children, young people, and their families and carers. 'The help we got around understanding her anxieties in school and in her day to day life was life changing for us a family' 'I wanted to share a note to thank 'A' and the rest of the team for the course. Please understand that this course has been life changing for us'. **Following a robust and very competitive recruitment process Dr.Dawn Lawson has been appointed as our new director of strategy & change**. Dawn started her career in learning disabilities and has held senior roles in several NHS providers. More latterly her roles have included being the chief operating officer for the Yorkshire & Humber Academic Health Science Network and the chief executive for Liverpool Health Partners. She brings vast experience of partnership working, innovation and improvement to us and I very much look forward to her joining us in September.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

29 June 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

NHS
South West Yorkshire Partnership
NHS Foundation Trust

During challenging times it is 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

We celebrated **Estates and Facilities Day** by saying a big thank you to all our estates and facilities colleagues for everything they do. Our heath heroes bronze medal winner Katie Whittam is here photographed giving cakes and refreshments to staff as a thank you. They help us to live our values every day.

With **all of us** in mind.

Our priorities for 2023-24

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Golden threads	Strategic objective	Priority
Recovery focused and trauma informed Social responsibility and sustainability Equality, involvement and addressing inequalities	IMPROVING HEALTH 	Address inequalities involvement and equality in each of our places with our partners
	IMPROVING CARE 	Transform our older people inpatient services Improve our mental health services so they are more responsive, inclusive and timely Improve safety and quality
	IMPROVING USE OF RESOURCES 	Spend money wisely and increase value Make digital improvements
	GREAT PLACE TO WORK 	Inclusive recruitment, retention and wellbeing Living our values

Improving health: The Trust, in partnership with Nova has been successful in retaining the contract for Live Well Wakefield services. Congratulations to everyone involved.

Improving care: Following an in depth recruitment process **Tracey Smith** has been appointed as our new chief psychological professions officer. Tracey has been the clinical lead on our work to become a trauma informed organisation.

Great place to work: Along with the West Yorkshire Health and Care Partnership we have been shortlisted for a HPMA award for our work in delivering virtual recruitment fairs. The mental health, LD and autism collaborative is also nominated for a workforce development award.

The national, regional and local context

South West Yorkshire Partnership NHS Foundation Trust

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.

Your home, your choice
West Yorkshire Housing Partnership have launched your home, your choice which is a new area wide campaign urging everyone to think about rightsizing homes sooner rather than later. Rightsizing means finding a home that's right for you now and in the future.
Find out more on the West Yorkshire Health and Care Partnership website.

Barnsley district nurses joined the carers' roadshow in Barnsley town centre. The team provided information about the diverse role of the district nursing service and how this can support carers. They also provided mini health checks and provided advice, support and helped signpost carers to other services.

The Barnsley Health and Care Plan 2023-2025 has been published. You can find the plan on the South Yorkshire ICS website.

The West Yorkshire Staff Mental Health and Wellbeing Hub has a new wellbeing message-taking and call-back service. All staff can use the confidential service free of charge. Call 0800 183 1488 and a member of the team will call back within 72 hours.

10 years of Creative Minds. Our linked charity Creative Minds celebrated 10 years of using collaborations and creativity to support health and wellbeing with a conference in partnership with University of Huddersfield. The event reflected on 10 years of developing creative health and wellbeing approaches and took a look at visions for the future.

Improving Health
Our performance in May

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NHS Foundation Trust

- **53.6%** of people completing Talking Therapies treatment and moving into recovery
- **99.8%** of Talking Therapies referrals beginning treatment within 18 weeks. **98.6%** within 6 weeks.
- **88.2%** 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)
- **94.6%** of people with a risk assessment/staying safe plan in place within 7 days of first contact (for community)
- **89.4%** of people died in a place of their choosing
- **81%** in CAMHS services waiting less than 18 weeks for treatment

We supported **men's mental health week** which encourages men to talk, and seek support should they need it. Throughout the week we shared stories from some of our staff members through blogs and a podcast. Find out more on the intranet, and remember that any member of staff can self-refer to occupational health for support.

From 5 June **ReSPECT** (recommended summary plan for emergency care and treatment) was implemented across all Trust sites. Read more information on the intranet.

The **perinatal mental health team** have been talking on the Rush Hour Rangoli radio show to raise awareness of perinatal mental health in South Asian communities, and how to access support. Listen again on their website.

With **all of us** in mind.

Improving Care
Our performance in May

South West Yorkshire Partnership NHS Foundation Trust

- **574** inappropriate out of area bed days
- **1** young person under 18 admitted onto adult inpatient wards
- **68.6%** waiting for referral to assessment within 2 weeks
- **2.1%** of service users clinically ready to discharge
- **85.7%** of service users on CPA offered a copy of their care plan
- **96.6%** of our service users have their ethnicity equality data recorded, **43.5%** their disability status, **43.4%** their sexual orientation, and **99.8%** deprivation (postcode)

97% of respondents in the friends and family test rated our general community services either good or very good; **85%** in our mental health services, **85%** CAMHS, **100%** for learning disability services, and **50%** for ADHD services.

The choose well for mental health guide for adults has been updated to reflect changes to local services. You can find the most up to date versions on our Trust website.

The **Electronic Prescribing and Medication Administration (EPMA)** project moves into business as usual from 3 July. Since March 2023, EPMA has been implemented in all our mental health inpatient wards. We recognise the positives from the MH inpatient roll out and have an ambition to expand its use further. There are a few changes to be aware of which include how to log enquiries, removal of Full Discharge in SystmOne and documentation, details of these can be found on the intranet.

A group of volunteers with direct experience of the impact of suicide have bravely opened up to share their insight and thoughts on good practice within mental health services in West Yorkshire. **The nine-minute film is a thought-provoking watch for everyone**, we all have a part to play in preventing suicide.

With **all of us** in mind.

Improving Care Incidents in May

NHS
South West Yorkshire Partnership
NHS Foundation Trust

In May we reported:

- **1,253** incidents – **863** rated green (no/low harm)
- **323 were rated yellow and 57 rated amber**
- **10** 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
- **28** patient safety incidents that resulted in moderate or severe harm or patient safety related death. They were **16** pressure ulcer category 3 incidents and **1** category 4 pressure ulcer incident, **7** self harm incidents, **2** physical violence (contact made) against patient by patient, **1** slip, trip or fall – patient and **1** apparent suicide.

We had **186** restraint interventions in May, a reduction of 6 incidents from April. **86.6%** of prone restraints were 3 minutes or less. We continue to offer support and advice to teams around reducing restrictive interventions.

We had **53** falls in May, which is a **increase of 19** from the previous month.

We had 35 pressure ulcers in May. A lapse in care was identified in one of these.

Talk to the trio is a chance for an open discussion with our executive trio about anything that interests you, or you want to discuss, promote or highlight. There is no set agenda – this is about you, your thoughts, feelings and experiences. The next dates are Tuesday 4 and Thursday 20 July (virtual). More information is on the intranet.

Think. Check. Share.

There were **9 confidentiality breaches** in May. All of us can reduce the number of patient data or sensitive information breaches at the Trust. Please make sure you stay up to date with your mandatory IG training.

With **all of us** in mind.

Improving Care
Information governance

NHS
South West Yorkshire Partnership
NHS Foundation Trust

All of us can help to reduce the number of patient data or sensitive information breaches at the Trust. Before you share anything confidential think, check and only when confident, share.

- When speaking to a patient remember to always ask if you have the correct contact details and make any requested changes straight away
- Double check preferred contact channels for patients and always make sure that the contact details you have are accurate and up to date
- When sharing sensitive or personal information over the phone always double check who you are speaking to and only share information if appropriate consent is in place
- How you store information is important. Remember to delete information that you no longer need, and to remove information from shared drives, document libraries and emails if its stored appropriately elsewhere
- We see information that others don't. Protecting this information also protects the people we care for

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.

Many of our staff and service users continue to face difficulties related to the cost of living. Information on local support available can be found on the intranet, and information for service users is on our website. Please share these resources where appropriate.

Our Moving Forward from COVID group has now stood down, with issues now being picked up in our regular IPC meetings. However, we need to stay vigilant and do whatever we can to keep us all safe. The Moving Forward group can stand back up quickly if needed.

With **all of us** in mind.

Improving resources
Our finances in May

NHS South West Yorkshire Partnership NHS Foundation Trust

Performance Indicator	Year to Date	Forecast 2023/24
Surplus / (Deficit)	£0m	£0m
Agency Spend	£1.8m	£9.8m
Financial sustainability and efficiencies	£1.5m	£11.1m
Cash	£77.7m	£76.9m
Capital	£0.8m	£8.8m
Better Payment Practice Code	97%	

In May 2023 the financial position is a deficit of £0.2m which is lower than plan. Year to date there is a surplus of £44k. The main driver in this movement from month 1 is the estimated impact of the national Agenda For Change pay award.

Our agency spend target for 2023 / 24 is to reduce from £10.0m to £8.7m. Our run rate is higher than this

The Trust financial plan includes a sustainability programme totalling £12.0m and is directly linked to the Trust priority of spending money wisely.

The Trust cash position remains strong at £77.7m

To date capital expenditure is £0.8m with significant progress made on the door replacement programme.

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

A great place to work

Our performance in May

- **4.6%** sickness rate for the month. The rolling 12 months sickness rate is **5.3%**
- In May we had new **54** starters to the Trust, and **35** leavers
- We currently have **4,266** substantive members of staff
- **74.9%** of staff have a completed annual appraisal
- We are on target for our **IG mandatory training**. It is now **95.9%.** Thank you to everyone who helped us reach 95% compliance by 23 June.

On 1 June we marked Volunteers' Week, an opportunity to recognise and celebrate the contribution volunteers make to our communities. Read about how Lou was struggling with her mental health until one day she saw a poster for Wakefield Recovery College…

Thank you to the LGBT+ staff network for sharing your stories as part of Pride Month, and helping our staff understand how we can support our LGBT+ colleagues. You can read Donna's story and Chris's story on our website.

Upcoming industrial action. A five day strike by junior doctors is planned between 7am on Thursday 13 July to 7am on Tuesday 18 July. Consultants have also voted to take part in strike action on Thursday 20 and Friday 21 July for 48 hours. The safety of our patients, and the wellbeing of all of our staff is our highest priority. We value all of you and respect your rights to engage in industrial action. If you have any questions, please speak to your line manager or union representative, who will be happy to help.

Learning Disability Week 2023 was celebrated across the Trust. Our learning disability teams were involved in lots of events, which you can read about on our website. Thank you to all staff and service users who contributed to our events to help raise awareness and educate others.

We want to retain talent, skills and experience. If you're thinking about moving onto a different role, contact the people directorate in confidence to discuss possible like for like employment opportunities within the Trust. When leaving the Trust, staff should be offered a retention discussion and asked to complete an ending employment questionnaire.

How we're celebrating 75 years of the NHS – 5 July 2023

South West Yorkshire Partnership NHS Foundation Trust

Moving…

Complete 75 miles in June or July – run, cycle, swim or walk a mile for every year of our NHS. And don't forget to let EyUp! know what your planning by registering your interest.

Parkrun for the NHS at a local event on Saturday 8 or Sunday 9 July. Find more on the intranet.

Munching…

On Wednesday 5 July – join EyUp! Who will be selling tea, coffee and sweet treats in the Fieldhead and Kendray canteens. If you would like to host your own event, fill out a form.

And memories…

Share your memories of the NHS by submitting a story via our website. We will be **sharing your stories throughout July** showing how our NHS makes a difference everyday.

With **all of us** in mind.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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

Make sure you know about ReSPECT and how it impacts on what you do.

Watch the volunteers' film on suicide prevention. It might help save someone's life.

Think, check, share. Do everything you can to help protect data and confidential information.

Share your experiences and learning with our Exec Trio at their 'talk to the trio' sessions.

Help us to retain talent, experience and skills by encouraging discussions about the future job opportunities.

Celebrate the NHS75 birthday by taking part in Trust events.

Look after yourself and others wellbeing. There is support available.

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 July 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**

The Board Assurance Framework has now been updated for 2023/24 as approved by Trust Board in April 2023.

There are 14 strategic risks for 2023/24:

Improving health – 4

Improving care – 4

Improving resources – 3

Make this a great place to work – 3

On 13 July 2023, the Executive Management Team (EMT) fully reviewed the updated BAF for 23/24 to consider current circumstances and the grading of strategic risks.

EMT discussions reflected the fact that the external environment in which the Trust operates continues to evolve, including factors such as high levels of demand, both in terms of numbers of referrals into services and acuity and complexity in presentation, the impact of the cost-of-living crisis, industrial action and the ongoing need to support staff wellbeing.

Following EMT discussion it is recommended changing the grading of Risk 4.3 from Amber to Yellow. The rationale for this is explained below.

Board should note the score of new risk 2.4 - Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience is still to be determined. Key criteria and evaluation of the risk is currently taking place to provide a view and recommendation.

Strategic Risk Ratings	Q1 2023/24
Red	0
Amber	5
Yellow	8
Green	0

In Quarter 1, a comprehensive review of controls, assurances and target dates for actions took place with lead directors. A summary update is included below:

Risk 1.1	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	2 new controls
Risk 1.2	Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision	1 new control
Risk 1.3	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	1 new assurance
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	1 new assurance
Risk 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.	1 new assurance
Risk 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
Risk 4.3	Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies.	1 new control

EMT has given careful consideration to all strategic risks with a focus on the following:

Risk 1.1 - 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. To remain at Yellow. A discussion took place noting the changing financial landscape of integrated care systems (ICS) and what impact this may have. This risk will be closely monitored as revised ICS operating systems are developed.

Risk 1.2 - Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. EMT discussed the current wording of this risk and queried whether the wording accurately reflected the context of the risk fully.

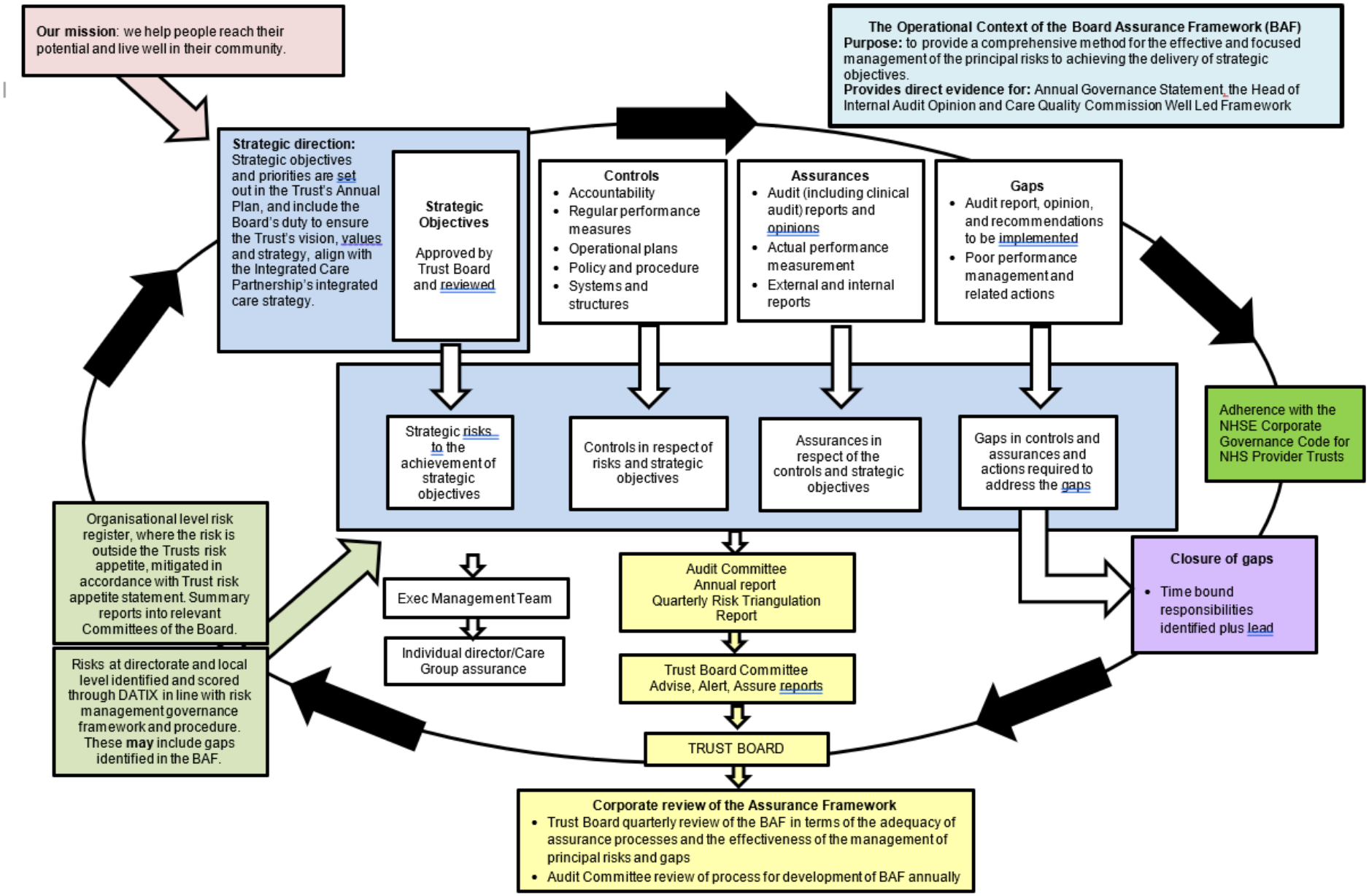
New wording for this risk was developed during the meeting and is submitted today for Board approval: **Accommodating variation in approaches to meet local population needs could lead to unwarranted variation in service provision.**

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 – To remain Amber. EMT discussed that current level of demand for Trust information remains high and Trust capacity to meet this demand holds the Amber grading at this time. It is envisaged this risk could move to a yellow rating within the next two quarters. The full impact of the recommendations from the rapid review into data on mental health inpatient settings by Dr.Geraldine Strathdee are being evaluated.

	Risk 4.3 - Failure to support the wellbeing of staff EMT agreed the Trust wellbeing offer is extensive and needs to be monitored. It was also noted there have been a number of noted improvements since Q4 of 2022/23. For example, the Trust's staff absence rates and turnover rates have reduced. The Trust benchmarks well against other trusts of a similar type in respect of sickness levels and the results of the 2022 staff survey reflect a slight improvement. EMT recommends that this risk moves from Amber to Yellow. The view of EMT is that the ratings of individual strategic risks for Q1 are representative of the operating environment and pressures within our services.
Recommendation:	**Trust Board is asked to DISCUSS this report and APPROVE the proposed updates to the Board Assurance Framework and AGREE the revised wording for strategic risk 1.2.**

BOARD ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

South West Yorkshire Partnership NHS Foundation Trust



Board Assurance Framework (BAF) – 2023/24

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	22/23	2023/24			
			Q4	Q1	Q2	Q3	Q4
Improve health	1.1 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		Y	Y			
	1.2 Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision		Y	Y			
	1.3 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		Y	Y			
	1.4 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		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			
	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.		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			
	2.4 Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience		N/A	TBC			
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			
	3.2 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		Y	Y			
	3.3 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		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 and staff experience and the inability to sustain safer staffing levels		A	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	Y			

Strategic objective	Strategic risk	Page ref	22/23	2023/24			
			Q4	Q1	Q2	Q3	Q4
	4.3 Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies.		A	Y			

Key:
Lead Directors: CEO = Chief Executive Officer, DFR = Director of Finance, Estates & Resources, CPO =Chief People Officer, DNQ = Chief Nurse/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

Risk appetite:

Strategic risks: Risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans.	**Risk appetite Open/High**
• Delivering transformational ensuring a safe place to receive services and a safe place to work. • Developing partnerships that enhance Trusts current and future services. • Delivering the Trust social responsibility and sustainability strategy in line with the NHS long term and green plans • The risk the Trust fails to innovate and fulfil its strategic ambitions • Ensuring that equality, involvement and inclusion is central to everything the Trust does to reduce inequalities, tackle stigma and eliminate discrimination	

Strategic objective 1: Improve health	**Lead Director(s)**	**Monitoring and assurance**	**Overall assurance level**				
			2022/23	**2023/24**			
Links to ORR (risk ID numbers): 275, 695, 812,1157, 1511,1624, 1689	As noted below.	EMT, CGCS, MHA, Trust Board, CC	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
			Y	**Y**			
Strategic risks – to be controlled, consequence of non-controlling and current assessment							
Ref	**Description**						**RAG rating**
1.1	**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**						**Y**
1.2	**Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision**						**Y**
1.3	**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**						**Y**
1.4	**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**						**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 integrated partnerships in Barnsley, Calderdale, Kirklees and Wakefield. • Coordinating provider for West Yorkshire Adult Secure collaborative and lead provider for South Yorkshire Adult Secure collaborative, and partnering provider collaboratives regionally • Coordinating provider for forensic child and adolescent mental health services (FCAMHS) 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 has been involved in the development of place-based plans and priority setting.

Rationale for current assurance level (strategic objective 1: improve health)
• Involved in 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 further enhance child and family engagement. • The Trust insight report feeds into the Executive Management Team meeting and Equality, Inclusion and Involvement Committee • Integrated Performance Report (IPR) summary metrics month 2 23/24 - out of area beds – red, children and young people accommodated on an adult inpatient ward – 1 service user, learning disability referrals with completed assessment, care package and commenced delivery within 18 weeks – red, delayed transfers of care – green. • Transformation and priority programmes, including the measurement and impact on strategic risks, reported to EMT and Trust Board through the Integrated Performance Report (IPR). In addition EMT receive a monthly priority programme report showing progress against annual objectives. • 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 health inequalities and data interactive tool to inform the health 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. • Older peoples transformation in progress, preparation for consultation with the public is being progressed. • 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 has completed a review of mandatory training in respect of equality and diversity which will inform future plans. • All services have a baseline Equality Impact Assessment (EIA) in place. • Deliver and report on compliance with Equality Delivery System 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. • Asset based community engagement process developed and introduced to improve engagement with place-based communities.

Strategic objective 2: Improve care	Lead Director(s)	Monitoring and assurance	Overall assurance level								
			2022/23		2023/24						
Links to ORR (risk ID numbers): 275, 773, 905, 1078, 1132, 1159, 1424, 1522, 1530, 1545, 1568, 1649, 1650 1757, 1758,1820	As noted below.	EMT, CGCS, WRC, Trust Board	Q4		Q1	Q2	Q3	Q4			
			Y	A	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 leaving to a negative impact on quality of care.**	A
2.4	**Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience**	

Rationale for current assurance level (strategic objective 2: improve care)
• A band 7 Speech and Language Therapist has been established to take a lead role in our approach to dysphagia.

Rationale for current assurance level (strategic objective 2: improve care)
• 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 – green. • Improvement work around the FIRM risk assessment and care planning continues and the impact of work so far is showing positive change. This is being led by a task and finish group. • Waiting list management in SystmOne is complete and waiting list report is presented to the Finance, investment, and performance committee on a regular basis. • 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 improving access to care work is progressing. • 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 continues to be embedded with a particular emphasis on our learning from QI approach and application in practice of our IHI training. • Themes from serious incident investigations, are identified through clinical risk panel, and improvements are reported through clinical governance clinical safety committee. • In the main, positive Friends and Family Test feedback from service users. There is noted variance in areas of low returns and low scores, and solutions 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, pay expenditure, care group risk management and Sustainability all received significant assurance, DSPT (2022-3) substantial assurance. These all contribute the Head of Internal Audit Opinion which is currently on track to maintain the high Trust standard. • 94% 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. In May 2023, the CQC conducted an inspection of forensic inpatients and mental health inpatient services. • 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 has been updated in line with changes in national guidance in May 2023. • 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 is in place with piloted identified teams – senior responsible owners are the chief people officer and chief nurse/director of quality and professions. • "The care group quality and safety report" is presented to all EMT and 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				
			2022/23	2023/24			
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	Q4	Q1	Q2	Q3	Q4
			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	**Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives**	Y
3.3	**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**	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, pay expenditure, care group risk management and Sustainability all received significant assurance, DSPT (2022-3) substantial assurance. These all contribute the Head of Internal Audit Opinion which is currently on track to maintain the high Trust standard. • 94% compliance with internal audit actions. • Head of internal audit opinion for 22/23 was significant assurance. • Integrated Performance Report (IPR) summary metrics will be updated to reflect the new strategic priorities for 23/24 in Q1

Rationale for current assurance level (strategic objective 3: improve resources)
• Cash balance at month 2 of 2023/24 is £ £77.7m. • 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 are established. The South Yorkshire and Bassetlaw adult secure lead provider collaborative went live in May 2022The Trust is coordinating provider for forensic CAMHS for Yorkshire and Humber region which went live on 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. • The Trust has an approved digital strategy with the next update due to be presented to Trust Board at end of Q2 23/24. • Capacity has been obtained to progress Digital dictation in the Trust and is on track for delivery during 23/24 • New standing financial instructions and scheme of delegation approved by Trust Board (January 2023) and Members Council (February 2023). • Delivery of 2022/23 financial plan

Strategic objective 4: Make this a great place to work	Lead Director(s)	Monitoring and assurance	Overall assurance level				
			2022/23	2023/24			
Links to ORR (risk ID numbers): 1151, 1157, 1614, 1729	As noted below.	EMT, WRC, Trust Board	Q4	Q1	Q2	Q3	Q4
			A	Y			

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 and staff 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**	**Y**

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. • Agency scrutiny group has been developed to monitor and reduce agency spend across the Trust. • Staff turnover rates have stabilised but vary between care groups and service lines with turnover in inpatient areas presenting the highest numbers. The Trust benchmarks well against peer organisations. • 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 have been developed and are being monitored through PRC. Wellbeing for staff offer has been revised and refreshed with more local wellbeing champions being developed. • The internal audit of Trust exit process for leavers is now complete and has been reported to Audit Committee. Action plan complete. • The Trust now has a full and substantive board including both executive and non-executive roles and new associate non-executive director. • 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. • 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 annual report is taken through PRC. A freedom to speak up steering group has been developed that will now report into PRC. • Freedom to speak up mandatory training in place 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 that took place in May • A full time diversity and inclusion lead in post to support diversity and inclusion across the Trust. • 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 in place 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.

Rationale for current assurance level (strategic objective 4: make this a great place to work)
• OD and wellbeing facilitator is in post from August 2023 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
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

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 mental health, learning disability and autism programme board. Partner in SY provider 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 are in place to reflect care pathways (I,P)	COO	1.1
C187	Governance arrangements are in each place in both West and South Yorkshire integrated care systems, and in place. These will be subject effectiveness reviews when required.	DSC/DPD	1.1

Controls (strategic risk 1.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C188	South Yorkshire Mental Health Learning Disability and Autism Provider Collaborative now in place. Operating in private and meetings to be public from September 2023	DSC/DPD	1.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
New operating plans based on a 30% reduction for both ICB's have the potential to impact upon capacity and influence to achieve the strategic objectives of the ICS and as a result any potential on the Trust and service provision across place.	October 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. Review further in October 2023.	October 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. Reviewed in July 2023, work continuing to progress and to be reviewed further in October 2023	October 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, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT.. (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

Strategic risk 1.2 Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision

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
C190	Place based plans are now in place and the Trust has been fully engaged in the planning process	DSC/DPD	1.2
C193	Alignment of Trust plans with Integrated Care Boards and alignment of operational and quality plans through place governance structures	DNQ/DPD	1.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead

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
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, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	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.	Annual unannounced and planned visits programme in place and annual report is now received directly by the Clinical Governance Clinical Safety Committee	DNQ	1.1, 1.2, 2.3

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)**
	Reports on these visits are provided to the EMT, Clinical Governance &Clinical Safety Committee (CGCS) Trust Board and Members' Council.	(CGCS). Quality monitoring visits for 2023/24have started and will be reported into CGCS Committee in due course. (P, N) (E)		
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 investigations and dissemination of lessons learnt and good clinical practice across the organisation. We continue to embed 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 People & 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.	October 2023	DFR
The new people directorate structure and great place to work strategy is in place but vacancies within the people directorate could pose a risk to both achievement of outcome and timescales. Gaps still exist with new staff starting in post towards the end of Q2.	October 2023	CPO

Strategic risk 1.3
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

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 priority areas of work against strategic objectives for 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

Controls (strategic risk 1.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C26	Community reporting is available 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
C38	Trust website rated good on Accessible Information Standard. (P, I, E)	DSC	1.3, 1.4, 2.4
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	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
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) (I,E,P,N)	DSC	1.3
C171	Health Intelligence support role now in place (I,P)	DSC	1.3
C184	Targeted programmes are being delivered through linked charities (I,E,P)	DSC	1.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
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. Reviewed in July 2023, work continuing to progress and to be reviewed further in October 2023	October 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, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	1.1, 1.2, 1.3, 2.3, 3.3

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)**
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
A43	Waiting list reporting including health inequalities data	Reported in OMG quarterly and improving access to care group quarterly (P,N,I)	DSC	1.3,2.1

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**
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. Appointment has been made to deliver training. Review further in January 2024.	January 2024	DSC

Strategic risk 1.4
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

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 mental health, learning disability and autism programme board. Partner in emerging SY provider 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
C26	Community reporting is available 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
C35	Translation and interpretation service in place as well as inequalities interactive tool. (I)	DSC	1.3, 1.4, 2.4
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	1.3, 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

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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
New operating plans based on a 30% reduction for both ICB's have the potential to impact upon capacity and influence to achieve the strategic objectives of the ICS and as a result any potential on the Trust and service provision across place.	October 2023	DSC/DPD
Health inequalities data is in place, and being analysed and considered, the next key step will be to use the data to inform service change and developments. To review each quarter.	April 2024	DSC/DPD

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 2023/24 work plan. Quality strategy published March 2023. (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 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)	DFR	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. Work continues with an expectation of funding to be extended beyond September 2023. Review further October 2023.	October 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, into EMT on a regular basis. (I) (P)	COO	2.1
A43	Waiting list reporting including health inequalities data	Reported in OMG quarterly and improving access to care group quarterly (P,N,I)	DSC	1.3, 2.1, 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

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. CGCS continues to oversee the learning from SI action plans, with the committee developing reports that more clearly evidence the links between the incident and the learning is the gap. However, this is work in progress. To review again October 2023	October 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 continue to embed 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
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 from January 2023. Comms campaigns, action plans and thematic reviews continue. Fluctuating numbers of incidents are being reported 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. Mandatory training standard of 95% was achieved for the submission of the data security and protection toolkit for 30 June 2023. Reviewed in July 2023 to review further in October 2023 to ascertain the impact of training on IG breaches.	October 2023	DFR
Work on the inpatient priority programme is underway and is using learning to improve safe and effective care delivery. 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, work continues, further update available in October 2023.	October 2023	DSC/DNQ

Strategic risk 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.

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

Controls (strategic risk 2.3)			
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
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 workstream for Improving Access to Care 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
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
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
Health inequalities data is in place, and being analysed and considered, the next key step will be to use the data to inform service change and developments. To review each quarter.	April 2024	DSC/DPD
Safer staffing establishment being developed for community services as part of community serviced transformation programme. Safer staffing establishment being developed for community services as part of community serviced transformation programme. Update was included in the six-monthly safer staffing paper that went to April Board. This will be reviewed further for the next 6 monthly safer staffing report, due in November 2023.	November 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 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, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT.. (I) (P)	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 2023/24 work plan. Quality strategy published March 2023. (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

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)**
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
A43	Waiting list reporting including health inequalities data	Reported in OMG quarterly and improving access to care group quarterly (P,N,I)	DSC	1.3, 2.1, 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 r focus on patient flow and discharge, including continuing the principles of the national one hundred day discharge challenge. 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 October 2023.	October 2023	COO
Specific demand for children's neurodevelopmental (ADHD.ASD) assessments in Calderdale and Kirklees exceeds capacity. Resources have been agreed with commissioners to try and improve the position. Additional support is in place form an external partner. Demand continues to rise beyond commissioned capacity. Demand and capacity with commissioners is being revisited. In all areas demand for adult ADHD services is beyond commissioned capacity, this is in line with the national picture. Work is taking place in each ICS to understand the rising demand and agree how this can be addressed. Review in October 2023.	October 2023	COO

Strategic risk 2.4
Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience

Controls (strategic risk 2.4)			
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
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
C26	Community reporting is available 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
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Equality, Inclusion, and Involvement Committee. (I)	DSC	1.3, 1.4
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, 1.4, 2.4
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
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
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
C136	Inclusive Leadership Board Development (ILDB) programme on inequalities completed March 2022 with future board development programme being established. (P,I)	CPO	4.2
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
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
C167	Insight programme – developing future Board members from diverse backgrounds (P, I, E)	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 (P,N,I,E)	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 (P, I, E)	CPO	4.2
C191	Trust medical appraisal and revalidation process aligns to general medical council report (Fair to refer 2019)	CMO	2.4
C194	Waiting list management in SystmOne is in place	DSC	2.4

Gaps in control – what do we need to do to address these and by when?	Date	Director lead

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)**
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, 2.4
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 2.4
A35	Equality interactive tool presented to Equality, Inclusion, and Involvement Committee	Regular reports and papers provided. (P) (I)	DSC	1.4, 2.4
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	2.4, 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	2.4, 4.1, 4.3
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, 2.4
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	2.4, 4.3
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	2.4, 4.2
AXX	Waiting list report including analysis in relation to protected characteristics	Reported into FIP committee (I, E, P, N)	DSC	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
Monitoring arrangements need to be introduced to determine how quickly discrimination issues are being resolved. A feedback mechanism needs to be determined for issues relating to discrimination to demonstrate that progress is being made. Tangible outcome measures need to be identified to be able to demonstrate progress.	October 2023 October 2023 October 2023	CPO/DNQ/CMO/COO CPO/DNQ/CMO/COO CPO/DNQ/CMO/COO

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
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. The OMG workplan has been aligned to focus on the key areas of finance and performance on a rotational basis (I)	COO	3.1, 3.3
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director with recent and relevant financial experience. (I)	DFR	3.1, 3.3

Controls (strategic risk 3.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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. Update July 2023 – work ongoing and further updated to be provided in October 2023 CIP challenge for 23/24 is currently expected partially through non-recurrent measures. Plans need to progress to identify further recurrent schemes.	October 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 r focus on patient flow and discharge, including continuing the principles of the national one hundred day discharge challenge. 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 October 2023.	October 2023	COO
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. Quality and safety remain priorities in line with Trust values.	October 2023	DFR

Strategic risk 3.2
Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.

Controls (strategic risk 3.2)			
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, 3.2
C86	C86Weekly Operational Management Group (OMG) chaired by Chief Operating Officer providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. The OMG workplan has been aligned to focus on the key areas of	COO	3.1, 3.2
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director with recent and relevant financial experience. (I)	DFR	3.1, 3.2
C94	Agreed Trust workforce plan in place which identifies staffing resources required to meet current and revised service offers. Also describes how we meet statutory requirements re training, equality, and diversity. (P, N), (I)	CPO	3.2
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	3.2
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DSC	3.2
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	3.2
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	3.2
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2023-24 priorities. (P), (I)	DSC	3.2
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	3.2
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
C151	Integrated Change Framework includes escalation process for issues / risks to be brought to the attention of the Executive Management Team. (P,I)	DSC	3.2
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	3.2

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. Work ongoing to be updated in October 2023.	October 2023	CPO/COO/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
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, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT.. (I) (P)	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, 3.2

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)**
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, 3.2

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

Strategic risk 3.3
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

Controls (strategic risk 3.3)			
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	1.4,3.3
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and yearly report to Trust Board. (I)	DFR	2.1,3.3
C61	I-hub platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate, and improve. (I)	DSC	2.2,3,3
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	3.2,3.3
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DSC	3.2,3.3
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	3.2,3.3
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	3.2,3.3
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	3.2,3.3
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	3.2,3.3
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	CEO	1.1, 1.2, 1.3. 3.3
C134	Workforce strategic groups established and is being reviewed alongside the new operational model and people directorate structure. (P, I)	DHR	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	3.2, 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	3.2 3.3
C169	Digital Strategy and Innovation Group meets quarterly to assess potential new and emerging digital opportunities (P, I)	DSC	3.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
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 3.3)				
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
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, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT (I) (P)	EMT	1.1, 1.2, 1.3, 2.3, 3.3

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)**
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 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**

Strategic risk 4.1

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

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	Chief medical officer 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. Reviewed in July 2023 work in progress. Further review in October	October 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. Planning process is complete with a trajectory of 3% across the Trust for the year 23/24. The gap remains due to the continuing growth in establishment October 2023	October 2023	CPO
Recruitment process has been completed for a replacement band 8a leadership and management development lead. To take up post end of Q2 23/24. The delivery of leadership activity throughout the Trust is reduced in the interim period until this time.	October 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 People 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 PRC 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

Controls (strategic risk 4.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C103	Education and training governance group in place to agree and monitor annual training plans. (I)	CPO	4.1, 4.2
C115	Appointment of diversity and inclusion lead 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. (P,I)	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
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 (P,N,I,E)	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 (P, I, E)	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 to be incorporated into future reporting.	October 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
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 EMT and 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 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

Controls (strategic risk 4.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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 in place. (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
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	Diversity, inclusion and belonging lead in place(P) (I)	CPO	4.3
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
C192	Medical appraisal has a wellbeing section which is reviewed by the appraisal and validation team on an annual basis (aligns to GMC fair to refer report 2019)	CMO	4.3

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Staff sickness rates have reduced in Q1.. 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. The Trust continues to benchmark well against other like organisations. The current focus is on stress and anxiety as identified area of improvement. Reviewed in July 2023 to review further in October 2023.	October 2023	CPO
The Occupational Health Service are in the process of adopting a trauma informed approach to improve the offer to Trust staff. This being piloted at present with a position update expected towards to the end of Q2.	October 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. Wellbeing champion roles have been established with start dates of end of Q2.	October 2023	COO/CPO

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 July 2023
Agenda item 9.2

Private/Public paper:	**Public**		
Title:	**Quarter 1 Corporate / Organisational Risk Register 2023/24**		
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		
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 board of directors should 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 Partnership (ICP), Integrated Care Board (ICB), and place-based partnerships. The board of directors should ensure the Trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives.		
Any background papers / previously considered by:	Previous quarterly reports to Trust Board. Assessment of allocated risks is a standing agenda item at all Board committee meetings.		
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**

With **all of us** in mind.

	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. Two new risks have been identified for Trust Board discussion and approval.

New Risk:

Risk ID	Risk Owner	Description
New risk	Chief Operating Officer	Maintaining people who are clinically ready for discharge in an inpatient bed, impacts on bed capacity.

A new risk has been developed in relation to the number of people clinically ready for discharge who continue to stay in acute mental health inpatient and learning disability services, which is having an impact on bed capacity. The executive directors have graded this risk 12 (amber) (consequence 3 “moderate” x likelihood 4 “likely”). This risk will be monitored and reviewed by the Clinical Governance and Clinical Safety Committee.

New Risk:

Risk ID	Risk Owner	Description
New risk	Chief People Officer/ Chief Nurse and director of Quality and Professions	The current appraisal and supervision process including issues with the WorkPal system may impact on staff retention, wellbeing and development, clinical practice and regulatory oversight.

This new risk has been developed to reflect some teams are using different appraisal and supervision processes, e.g., paper based and/or electronic. The executive directors have graded this risk 9 (amber) (consequence 3 “moderate” x likelihood 3 “possible”). This risk will be monitored reviewed by the People and Remuneration Committee and the Clinical Governance and Clinical Safety Committee.

Risks within the risk appetite

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.

This risk has been reviewed by EMT and they have recommended a reduction in the risk score from 16 (red) to 12 (amber), with a reduction in likelihood from 4 “likely” to 3 “possible”. Silver command meetings

have been established to manage industrial action and a separate strike committee has now been established.

Risk ID	Risk Owner	Description
1114	Executive Director of Finance, Estates and Resources	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

The Executive Director of Finance, Estates and Resources has reviewed the risk score with members of the Finance, Investment and Performance Committee and, due to increasing financial pressure across the Trust and wider NHS, they are recommending an increase in the risk score from 6 (yellow) to 9 (amber), with an increase in likelihood from 2 “unlikely” to 3 “possible”.

Heat map

Appendix 1 shows the heatmap of the organisational / corporate risk register. In line with best practice the risk scoring and total risk timelines have been extended to show a longer-term trends from January 2021 to July 2023.

A summary of findings are below:

- The number of risks has increased from 33 to **35 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 three red risks aligned to Improving Care, a decrease of one from Q4 22/23.
- There are two red risks aligned to Improving Resources, this maintains the Q4 22/23 position.
- There is one red risk aligned to Making this a great place to work, this maintains the Q4 22/23 position
- The accumulative risk score as at 25 July 2023 is **384, an increase of 29 from Q4 22/23** with an average score of **10.97** (amber) an increase from **10.75** (amber) in Q4 22/23.

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 - Maintaining people who are clinically ready for discharge in an inpatient bed, impacts on bed capacity.** • **AGREE to add the new risk - The current appraisal and supervision process including issues with the WorkPal system may impact on staff retention, wellbeing and development, clinical practice and regulatory oversight.** • **AGREE to the reduction in risk score for risk 1758** • **AGREE to an increase in risk score for risk 1114**

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 = Executive director of strategy and change (interim)
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 1 2023/24

Trust Board: 25 July 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

New Risks (developing)

Risk ID	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
1. **TBC**	Maintaining people who are clinically ready for discharge in an inpatient bed impacts on bed capacity	**COO**	CG& CSC	• Patient flow processes establish barriers to discharge on admission • Routine multidisciplinary reviews • Care programme approach and care plans in place • Partnership work with commissioners including an agreed governance structure and meetings to manage out of area and cessation plans • Care Closer to Home Partnership Group and Care Closer to Home steering group • Workstreams in place to address specific areas • Pathway for people with trauma informed emotionally unstable personality disorder is in place Barriers to discharge reports link into place-based delays in discharges. • MADE (multi agency discharge meetings) are in place in each area	3 moderate	4 likely	12	8-12 Strategic risk	• Detail of the actions to improve patient flow are set out in the improvement plan. These are informed by the principles in the 100 day discharge challenge (COO review September 2023) • The ongoing impact of DTOC patients is reviewed through the MADE meetings ,improvement work and the partnership group. (COO September 2023) • Where MADE meetings have not reached a solution, a Gold command meeting will be established. (Ongoing, COO review September 2023) • The secondary care pathway in West Yorkshire is used to share learning of themes to barriers to discharge to inform future work streams. Similar work has commenced in South Yorkshire (Ongoing COO to review in September 2023) • Review is underway in relation to the identification and reporting of people who are clinically ready for discharge (COO to review September 2023) • Training for staff for people with trauma informed emotionally unstable personality disorder continues (COO, September 2023)	31 December 2023	EMT OMG CG & CSC Trust Board	6	**Key changes: Trust Board to agree new risk, risk description and risk score.** Since the risk was first escalated, the number of people who are reported as clinically ready for discharge has reduced to expected thresholds. However, the change of definition may be impacting this.	September 2023
2. **TBC**	The current appraisal and supervision process including issues with the WorkPal system may impact on staff retention, wellbeing and development, clinical practice and regulatory oversight.	**CPO/ DNQ**	PRC CG & CSC	• Appraisal policy in place • Regular workshops and training on appraisals • Intranet guide, resources and support regularly updated. • Regular Trust wide communication • Regular monitoring by PRC and Trust Board through the IPR	3 Moderate	3 Possible	9	8-12 Business Risk	• Full procurement exercise to be undertaken for Appraisal system by Dec 23 to ensure most suitable system is being utilised by the Trust which must interface with existing workforce systems (ESR) – January 2024 (CPO, Jan 2024) • Working with Workpal provider to increase system flexibility, particularly linked to reporting and 12 month rolling appraisal window. (CPO, ongoing, review September 2023)	31 March 2024	PRC CG & CSC EMT OMG Trust Board	6	**Key changes: Trust Board to agree new risk, risk description and risk score.** Systems interoperability (ESR does	September 2023

ORGANISATIONAL LEVEL RISK REPORT

Risk ID	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
				• Local systems are in place to ensure completion and oversight of appraisals					• Inpatient Lead supporting improvement work across the wards (COO, DNQ, January 2024) • People, Performance and planning lead due to start August 2023 (CPO, Aug 2023) • Limited resources in the people planning performance function, additional resources to be sourced (CPO, September 2023) • Local arrangements being created to record appraisals, these need to be moved from paper based recordings to the Workpal system (COO, September 2023) • Supervision Policy is currently being reviewed (DNQ, September 2023)				not link to the system so managers are not automatically assigned correctly)	

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk level 15+

Risk ID	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
3. **1151**	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. • 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 recruitment plans and processes. • Workforce plans incorporated into new business cases. • Workforce strategy action plan. • Retention plan developed. • Working in partnership on international recruitment. • Inpatient ward workforce review with revised skill mix. • Marketing of the Trust as an employer of choice. • Workforce planning processes including development of new clinical roles. (CPO/DNQ) • Internal staff transfer report to understand internal turnover in more detail	4 Major	4 Likely	16	8 - 12 Business Risk	• Proposal for On Boarding System to include recruitment/career Microsite with the view to complete testing and roll out (CPO, September 2023) • Exploring use of recruitment and retention premia in inpatient settings, paper to EMT (CPO ongoing discussion at EMT) • Collaborative recruitment initiatives with West Yorkshire Mental Health and Learning Disabilities and Autism Collaborative (ongoing, CPO) • Review of entry level qualifications in support worker roles CPO, September 2023) • Internal transfer system to continue to be promoted (CPO Ongoing 2023) • Applicant Tracking System (ATS) to be fully delivered by September 2023 (CPO, September 2023) • Introduction of ATS system to be implemented to replace NHS 3 (CPO, September 2023)	30 September 2023	Care Group (weekly) CG&CSC PRC EMT (monthly) Trust Board	9	BAF Ref, SO 3, 4	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	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
4. **1530**	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 order to respond to changes in demand.	4 Major	4 Likely	16	1 – 6 Clinical risk	• Continue to work with partners in each place to monitor and manage changes in demand and hotspots. (COO/ CPD, Review September 2023) • Where the need for additional capacity is identified work with commissioners to agree the required changes (COO, ongoing, review September 2023) • Full review of demand has been completed with discussion ongoing with Improving Access to Care group (COO, September 2023)	30 September 2023	CG&CSC EMT (monthly) OMG Trust Board	4	BAF ref SO 2	September 2023

ORGANISATIONAL LEVEL RISK REPORT

Risk ID	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
5. **1080**	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. • 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. • Schedule of ongoing communications and education on cyber awareness for all staff to continue via Trust standard communication channels. • DSPT Cyber and Information Governance met (substantial) and	5 Catastrophic	3 Possible	15	8-12 Strategic risk	• Review business continuity plans with frontline services following the cyber-attack on Advanced (NHS IT system provider) (DFR, Q2, 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 presented to EMT, approval on hold pending overall financial position in Q2 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, 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)	Review 30 September 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	BAF Ref, SO 2 & 3	September 2023

Risk ID	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
				includes additional resilience to mitigate the risk presented by the Ukraine conflict • Cyber security enhancements to support move towards advanced monitoring capabilities completed • 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. • Data retention policy in place • Annual cyber table top exercise takes place • Implementation of Multi-Factor Authentication (MFA) across the Trust • Introducing Digital Technology Assessment Criteria (DTAC) requirements which includes cyber security considerations into Trust procurement/tendering processes for digital/IT solutions/services									

Risk ID	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
				Cyber Essentials Plus re-accreditation achieved in 2023										
6. **905**	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 • Medical staff bank established. • Allied Health Professionals master agency contract in place. • Staffing levels monitored locally by matrons and / or service managers. presenting need. • Risk panel monitors all incidents including the occasions where newly qualified nurses undergoing preceptorship are asked to take charge of a shift. • Care Group meetings review safer staffing • Staff redeployment process in place • Overtime is available as part of a range of temporary staffing options • Bank recruitment now embedded • New roles group leads on the development of a range of options including ACP (Advanced Clinical Practitioner)	4 Major	4 Likely	16	1-6 Clinical risks	• Roll out of Safe care ongoing throughout 2023/24 including review of effectiveness (DNQ/ CPO, September 2023) • Working with partners across ICS as part of the inpatient service improvement programme (COO/ CPO, to review September 2023) • The focus on recruitment to inpatient areas continues (CPO, review monthly, September 2023) • A full review of inpatient ward establishments is underway and reporting through the inpatient service improvement programme (September 2023, DNQ)	30 September 2023	EMT (monthly) OMG Safer staffing inpatient and community group CG&CSC Trust Board	6	BAF Ref, SO 2 & 3	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	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
7. **1568**	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 • Seclusion rooms on different wards can be accessed if available based on risk assessments and provide the appropriate level of security • Incidents are reported on Datix and monitored through risk panel • Process in place for the Estates Team to respond to urgent requests for repair • 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 • Joint working between Estate and operational teams.	4 Major	4 Likely	16	1-6 Clinical risk	• The clinical environment and clinical safety group is overseeing the accelerated seclusion programme (DNQ, September 2023) • Learning from the work in forensics, Horizon and other similar organisations, this will be used to inform improvements in acute services and will be overseen by the clinical environment and clinical safety group (DNQ, September 2023)	30 September 2023	CG&CSC EMT monthly OMG (regular updates) Clinical Environment clinical safety group Trust Board	4	BAF Ref SO 2 <u>Update:</u> A costed plan is in place to bring each seclusion room up to the required standard. Exec TRIO were considering a reduction in the risk score to 3 possible but given the recent damage on acute areas we will maintain the score as 4 likely (16). All but one seclusion room in forensics (Gaskell) (empty ward) have work carried out in relation to removing the vinyl.	September 2023
8. **1368**	Risk that given demand and capacity issues across South & West Yorkshire and nationally, children and younger people requiring admission to hospital will be	**COO**	CG & CSC	• Bed management processes are in place as part of the new care model for Tier 4. Other controls include: • Community options are explored. • Protocol in place for admission of children	4 Major	4 Likely	16	1-6 Clinical risk	• Wrap around in reach 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 December 2023) • The collaborative is exploring further out of hospital support to children to avoid hospital admission (COO, September 2023)	30 September 2023	CG & CSC EMT (monthly) OMG Trust Board (each meeting through	4	BAF ref: SO 3 Note: Due to increased acuity and issues in the current inpatient service, the	September 2023

Risk ID	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
	unable to access a CAMHS bed. This could result in young people being care for on adult wards in the secure CAMHS estates or secure hospitals			and younger people on to adult wards. • CAMHS in-reach support to mental health wards and to acute hospitals • (where younger children are waiting for a tier 4 bed). • Regular report to board (IPR) • Safeguarding team provides scrutiny of all under 18 admissions. • Leeds and York Partnership FT have established the care collaborative board to lead work across the system • System-wide panels take place to review the demand and take action to address delays i • 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.					• The executive trio ensure appropriate escalation to partners where an appropriate solution for a child is not available (TRIO review September 2023) • Data on the number of children admitted to adult wards is being compared with bed closure data over the last 6 months to understand the impact of closures and to indicate whether there are other factors to consider. (COO, September 2023)		integrated performance report)		collaborative have not yet reviewed the out of hospital support so the date has been moved.	

Risk level <15 Risks outside the risk appetite

Risk ID	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
9. 1114	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. • 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	3 Moderate	3 Possible	9	1-6 Financial risk	• Development of a longer-term financial sustainability plan (DFR, end of Q2) • reinstatement of efficiency delivery and monitoring. (DFR, Ongoing review via OMG monthly) • Implement patient level costing for use by Directorates (DFR, August 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)	30 September 2023	EMT (monthly) FIP (monthly) OMG Trust Board (quarterly)	4	BAF Ref, SO 3 **Key changes: Trust Board to agree an increase in likelihood from 2 unlikely to 3 possible (risk score increased from 6 to 9 (amber).** FIP members have asked executive directors to review the risk score in relation to increasing financial pressure across the wider NHS and the Trust.	September 2023

ORGANISATIONAL LEVEL RISK REPORT

NHS South West Yorkshire Partnership NHS Foundation Trust

Risk ID	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
10. **1757**	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	• The EBME contract has been reviewed and awarded, part of the new contract. • COO has circulated comms to Managers • Equipment register in place • Purchasing process • Appointment of project manager • Raised awareness in the Care Group governance meetings and the CG&CSC (see assurance and monitoring column) • Partnership working with Mid Yorkshire NHS Trust	4 major	3 possible	12	Clinical risk 1 - 6	• A SBAR (situation, background, assessment, recommendation) to be completed by the end of July 2023 (DNQ) • Review Medical devices workload and review business case for trust wide medical devices officer (DNQ and DFR, October 2023,) • Full review of the electrical Biomedical Medical Engineering / Equipment EBME list (DNQ and DFR, Ongoing review fortnightly, updated paper, funding extension was approved by EMT • There is a wider piece of scoping work being undertaken to review other servicing contracts for medical devices e.g. scales, bladder scanners etc (DNQ and DFR, Review monthly, ongoing) • 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 September 2023) • Medical devices requisition and approval process under review (DNQ Ongoing review 2023) • In an attempt to increase servicing rates, areas and have been contacted to instigate compliance and prompt services to service their devices (DNQ, November 2023)	30 November 2023	Clinical governance / care group clinical governance CG&CSC Safety and resilience TAG OMG Medical Devices TAG EMT Trust Board	2	Notes: Identified recurrent budget issue There are legislative impact in relation to this risk: Health and Safety at Work Act 1974 Medicines & Healthcare products Regulatory Agency (MHRA) bulletin, Device Bulletin - Managing Medical Devices, Guidance for Healthcare and Social Services Organisations DB2006(05)	September 2023
11. **1820**	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	**COO CMO DNQ CPO**	CG & CSC PRC	• Agendas and terms of reference for Care Groups and OMG • 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 review in place	3 moderate	3 possible	9	1-6 Clinical risk	• Develop a process to improve triangulation with regard to incidents / grievances / workforce issues, to identify hotspots (DNQ, September 2023) • To deliver the improvement plan relating to Quality and Safety within Mental Health, Learning Disability and Autism Inpatient services (DNQ, To review monthly, Ongoing 2023) • Work has commenced on practice and reporting of supervision (DNQ, August 2023)	30 September 2023	OMG EMT CGG CG&CGC PRC Trust Board	3	The People and Professions forum (nursing and people directorate) meet to discuss the process to improve triangulation to identify potentially	September 2023

Risk ID	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
	acuity, could have a detrimental impact on the culture of a team which could then lead to patient harm.			• OMG and PRC receive detailed reporting • Safer Staffing reporting into monthly IPR • Incident, quality, and reporting monitoring in Care Group Quality and Governance Groups, and at the Clinical Governance Group • Quality Monitoring Visits, • Freedom to Speak up processes and , Equity Guardians and Dignity and Respect champions in place • Regular informal and formal meetings with Trust regulators • Clinical Governance and Clinical Safety committee has oversight • Established forums to discuss any areas of concern and good practice • Two People Business Partners have now been appointed and in post • An agency scrutiny group has been set up to look at reducing agency workers and increase bank recruitment					• Progress the complaints improvement programme (DNQ, August 2023) • Inclusive culture and management plan in place and roll out commenced (CPO August 2023) • Developing an approach and policy to adopt just and learning principles across our employee relations workshop arranged for 2023 (CPO, review September 2023) • To explore new and innovative ways to deliver learning and development to enable staff to be released in shorter periods (Ongoing, CPO)				poorly performing units.	
12. **1729**	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 and wellbeing support centre as part of the Workforce Support Hub. • Self help guide for and coaching for managers to support their own and teams wellbeing and resilience. • Staff counselling. • Link to the regional (ICS) health and wellbeing offer. • Health lifestyle support on Stop Smoking and weight management. • Support and engagement from all staff networks.	3 Moderate	4 Likely	12	1-6 Compliance risk	• Wellbeing champions to be appointed in each of the clinical areas (CPO/COO, December 2023) • Local action plans in relation to staff survey results are being implemented. (CPO September 2023)	31 December 2023	Safer staffing reports (monthly) Moving forward group PRC EIIC OMG EMT	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	September 2023

Risk ID	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
				• Equality Impact Assessment of staff health and wellbeing offer and occupational health. • Effective supervision practices • Data analysis and hot spot reporting Trust wide • Communications brief with well being messages for all staff • Annual flu vaccination programme in place • Financial wellbeing information and support available to staff • Wellbeing embedded in recruitment, induction and onboarding initiatives							Trust Board		trend. Trust performance benchmarks well compared to local peers. Wellbeing champions are established – this will continue to be monitored	
13. **1614**	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. • Inpatient services priority programme in place • Internal reporting including waiting lists, length of stay, complaints, concerns and compliments • Safety and quality relayed clinical incidents • Clinical risk and care plan improvement project in place • Quality Monitoring Visits • Bank and agency staffing • Critical incident de briefs • Safer staffing groups • Freedom to speak up guardian in place • Quality focused updates from in-patient areas are presented to the Clinical Governance Group • Protocol is in place to support safe practice during seclusion and	4 Major	3 possible	12	1-6 Compliance risk	• New roles being explored across the WY Mental Health Collaborative (DNQ, September 2023) • Review of pilot regarding robust handover processes (DNQ, Review August 2023) • further roll out of Tendable in Forensic and community services (DNQ, September 2023) • Safecare is being piloted in Forensics with a plan to roll out to Barnsley mental health Inpatient in 2023 (DNQ Review November 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)	September 2023

Risk ID	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
				restraint when working with reduced substantive staff • 'Tendable' (outcome monitoring tool) is in place in Mental Health Inpatient Units										
14. **1689**	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	• Joint Strategic Needs Assessment (JSNA) in each place • Integrated strategy and associated action plans • Workforce data including WRES and WDES • Equality Impact Assessments (EIA) including action tracker in place • SystmOne equality data accessible via the Intranet • 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) • EIA digital administration tool to disaggregate data and actions being taken is now in place • EDS • Training and awareness sessions in place • Working with partners in each place to address inequalities through place partnerships	3 Moderate	3 possible	9	1-6 Compliance risk	• Making Data Count approach under development. Waiting list report used as example (DS, Review end of Q3 2023/24) • Building capacity and capability through EIA and equality and inclusion themed development sessions and diversity training (DS, Review end of Q2 2023/24) • Further work underway to embed the use of dashboard as part of routine monitoring (waiting times and access) (DFR/ COO, September 2023) • Developments of narratives and case studies to demonstrate impact and continuous improvement (DS, ongoing action, no change) • Involvement in place-based health inequalities programmes and contribute to these (DS/DPD/COO, ongoing, review March 2024) • Embed the EIIC and inequalities priorities within workplans for care group equalities (DS/COO, end of Q2 2023/24)	31 March 2024	Recovery and reset monthly EMT EIIC quarterly meeting and bi-monthly sub-committee EMT Trust Board	6	BAF Ref SO 1	September 2023

Risk ID	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 and care plans for 2023/24 all agreed in each place and Trust is a partner in these. • Equality data quality improved Triangulation of information from Trust systems, patient experience and involvement/engagement now in place • Targeted programmes in place through linked charities • Key priority programmes incorporating health inequality actions in place										
15. 275	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 and minutes from Health & Wellbeing board meetings. • Attendance and monitoring at contract forums. • Annual planning process.	4 Major	3 Possible	12	1-6 Clinical risk	• To work with partners in all places to address in year specific financial challenges (DFR/ DPD Quarterly reviews during 2023/24 (31/07/23/ 30/10/23/ 31/01/24/ 31/05/24)	30 November 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	BAF Ref: SO 1, 2 and 3	September 2023

Risk ID	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
				• 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) • Calderdale is captured in the Calderdale Cares document and delivery is overseen through the Health and Wellbeing Board. • Kirklees Delivery Collaborative in place. • 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 • Clinical and quality Trust representation now established in all place based quality committees									
16. **1624**	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	3 Moderate	3 Possible	9	1-6 Clinical risk	• Work is progressing well 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 December 2023) • Where a suite becomes blocked due to onward pathway arrangements, this will be escalated in line with pathways for people who are clinically ready for discharge (from the 136 suite). (Ongoing, COO to review September 2023)	31 December 2023	OMG CG&CSC EMT Trust Board (each meeting through integrated performance report)	3	BAF ref: SO1 Work with partners is progressing well with further joint arrangements being discussed. Systems are already working closer together with further development	September 2023

Risk ID	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
				bed, their care is delivered in line with the inpatient pathway and admission to the ward is actively progressed. • Datix reports are monitored • Funding agreed in Barnsley for additional staffing capacity • Joint work within integrated systems is in place.										being discussed. No additional funding has been provided for Calderdale or Wakefield. Additional resources have been provided in Barnsley. Access to the suite is impacted by patient flow in adult acute inpatient services and also by other pathways, such as learning disability services and CAMHS.	
17. 1511	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	4 Major	3 possible	12	1-6 Financial risk	• Partnership agreement and risk share in South Yorkshire – discussions ongoing (DFR, end of August 2023) • Submitted benchmarking information as part of national return across the WY providers (DFR, results expected September 2023) • Progress sub-contracts to signature still outstanding. Collaborative committee have set target for December 2023 (DFR, December 2023) • Ongoing dialogue with NHSE to resolve contractual position in relation to South Yorkshire provider (DFR, review end of September 2023)	31 December 2023	CC EMT (monthly) Trust Board	4	BAF ref: SO1	September 2023

Risk ID	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
				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 • Process and governance structures developed and agreed for South Yorkshire ASPC (Adult Secure Provider Collaborative)									
18. 1078	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	4 Major	2 Unlikely	8	1-6 Clinical risk	• Waiting list initiatives are in place with the Trust and a private provider which continues to partly address demand for Calderdale and Kirklees neurodevelopmental pathways (COO, September 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, September 2023) • Actions relating to access to CAMHS services and reducing inequalities are being implemented as part of the Improving Access priority workstream (COO, Review September 2023) • Additional work is underway to further improve the waiting list report and further roll out of equality monitoring as part of the report (COO, September 2023)	30 September 2023	OMG CG&CSC EMT - monthly Individual district performance reports reviewed by care group Trust Board	6	BAF Ref SO 2 Further improvement work is taking place to improve equality monitoring – actions continue to be appropriate and review dates extended Demand continues to outstrip commissioned capacity. Work is taking place at system and place level to	September 2023

Risk ID	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 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 • 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								understand this.	

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

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19. **1132**	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 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	4 Major	3 Possible	12	1-6 Clinical risk	• 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, September 2023) Waiting list reports are provided on SystmOne and being rolled out to all areas (COO/ DFR, review September 2023) • Hidden waits are being identified and will continue to be included as the waiting list reports are scrutinised (COO, September 2023) • Deprivation data has recently been included alongside ethnicity data – analysis and understanding of this data will be reported through the waiting list report (COO, September 2023) • Actions relating to access to services and reducing inequalities are being developed as part of the Improving Access priority workstream (COO, September 2023) • The executive TRIO are reviewing the clinical assessment processes to ensure that clinical risk is informed by any inequality issues (TRIO, Ongoing 2023)	30 September 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 waiting list has now got some data for protected characteristic (TRIO)	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

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20. **1159**	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. • Fire safety figures are now broken down between e-learning and face to face training. • 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 locations where additional oxygen could be used. • Health and Safety annual report submitted annually to Trust Board. • CGCS and the Audit Committee are updated	4 Major	3 Possible	12	1-6 Compliance risk	• To implement the smoke free policy 31 March 2024 (DNQ) • A further review of the approved vape is being undertaken as part of the smoke free policy (CMO ongoing • 2023) • The rollout programme reviews of the sprinkler system at the Estates TAG and fire risk assessment take place yearly (Yearly, DFR, November 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	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. Continues to be installed.	September 2023

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				(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 • The annual statement of fire safety compliance approved at EMT on 23 March 2023 • Fire training offer is reviewed to ensure it meets operational services availability. • The smoke free policy is now approved									
21. **1424**	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 • Restraint reduction • Covid-19.	**DNQ CMO**	CG & CSC	• Clear policies and procedures, and reporting in place, providing framework for the identification and mitigation of patient safety risks. • Appropriate OMG, Clinical Governance Group and CGCSC escalation arrangements in place. • Reducing restrictive practice and intervention (RRPI) improvement plan implementation. • Formulation of informed risk management (FIRM) assessment training. (DNQ) • A group established to focus on improving performance in clinical risk assessment and care plan performance • Clinical Risk Panel monitors all staffing incidents to ensure	4 Major	2 Unlikely	8	1-6 Clinical risk	• 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, September 2023) • Complaints policy and metrics subject to further review with regards to quality and response times. Revised proposal agreed and under implementation (DNQ, August 2023, further to agreement in EMT) • We have a task and finish group who continue to meet, focused on an enhancing consistency of oversight of serious incidents and serious incident action completion across care groups (DNQ, September 2023)	30 September 2023	Performance & monitoring via EMT CG&CSC OMG Trust Board Patient Safety report & incident report as well as monthly reporting in the IPR	6	BAF ref: SO 2	September 2023

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				appropriate actions to be taken including scans of all red and amber patient safety incidents • The Clinical Environmental Safety Group oversees ligature risk • Patient Safety Specialist Roles in place • Trust wide learning forum, (SI) facilitated by the Nursing Directorate. • The RRPI team support learning with front line colleagues • RRPI Team are supporting a shared approach to the Collaborative Bank (DNQ) • Regular Patient safety learning events (DNQ) • Quality strategy approved. • Care group governance is aligned to ensure consistency										
22. 852	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	• Internal audit report on the Data Security and Protection Toolkit for 2023 was substantial. • Trust maintains access to information governance training for all staff and achieved the mandatory training target of 95% presented to Board in June 2023. • Designated Caldicott guardians and Senior Information Risk Owner (SIRO) (and deputies) in post. • Qualified and experienced data protection officer in post • Trust has appropriate policies and procedures that are compliant with GDPR. • Improving Clinical Information and	4 Major	3 Possible	12	1-6 Compliance risk	• Increase in training available to teams including additional e-learning and self-assessment using workbooks. (DFR, end of April 2024) • Bespoke team training in relation to IG incidents will be rolled out over 2023/24 (DFR, April 2024) • Currently working on improving processes for capturing positive consent to share using a digital solution (DFR, September 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 September 2023)	30 April 2024	ICIG OMG EMT AC Trust Board	4	BAF Ref, SO2	September 2023

ORGANISATIONAL LEVEL RISK REPORT

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				Governance group in place which is the governance group with oversight of IG issues reporting into EMT. • 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 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									
23. **1319**	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	**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.	3 Moderate	4 Likely	12	1-6 Clinical risk	• The actions in place that aim to reduce admissions and reduce length of stay with a focus on effective discharge from hospital to remain in place and are reviewed on an ongoing basis to ensure they remain fit for purpose and continue to be aligned with the follow up actions from the 100 day discharge initiative (COO Review September 2023)	30 September 2023	OMG CG&CSC EMT Trust Board	4	BAF ref, SO 3 PICU work across West Yorkshire is overseen by the secondary care pathways group, chaired	September 2023

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	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.			• 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. • The associate director, adult and older people mental health care group chairs the PICU network across the West ICS, which reports to the West Yorkshire secondary care pathways group, chaired by COO.					• Play a lead role in the PICU work across West Yorkshire to improve pathways through the services (COO review September 2023) • Continue to work with local places to address barriers to discharge. (COO, ongoing, review September 2023) • Continue to 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, review September 2023) • Additional funding to support discharge packages is still available. Teams continue to work with partners across the ICS to make best use of the available resources. (COO, September 2023) • Maintain the option to block purchase beds, using the continuity of care principles, to support demand through 2023/24 (COO Review September 2023)				by COO, SWYPFT The 100 day discharge initiative has formally closed, but the principles are used for follow up improvement work.	
24. 1585	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 Financial risk	• Updated estates strategy currently being developed (DFR, end of July 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 in relation to the overall capital programme (DFR, end of July 2023)	30 September 2023	EMT (monthly) FIP (monthly) Trust Board	4	BAF ref: SO 3 Note: The Trust was not successful with the national hospital programme	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

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25. **1157**	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	• 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. • National review of EDS with local implementation actions being developed (CPO) • Reciprocal mentoring and shadow board programme in place • Internal review panels in place for disciplinary and grievance cases related to discrimination on the grounds of race.	3 Moderate	3 Possible	9	1-6 Compliance risk	• Launch of Equity Guardians roles to be further developed and embedded across services. (CPO and DNQ, September 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 September 2023) • Develop our approach to diversity and leadership including our approach to talent management (CPO, review November 2023) • Work commenced with external partner (Leadership and Talent Development Coach) to support inclusive culture (CPO, phase 1 to be delivered by end of August 2023) • Use of staff survey data to improve staff experience with a focus on feedback from all diverse groups (CPO, August 2023) • FLAIR survey concluded and currently being analysed (CPO, August 2023) • Appointment of one new People Business Partner to support the development of inclusive action plans using workforce data to drive change (CPO, August 2023) • Developing the allyship model (CPO, September 2023) • Development of equality dashboards for EIIC to track data, progress and improvements (CPO, ongoing, review September 2023) • A discussion on the options for improving diversity in leadership roles to be presented in EMT, further engagement to take place to develop the work (CPO September 2023)	30 September 2023	EMT (quarterly) EIIC Committee (quarterly) Trust Board	6	BAF ref, SO 1 and 4	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

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				• Race Forward programme has been relaunched with a series of meetings now in place (DNQ) • Ongoing engagement with regional partners and our regional lead from NHSE with regards to disparity in ethnicity representation across nurse bandings • Two new People Business Partners have now been appointed and in post to support the development of inclusive action plans using workforce data to drive change (CPO) • New Leadership and Management Lead appointed to support inclusive leadership appointments (CPO)										

Organisational level risks within the risk appetite

Risk ID	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
26. **1758**	The risk of disruption to services and reduction in staff due to industrial action and our inability to deliver care.	**CPO/ COO**	PRC	• Risk is reviewed monthly due to ongoing industrial action • 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 • Regular reporting to OMG and EMT • High level comms messages agreed. • Stepping down procedure agreed. • Meeting arranged when needed to discuss terms and conditions and pay with the trade unions as new strike days for different groups of staff emerge • Silver command meetings have been re-established to manage the industrial action • A separate strike committee was established to manage and consult with the BMA on the terms and conditions for those doctors striking. This group can be reconvened as needed.	4 major	~~4 Likely~~ 3 possible	~~16~~ 12	8 – 12 Strategic Risk	• Follow national guidance issued by NHS England and NHS Employers • 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) • Continue to develop supportive communication messages to staff asking for support to maintain essential service (Ongoing as information emerges, 2023/24)	30 September 2023	PRC OMG EMT Joint Information Cell Task and Finish Group Trust partnership forum Trust Board	9	BAF ref: SO 2 **Key Changes: Trust Board to agree a decrease in risk score from 16 (red) to 12 (amber).** Strike action - Junior doctors (BMA) 13-18 July 2023, senior doctors (BMA) 20 and 21 July 2023	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	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
27. **695**	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy	**DS**	CG & CSG	• Annual objectives and programmes in place • Service quality metrics in place • Active engagement in West Yorkshire and South Yorkshire Integrated Care Systems/ • Regular review and update of the strategy by Trust Board. • QIA process in place for all significant change. • EQIA trust wide in place • Annual objectives and priorities and programmes in place • Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives. • Involvement 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) • Trust-wide integrated change process in place • Focus on working towards the strategic ambitions of the Trust. (EMT) • Internal place integration group now established • Stakeholder engagement plans reviewed and in place. • Measures in place to monitor the impact of the headline initiative from the social responsibility and sustainability strategy for responsive and inclusive services	3 Moderate	2 Unlikely	6	1-6 Clinical risk	• Close involvement in Barnsley plan to monitor potential impact and take measures to mitigate. (DS and COO September 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, September 2023) • To deliver priorities within the sustainability strategy, (DS, March 2024) • Develop and introduce sustainability impact assessments (DS, March 2024)	31 March 2024	EMT (monthly) Transformation board (monthly) OMG (weekly) CG&CSC Trust Board	6	BAF Ref: SO1 & 2	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	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
28. **812**	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 • Bi-annual EMT and Trust Board investment appraisal report • Progress on system and service transformation reviewed by EMT and Trust Board. • Active engagement in West Yorkshire and South Yorkshire Integrated Care System (ICS) • Financial control process to maximise contribution. • WY MHLDA specialised services board • Approach to collating and reporting insight from stakeholders place. • Horizon scanning for new business opportunities. • Trusts pro-active involvement and influence in system transformation programmes, which are led by commissioners and includes new models of care. • Clinical and quality Trust representation in place and ICS level quality boards (DNQ/CMO) • Trust have been involved in all Place based plans	3 Moderate	2 Unlikely	6	8-12 Strategic risk	• On-going review with ICBs of our plan during 23/24 (DPD, 31 March 2024) . • To continue to develop Barnsley Integrated Health and Care Alliance with partners delivering on agreed plans and priorities (DS/COO, October 2023)	31 March 2024	CG&CSC EMT (monthly) Trust Board	6	BAF Ref, SO 1 & 3	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	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
29. **773**	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 and Wakefield commissioners • Stakeholder plans in place • Involvement in the Overview and Scrutiny Committees (OSCs) regarding transformation proposals as required. • The prospectus that sets our Trust Offer has been reviewed and refreshed	3 Moderate	2 Unlikely	6	8-12 Strategic risk	• Proactive development of relationships with GP Federations to identify opportunities for collaboration and alignment is underway. (DPD/ COO, Review March 2024) • Maintain strong links with national bodies to influence local and national systems thinking in relation to mental health and community services. (DS/ CE, Ongoing, review in October 2023) • Alignment of priorities through provider alliances and integrated care partnership (DPD/ DS, September 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, September 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	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	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
30. **1649**	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 • Choking awareness training slide pack produced and circulated • MDT choking risk assessment for all inpatient areas in place • The Trust secured the services of an independent SLT provider to deliver additional SLT resource in Barnsley and in Wakefield inpatient services • 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. • Adult Dysphagia and Choking Policy has been approved by EMT • 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 • Trust wide SALT business case is now complete	3 Moderate	3 Possible	9	8-12 Strategic risk	• Audit planned regarding compliance and quality improvement for the choking screening tool (DNQ, Undergoing audit 31 October 2023) • Review of process/es for staff when patients are on escorted and unescorted leave and have an existing choking need, including a review of the legal processes (September 2023, DNQ/CMO) • Trust central resource for SALT, next stage is confirming contribution from Kirklees and Barnsley. Job descriptions are being developed (DNQ, September 2023)	30 September 2023	CG&CSC OMG EMT (monthly) Trust Board	6	BAF Ref: SO 2	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	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
31. **1650**	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 Business risk	• 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, October 2023) • Each area will maintain a risk assessment to understand the potential climb risks. (COO, ongoing, review quarterly October 2023) • Where appropriate supervised access to garden areas is maintained. (ongoing, review quarterly (COO, October 2023) • The clinical environment safety group meeting will review this risk and make a recommendation regarding future actions (DNQ, Review every 6 months) • Operational, clinical and Estates teams are working together in the clinical environment clinical safety group to review the recent incident in adult acute services and use learning from previous incidents in forensic services. (COO/DNQ review September 2023)	31 October 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.	September 2023
32. **1217**	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.	3 Moderate	3 Possible	9	8-12 Strategic risk	• 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 2024) • Build capability to enhance capacity through programmes including IHI, QSIR (Quality, service improvement and redesign programme) and other development programmes (DS, March 2024)	31 May 2024	Quality Strategy update to CG&CSC AC OMG EMT Trust Board	9	BAF Ref, SO 3	September 2023

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	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
				• 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					• Discussions ongoing with each place ICB team to review opportunities for transfer of capacity as part of ICB operating cost review (DPD, December 2023)					
33. **1432**	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 include succession planning and talent management. • Leadership and management framework in place • Coaching and mentoring offer • Appraisal Policy . • Board succession plan reviewed annually • Comprehensive management and leadership programmes • Key element of Trust Workforce Strategy. • Shadow Board Programme and Reciprocal mentoring programme	3 Moderate	2 Unlikely	6	8-12 Strategic risk	• Develop our approach to diversity and leadership including our approach to talent management, (CPO, review September 2023) • Supporting Fellowship Programme across the system as opportunities arise (CPO, Ongoing 2023) • OD plan being developed (CPO, September 2023) • Review of succession plans following new Board appointments (CPO, September 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	30 September 2023	PRC EMT Trust Board	4	BAF Ref: SO 3	September 2023

ORGANISATIONAL LEVEL RISK REPORT

Risk ID	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
				• Streamline Internal transfer process established					enrolment on bank (CPO and COO, review August 2023)					

South West Yorkshire Partnership NHS Foundation Trust

COVID-19 RISKS

Risk level <15 – risks outside the risk appetite

Risk ID	Description of Risk	Risk Owner	Nominated Committee		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
34. **1522**	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. • Communication to all staff as required. • Provision of appropriate personal protective equipment during any outbreak, in line with national guidance. • Bronze, silver and gold command incident processes available to be reinstated as and when required. • Self-isolation guidance. • Covid-19 pathway including cohort protocol developed and implemented as required. • Ongoing IPC team offer to services as part of Covid-19 response. • Agreed pathway with acute providers to access clinically appropriate support for Covid-19. • SBAR templates are produced to share learning from outbreak management investigations. • Timely delivery of flu vaccination programme • Routine reviews of IPC BAF reported to NHS England and NHS Improvement via CGCS committee. • Ongoing review of IPC practice in line with regional and national guidance, and local feedback.	4 Major	3 Possible	12	1-6 Clinical risk	• Work ongoing around promotion of vaccinations to both staff and service users (DNQ, Ongoing) • Continuing monitoring of any Covid-19 cases and outbreaks (DNQ, review end of Ongoing)	30 September 2023	CG&CSC EMT (monthly) Moving Forward Group OMG ICIG Trust Board	4	BAF ref: SO 2 Note: Moving forward group stood down in June 2023	September 2023

South West Yorkshire Partnership NHS Foundation Trust

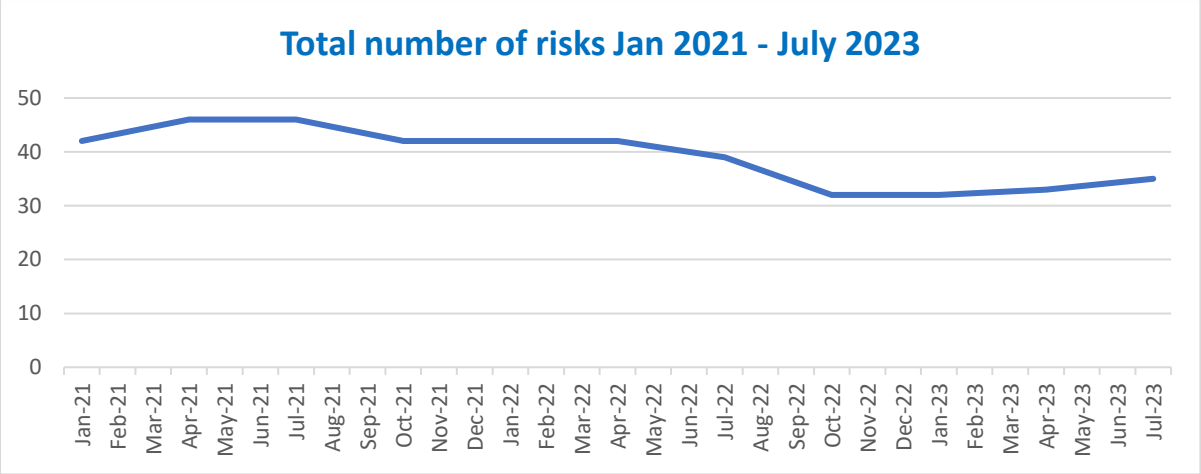
Risk ID	Description of Risk	Risk Owner	Nominated Committee		Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Covid-19 information leaflets provided 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. • Service user Covid-19 vaccination programme is delivered in line with national guidance. • 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 Ward and IPC colleagues work in partnership to identify clinically vulnerable service users who arrive in our care.									
35. **1545**	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	**CMO**	AC	• Covid Inquiry lead, Executive lead (CMO) and oversight committee (Audit) in place, linked into national inquiry • Learning events and covid inquiry task and finish group established. • Document control in place for all levels of command structure including hard copy (safe haven)	4 Major	3 Possible	12	1-6 Compliance risk	• 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, October 2023) • The Trust anticipates involvement in modules 4 and 6, however given the framework for the modules we will not be core participants but will support Acute and Local Authority	31 October 2023 The completion date has been extended due to modular approach to inquiry	AC Moving Forward Group Covid Inquiry Task and Finish Group	6		October 2023

Risk ID	Description of Risk	Risk Owner	Nominated Committee		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
	the public inquiry.			• 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. • Reports to EMT, Audit Committee and Trust Board via AAA report.					colleagues.(DDCG, Review October 2023)	(NHS Trusts module 3 to commence 2023 (continue to review on a monthly basis)	OMG EMT Trust board			

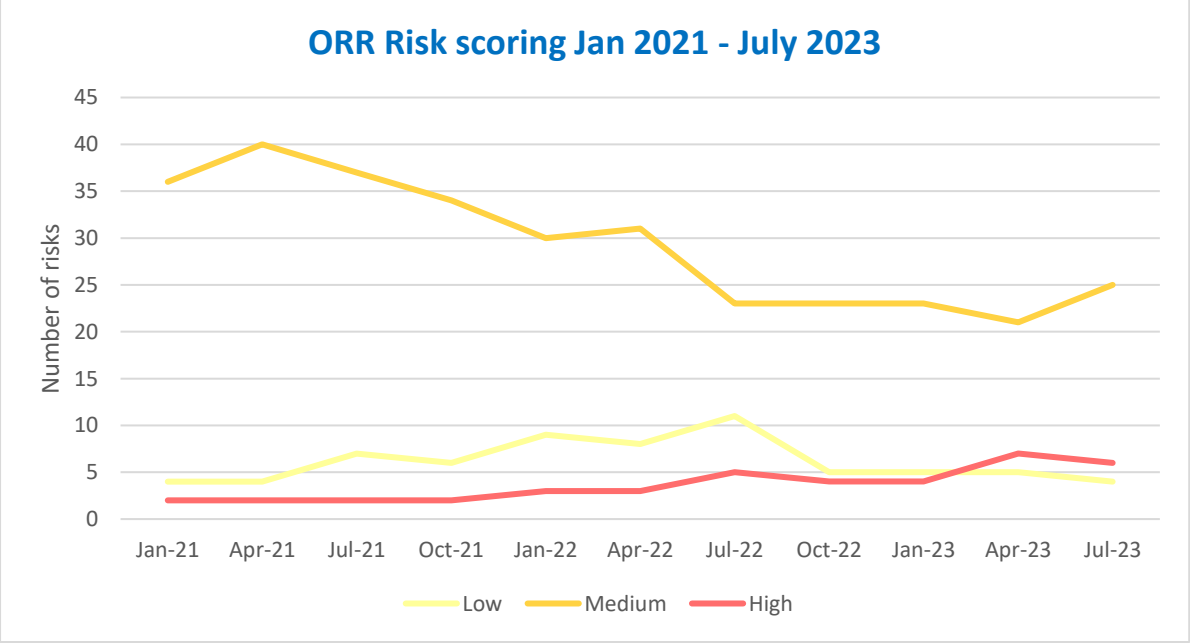
Trust Board
25 July 2023
Organisational Risk Register (ORR)
Quarter 1 Analysis, January 2021 – July 2023

Appendix 1

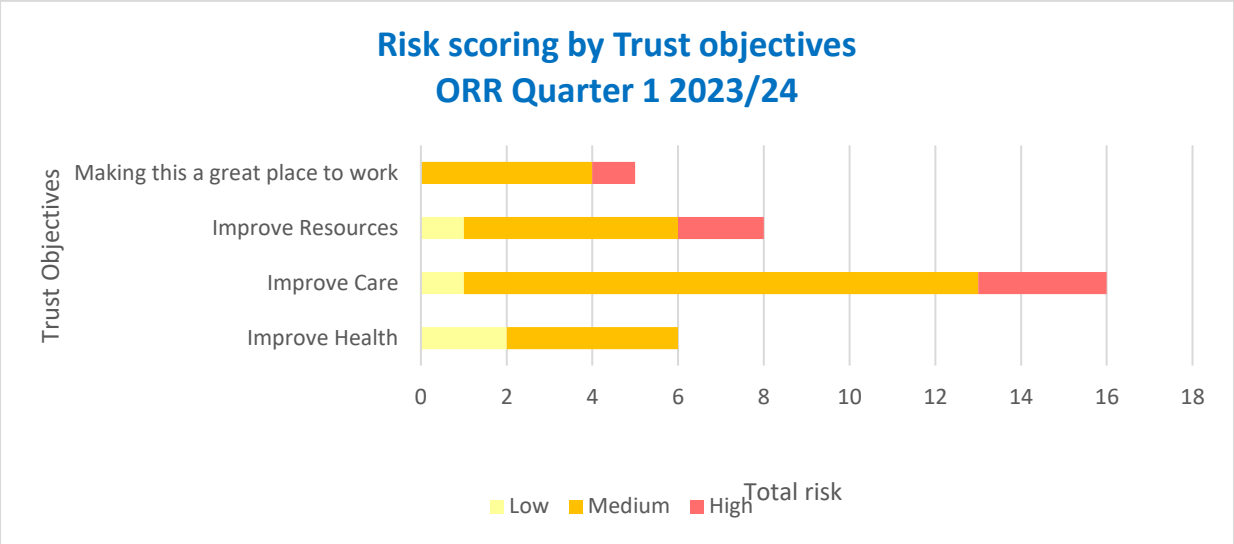
Total number of risks from January 2021 to July 2023



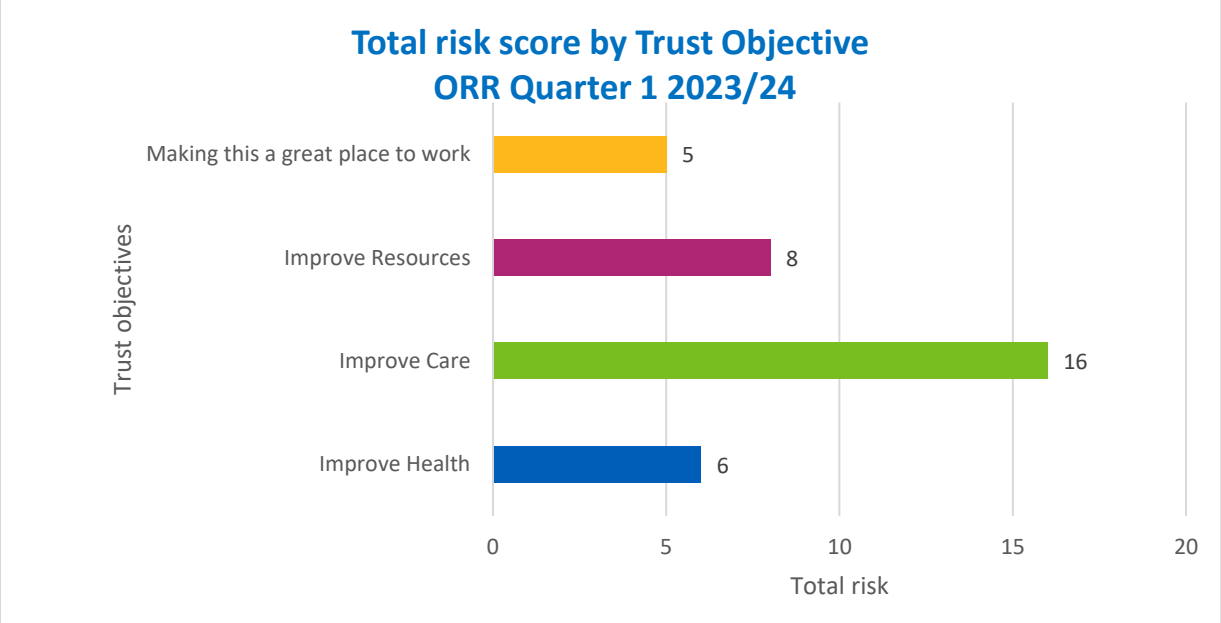
Total risk score by grading from January 2021 – July 2023



A breakdown of Trust objectives ORR Quarter 1 2023/24



Total number of risks by Trust objectives ORR Quarter 1 2023/24



South West Yorkshire Partnership NHS Foundation Trust

Trust Board July 2023
Agenda item 9.3

Private/Public paper:	**Public**		
Title:	**Annual Health and Safety Report 2022/23**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	**Nick Phillips - Deputy Director of Estates and Facilities** Emma Hilton – Emergency Planning Advisor		
Mission/values:	We are respectful, honest, open and transparent We improve and aim to be outstanding We are relevant today and ready for tomorrow		
Purpose:	To update Trust Board on activity and progress against the safety services annual work plan and reactive work in 2022/23 and to seek Board approval for 2023/24 action plans		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources		
	Make this a great place to work	✓	
BAF Risk(s):	Risk 2.2 - Failure to create a learning environment leading to lack of innovation and to repeat incidents. Risk 4.3 - Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The safety team supports the Trust to discharge its responsibilities under health and safety, security, fire and emergency planning legislation and guidance and ensures compliance with the Trust's contractual obligations.		
Any background papers / previously considered by:	Audit Committee receives regular safety services updates throughout the year. Executive Management Team on 7 June 2023 Audit Committee received the report on 11 July 2023		
Executive summary:	This annual health and safety report is presented to Trust Board to provide assurance that the Trust has discharged its responsibilities under health and safety, security, fire and emergency planning legislation and guidance and ensures compliance with the Trust's contractual obligations.		

	This report is designed to provide an overview of the key achievements from all respective areas of health & safety, security, fire safety and emergency preparedness, during 2022/2023, and any areas of development within 2023/2024. Areas of development are provided in action plans and presented as an appendix. The team works to implement national safety legislation into policy, procedure and practice, including the Health & Safety at Work etc. Act 1974, the Civil Contingencies Act (2004) and the Management of Health & Safety at Work Regulations 1999.
Recommendation:	**Trust Board are asked to APPROVE the annual report for 2022/23 and NOTE the work plan for 2023/24 for safety services.**

South West Yorkshire Partnership NHS Foundation Trust

Health & Safety Annual Report for 2022/2023 and objectives for 2023/24

Nick Phillips - Deputy Director, Estates & Facilities

With **all of us** in mind.

Contents

Appendices

1. Executive Summary

This report has been produced to provide an overview of the activity within safety and security services in 2022/23 and to provide assurance to the Board on activity and to provide assurance that the Trust is complying with relevant legislation in the safety and security and emergency, preparedness, resilience and response (EPRR) fields in 2023/24. Overall safety and security management has been in line with annual plans.

Overall, the following points are of particular note:

- The Health & Safety team supported Trust wide services to review and adapt Covid-19 premises assessments and working arrangements from the previous year along with providing advice to managers and staff as learning from working with Covid-19 evolved.
- Covid-19 premises assessments continued to be set at three monthly reviews as learning and government guidance evolved throughout the year.
- A business as far as reasonably practicable approach was pursued with regular contact with other NHS trusts maintained across the region to ensure a consistency with provision of advice to Trust services.
- The Trust continued to work with the Health and Safety Executive.
- The Health & Safety team also supported Trustwide ligature audits, covering inpatient areas and community settings.
- Further work to improve fire safety resilience by commissioning of the scheme to provide a water mist fire suppression system to Chippendale and Appleton Wards at Newton Lodge.
- Replacement of obsolete fire alarm panels together with some detectors throughout the Fieldhead site.
- Fire training - 136 instructor lead fire sessions (including via MS Teams) sessions for essential training were delivered noting Trustwide fire training attendance was 89.4%.
- The recruitment of a new senior security officer.
- The delivery of Business Continuity Plan (BCP) workshops to services to enhance knowledge and understanding in how to write and construct a BCP.
- Delivery of Exercise COHERENCE to test the Trust's resilience in the event of a pre-planned national power outage.
- Rolled out departmental tabletop exercises on power outage to test local BCP arrangements.
- Worked alongside wider estates team and infection control to resolve the water quality issues on the ‘’oaks building at Kendray following a water supply interruption.

2. Introduction

This report is designed to provide an overview of the key achievements from all respective areas of health & safety, security, fire safety and emergency preparedness, during 2022/23, and actions for areas of development for 2023/24. (See appendices)

The Trust health and safety team ensures that the Trust meets its statutory duties in relation to policy, procedure, and practice, for fire safety legislation, the Health & Safety at Work etc. Act 1974, the Civil Contingencies Act (2004) and the Management of Health & Safety at Work Regulations 1999 and to meet Care Quality Commission standards.

The above are supported by internal targets e.g., mandatory fire training. Details of compliance are referenced throughout this report.

3. Health & Safety

2022/23 continued to see challenges because of the Covid-19 pandemic. This impacted on the delivery of the annual action plan, but the Health & Safety Team ensured that usual risk issues continued to be addressed by:

- Continued partnership working with third parties, i.e. Other regional NHS trusts, Local Authorities, Health & Safety Executive (HSE) etc.
- Following and delivering the 2022/2023 Health & Safety action plan.
- Services being supported with their ongoing priorities, i.e., ligature audits and particularly frequent reviews of Covid-19 working measures.

The work included policy development, incident management and onsite inspections.

Achievements (2022/23)

Covid-19

- The Health & Safety team supported Trustwide services to review and adapt Covid-19 premises assessments and working arrangements from the previous year, along with providing advice to managers and staff as learning from working with Covid-19 continued to evolve.
- Quarterly Covid-19 premises assessments continued to ensure these could be updated regularly as learning and government guidance evolved throughout the year.
- The Safety & Resilience Task and Finish Group (TAG) continued to meet as planned via Microsoft Teams (MS Teams) meetings with attendance remaining consistent with strong engagement from all members.

Business as usual

- The Trust continued to work with other NHS trusts across places to ensure consistency with provision of advice to Trust services.
- The Trust continued to work with the Health and Safety Executive.
- The Health & Safety Team also supported service led annual Trustwide ligature audits, covering inpatient areas and community settings, including Trust buildings, buildings belonging to other health and social care organisations, and service user homes and other environments when required.

Annual health and safety monitoring

The Trustwide audit of health and safety took place between November 2022 and January 2023. The audit tool was reviewed and revised as appropriate by the project team, including a revised

section covering lone working arrangements to reflect new lone working device contract requirements.

The audit was designed to run in Survey Monkey, a web-based survey programme. The survey link was circulated via a targeted email. Regular updates were placed in the Trust weekly communications and on the intranet pages.

The aim was to assess overall safety position across the Trust, including areas such as completion and implementation of risk assessments, training and reporting of accidents/incidents. In summary:

- 186 out of 260 surveys were returned. It should be noted that some returns cover multiple areas so the figure would be higher for individual services (the process will be reviewed to prevent duplication for the 2023/24 survey).
- All care groups and corporate services who completed the survey achieved between 84% and 94% compliance.

The services that did not engage in the mandatory survey are still being reviewed and will receive a full Health & Safety Audit. Their action plans prepared by the Health & Safety team will be closely monitored by the operational management group, and progress updates to the Audit Committee as per the workplan.

- Performance was measured by the existing Trust formula (see below)
- Teams are expected to address gaps through local action that can be inspected by the relevant specialist advisers, through planned and reactive audits and inspections.

	91% - 100% compliance achieved (fully compliant)
	81% - 90% compliance achieved (partially compliant requires some improvement)
	Less than 81% compliance achieved (requires further work to achieve significant improvement)

Health & Safety Objectives for 2023/24

- Update inspection spreadsheet held by the Health & Safety team from results of Health & Safety 22/23 Monitoring programme.
- Review annual health and safety survey to remove duplication and ensure consistent reporting.
- Revise & update Trust Health & Safety Policy
- Revise & update Control of Contractors Policy
- Revise & Update Trust Slips, Trips & Falls Policy & Guidance with clinical colleagues.
- Undertake audits and inspections, based on the outcomes of the 2022/23 annual monitoring tool, providing support to teams where required. Update Health & Safety Intranet pages, ensuring policies & guidance along with all H&S Information are current with correct contact details.
- Ensure that RIDDOR (reporting of injuries disease and dangerous occurrences regulations 2013) reports are examined at senior management level and lessons learned are implemented.

Fire Safety

The annual statement of fire safety compliance has been approved by EMT (Executive Management Team). The statement confirmed that no fire safety enforcement action was taken against the Trust by the Fire Authority and that all fire risk assessments have been reviewed and remedial action taken where necessary.

Achievements

Work has continued to upgrade fire resilience by extending the Newton Lodge fire suppression system to cover Chippendale and Appleton wards.

Work has been undertaken to replace obsolete fire alarm panels together with some detectors throughout the Fieldhead site.

Maintaining effective consultation procedures with the Estates and Capital Planning teams to ensure that all appropriate fire safety precautions are included in all building projects (new buildings or adaptions/alterations to existing premises), and that fire safety investment is included in the annual minor capital plan.

Commissioning of an additional practical fire training unit located at Kendray Hospital.

Fire Training Data 2022/23

- 136 instructor lead fire training sessions (including MS Teams sessions) for essential training were provided.
- 901 staff attended instructor lead sessions.
- 4,082 staff completed refresher training via e-learning, compliance was 89.4% (against a minimum target of 80%)
- Training provision was initially restricted to e-learning for most staff, but following the revision of Covid-19 restrictions, we have increased the availability of face-to-face training

Fire Incidents

There were no “reportable fires” causing structural damage to buildings and requiring fire service intervention during the year.

There were 5 minor incidents where damage was restricted to the item first ignited and there was no damage (other than minor smoke damage) to the structure of the building.

Details:
1 deliberate bin fire in a ward area
2 fires caused by deliberate damage to mobile phones.
2 fires in bedrooms caused by deliberate ignition by the use of lighters.

Identified Significant Risks 2023/24

Changes to the Fire Safety Order 2005 (an amended by the section 156 of the Building Safety Act 2022) will not have any additional implications to fire safety compliance in the Trust.

Although fire training compliance exceeds the Trust target of 80%, this has mainly been achieved by e-learning because of Covid-19 restrictions. In order to meet the legal requirements of Firecode together with the Trust fire policy, it is essential that staff attend instructor lead sessions where required, especially for staff in patient facing roles. Sufficient training sessions have been scheduled throughout the forthcoming year to achieve compliance subject to good attendance.

Although there has been a significant reduction in Datix reports relating to contraventions of the smoke free policy, it is recognised that there remains a significant risk of fires in bedrooms where service users have access to contraband lighters.

Fire Safety Objectives 2023/24

- Continue with appropriate measures to reduce the number of false alarms and unwanted fire signal activations of the fire alarm systems in Trust premises.
- Ensure the provision of sufficient face to face fire training sessions (including practical sessions in our training units) in order to meet the requirements of Firecode and the Trust Fire Policy.

- Continue to rollout the programme of water mist fire suppression systems on wards.

5. Security

The security team has had a challenging year, however robust collaborative teamwork and planning has enabled the delivery of targets throughout the year.

Achievements

- Talks and meetings with police and partners are continuing in areas such as Prevent, redress, restorative justice, and support prosecutions where appropriate. Talks are also ongoing within the Trust to ensure incidents are reported to the police when appropriate, and staff are fully supported through the journey. Current partnership working and relationships with the police are now in a very positive position.
- A senior security officer has been appointed to replace existing staff. This is working well, and other Trust services have commented favourably on the support and communication they have received from the new security staff.
- Recruitment of 2 additional security officers is underway.
- Crime reduction surveys are continuing to be completed on an annual, risk-based schedule, all findings are reported, and hard Facilities Management (FM) issues reported to the Estates TAG.
- A Trustwide review and upgrade of closed-circuit television (CCTV) continues to be led by the estate's security team.
- The Preventing Violence and Aggression policy and Safe and Secure Environments policy are under review, due for approval in July and August 2023 respectively.

Security objectives for 2023/24

- Review and implementation of lockdown processes and procedures across various locations of the Trust.
- Continue to strengthen police liaison relationships.
- Ongoing support to community premises to address safety concerns when self-presenters attend sites and security presence during client consultations when risk assessment deems it appropriate.
- Assist estates in CCTV upgrade.
- Evaluate Trustwide security provision, taking a risk-based approach.
- Ensure compliance with The Violence Prevention and Reduction Standard in conjunction with RRPI leads.
- Recruitment drive for security officers based at Fieldhead.
- Audit key performance indicators (KPIs) & key performance targets (KPT's) for the lone worker and external security contracts.

6. Emergency Preparedness

2022/23 continued to be a pressured yet productive year for Emergency Preparedness, Resilience and Response (EPRR). The management of numerous incidents occurring at the same time became the norm with the continued support to the Covid-19 response, winter pressures and Industrial Action across a variety of sectors, all of which impacting the Trust to varying degrees.

Achievements

- The successful achievement of the NHS England Core Standards for Emergency Preparedness, Resilience & Response (EPRR), with 44 out of 55 standards fully achieved, 8 partially achieved and 3 not achieved. These achievement rates put the Trust into partial

compliance, which was a reduction on previous years, given that a number of standards were re-introduced along with numerous standard requirements changing. The EPRR team has successfully progressed compliance against the standards and continue to do so, working through a detailed action plan, to bring the Trust back to substantial compliance by October 2023.

- The delivery of the 22/23 annual staff influenza vaccination campaign for eligible staff resulted in 65% of staff vaccinated against a target of 90%. Whilst this fell short of the target, the Trust did benchmark well against comparable trusts.
- Delivery of Business Continuity Plan (BCP) workshops to BCP authors to enhance knowledge and understanding in how to write a BCP.
- Delivery of Exercise COHERENCE to test the Trust resilience in the event of a pre-planned national power outage.
- Rolled out departmental tabletop exercises on power outage to test local BCP arrangements.
- Implemented audit processes to ensure accurate compliance against the NHSE Core Standards for EPRR via 360 Assurance.
- The implementation of incident data collection methods in Datix to enable the EPRR team to support and debrief following incidents.

Potential Risks

The EPRR team are still working against a large backlog following the pandemic and also new concurrent incidents, leaving planned works to fall further behind. The work plan is used to ensure that compliance is a key priority for the EPRR team and that regular updates on progress are received in the safety trust action group (TAG) to monitor progress and any challenges to compliance.

Future Planning for 2023/24

- Prepare for the release of the Core Standards in June, reviewing progress and updating against current standards.
- Continue to review EPRR policies and plans to ensure lessons learned from incidents are embedded appropriately.
- Design e-learning packages for EPRR training in liaison with Learning and Development colleagues.
- Prepare and deliver annual tabletop exercise for a cyber-attack to take place in Quarter 3/ 4 and roll out local table top script for the loss of IT.
- Prepare and commence delivery of the 2023/24 staff influenza campaign before its handover to the People directorate when resources are in place, ensuring appropriate representation from all care groups and resources and expectations are met and lessons learned from the previous campaign are taken into account.

7. Conclusion

2022/2023 has been a productive and challenging year for Health and Safety, with a number of notable achievements recognised from each work stream. The success of the Health & Safety monitoring tool roll out; the extending of Newton Lodge fire suppression system to cover Chippendale and Appleton wards; the delivery of a number of table top exercises are a number of key achievements discussed within this report.

2023/2024 will be even more challenging with the need to redesign training packages to meet the changing workforce; the recruitment of staff to fulfil function levels and the revision of numerous policies, procedures, and plans. New targets will be implemented to enable the teams to meet the requirements of the Trust, its staff, and external standards throughout the next reporting year.

This report provides Trust Board with evidence of compliance that the Trust is meeting its statutory duties in relation to policy, procedure, and practice, for fire safety legislation, the Health & Safety at Work etc. Act 1974, the Civil Contingencies Act (2004) and the Management of Health & Safety at Work Regulations 1999 and to meet Care Quality Commission standards.

Appendix 1

Health & Safety Action Plan – 2023/2024

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target for Completion	Comments
Inspection spreadsheet held by Health & Safety Team to be updated from results of H&S 22/23 Monitoring programme. Visits To be planned for 23/24.	Adrian Snarr/Nick Phillips	Roland Webb/Aaron Luckarift	To ensure support can be accurately and promptly targeted to services & teams.	Q2	Planned audits, inspections and visits to teams are a fundamental element of the Trust's approach to HSG65.
Revise & Update Trust Health & Safety Policy.	Adrian Snarr/Nick Phillips	Roland Webb	The Trust Health & Safety Policy supports a reasonable and pragmatic approach to working	Q2	The revised Trust Lone Working Policy & Guidance will take & implement lessons learnt from the last three years.
Revise & Update Trust Slips, Trips & Falls Policy & Guidance.	Director of Nursing, Quality and Professions/ Adrian Snarr/Nick Phillips	Karen Greenbank Falls Coordinator/ Roland Webb	The Trust Slips, Trips & Falls Policy & Guidance. supports and guides measures required to reduce the risks as far as reasonably practicable approach to avoiding slips trips & falls	Q2	The Trust Slips, Trips & Falls Policy & Guidance is a joint Health & Safety/Clinical policy.
Revise & Update Trust Control of Contractors Policy	Adrian Snarr/Nick Phillips	Roland Webb/Tony Tipton/ Aaron Luckarift	The Trust Control of Contractors Policy supports a reasonable and pragmatic approach to ensure safe and effective working practices	Q2	The Trust Control of Contractors Policy details SWYPFT's approach to meeting its legal and moral duties.
Develop "Swollen Lithium Battery" Information and Guidance	Adrian Snarr/Nick Phillips	Roland Webb/Aaron	Discussed at the Safety & Resilience TAG, Lithium batteries can be	Q2	Faulty & swollen lithium batteries, whilst rare are a significant safety &

		Luckarift/ Andy Siddle	encountered in various devices, including phones & laptops		fire risk, yet not commonly known about.
Implement and complete audit/inspection programme by end of March and prepare for 2023/2024 monitoring programme.	Adrian Snarr/Nick Phillips	Roland Webb/Aaron Luckarift	Ensure effective Trust wide approach to health & safety monitoring & inspections for Trust Board assurance.	Q4	The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective health & safety measures within the Trust.
Update Health & Safety Intranet pages and ensure policies and all H&S Information is current with correct contact details.	Adrian Snarr/Nick Phillips	Roland Webb/Aaron Luckarift	To ensure Trust staff have reliable and pertinent access to Health & Safety Information.	Q4	As the roll out of new services evolve and working practices modernise, Health & Safety information will be updated as required.
Continue to monitor and improve notification systems for managers around the lone worker devices	Adrian Snarr/Nick Phillips	Roland Webb/Aaron Luckarift	To ensure mangers have the correct information to help them manage and improve use of lone worker devices.	Q4	The use of lone worker devices is a key safety component for many staff. Effective management information aids their use.

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Appendix 2

Fire Safety Action 2023/2024

No.	Action	Lead Director/ Senior Manager	Lead	Rationale	Target Date for Completion	Comments
1	Ensure sufficient training capacity for face to face fire lectures or practical fire training sessions are available.	Nick Phillips/ Martin Brandon	Ian Cass/ Dave Bedford	To increase provision of training to all areas of the Trust to ensure a higher uptake through wider availability and to meet the needs of the Fire Safety policy.	Q4	
2	Reduce the number of false alarm or unwanted fire signal activations of fire alarms by 20%	Nick Phillips/ Martin Brandon	Ian Cass/ Dave Bedford	To reduce attendance of the Fire Service to UWFS, to ensure their resources are able to attend actual incidents and to avoid impacting the Trusts reputation.	Q4	
3	Maintain an effective programme to ensure that fire risk assessments and fire plans are kept under review	Nick Phillips/Martin Brandon	Ian Cass/Dave Bedford	To comply with the legal requirements of the Fire Safety Order	Q4	

4	Ensure that team members are supported in maintaining professional competence by participation in relevant CPD events	Nick Phillips/Martin Brandon	Ian Cass/Dave Bedford	To ensure that fire safety advice provided meets current standards	Q4	
5	Continue the rollout of the water mist fire suppression programme in wards.	Nick Phillips/Martin Brandon	Ian Cass	To improve fire safety on wards	Q3	

Appendix 3

Security Action Plan 2023/4

No.	Action	Lead Director/ Senior Manager	Lead	Rationale	Target Date for Completion	Comments
1	Review and implementation of lockdown processes and procedures across various locations of the Trust.	Nick Phillips/ Martin Brandon	Johan Celliers/ John Sanderson	To ensure compliance with the NHSE Core Standards for Emergency Preparedness, Resilience and Response and also strengthen the safety of environments for staff, patients and visitors.	Q4	
2	Ongoing support to community premises to address safety concerns when self-presenters attend sites and security presence during client consultations when risk assessment deems it appropriate.	Nick Phillips/ Martin Brandon	Johan Celliers/ John Sanderson	To provide a safe and secure working environment for staff, patients and visitors.	Q4	
3	Assist estates in CCTV upgrade.	Nick Phillips/ Martin Brandon	Johan Celliers/ John Sanderson	Ongoing works from previous year – security input will ensure that the CCTV is sited in the most appropriate locations.	Q2	

No.	Action	Lead Director/ Senior Manager	Lead	Rationale	Target Date for Completion	Comments
4	Evaluate trust wide security provision, taking a risk-based approach.	Nick Phillips/ Martin Brandon	Johan Celliers/ John Sanderson		Q3	
5	Ensure compliance with The Violence Prevention and Reduction Standard in conjunction with RRPI leads.	Nick Phillips/ Martin Brandon	Johan Celliers/ John Sanderson	To maintain compliance against the NHS Contract in line with standard requirements.	Q4	
6	Recruitment drive for security officers based at Fieldhead.	Nick Phillips/ Martin Brandon	Johan Celliers/ John Sanderson	To strengthen security personnel at Fieldhead following loss of staff.	Q2	
7	Audit KPI's & KPT's for the lone worker and external security contracts.	Nick Phillips/ Martin Brandon	Johan Celliers/ John Sanderson/ Roland Webb	To ensure that the contract performance is adequate and to prepare for future contract renewals.	Q3	
8	Continue to strengthen police liaison relationships.	Nick Phillips/ Martin Brandon	Johan Celliers/ John Sanderson	Maintain relationships across multi agency partners	Ongoing	

Appendix 4

Emergency Preparedness, Resilience & Response Action Plan 2022/23

No.	Action	Lead Director/ Senior Manager	Lead	Rationale	Target Date for Completion	Comments
1	Prepare for the release of the Core Standards in June, reviewing progress and updating against current standards.	Nick Phillips/ Martin Brandon	Emma Hilton	The Trust compliance status in 2022 was declared as Partial with an action plan to progress compliance to Substantial in time for the next release of the Core Standards, which is due June/July 2023	Q2/3	Works progressing, with 2 standards to work towards full compliance to enable a Substantial Compliance declaration. The EPRR team will be audited in June/July by 360 assurance to ensure the self-declaration is accurate.
2	Continue to review EPRR Policies and Plans to ensure lessons learned from incidents are embedded appropriately.	Nick Phillips/ Martin Brandon	Emma Hilton	To ensure all plans and policies are up to date with relevant legislation and guidance from NHSE, and any lessons learned from internal and external incidents.	Q4	The Pandemic Flu Plan, Adverse Weather Plan, HAZMAT procedures, Fuel Crisis Plan, Bomb and Suspect Packages Procedures and Business Continuity Management Procedures are all due for review during this financial year and will be reviewed accordingly.
3	Design e-learning packages for EPRR training in liaison with Learning and Development colleagues.	Nick Phillips/ Martin Brandon	Emma Hilton	To provide staff with access to relevant training in line with NHS Core Standards.	Q3	A selection of courses have been sent to L&D to analyse content and costs for implementation.

4	Prepare and deliver annual table top exercise for Cyber Attack and roll out local table top script for Loss of IT.	Nick Phillips/ Martin Brandon	Emma Hilton/ Chris Crocker	To test knowledge and skills of trained commanders within the Trust in line with NHS Minimum Occupational Standards and portfolios.	Q3/4	Planning meeting to take place in June 2023.
5	Prepare and deliver the 2023 Staff Influenza campaign, ensuring appropriate representation from all Care Group's and resources and expectations are met and lessons learned from the 2021 campaign are taken into account.	Nick Phillips/ Martin Brandon	Emma Hilton/ Helen Whitelam	To provide protection to staff, patients and respective family and friends from seasonal influenza in line with NHS guidelines and CQUIN arrangements.	Q4	Planning meeting to take place in May 2023. Annual target is 70 – 90% of frontline healthcare workers to be vaccinated within the programme period.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 July 2023
Agenda item 9.4

Title:	**Freedom to Speak Up Annual report 2022/23**		
Paper presented by:	Adrian Snarr - Director of Finance, Estates and Resources		
Paper prepared by:	Julie Williams – Deputy Director of Corporate Governance Estelle Myers - Freedom to speak up guardian		
Mission/values:	This report helps to demonstrate the open honest culture within the organisation. The information from the National Guardian's Office (NGO) informs us that the greater the numbers coming forward to the freedom to speak up guardian the more this demonstrates the open culture.		
Purpose:	To review the data looking at the concerns and look at improvements that need to be made to help to create a just culture with psychological safety within the organisation.		
Strategic objectives:	Improve Health		
	Improve Care		
	Improve Resources		
	Make this a great place to work	✓	
BAF Risk(s):	Risk 4.3 - Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	By ensuring that the Trust has a robust freedom to speak up policy and procedures to support the delivery of strong People leadership across the places we provide care.		
Any background papers / previously considered by:	Presented to freedom to speak up steering group for review and comment. People and Remuneration Committee 13 July 2023		
Executive summary:	This annual report provides an overview of the governance, systems and processes the Trust has in place for FTSU; this report presents an annual review of the number, and types of cases that have been dealt with and provides information in relation to the latest cases that have been brought to the attention of the FTSU Guardians between 1 April 2022 and 31 March 2023.		

	It should be noted that due to delays at the National Guardians Office, national comparison data is not available for this annual report and will be included in the six-monthly update in November 2023. The reporting line for the FTSU guardian now sits under the Deputy Director for Corporate Governance to further ensure the independence of the role. During 2022/23 there has been a further increase in the number of individuals coming forwards which is likely due to improved awareness of the role and how it supports the culture of the organisation. Adult and older people mental health and learning disabilities are the main areas where concerns have been reported, albeit concerns have been reported from all care delivery groups and all disciplines in year. Closure timescales have seen an improvement with only 2 cases open over 70 days in 2022/23 compared to 21 in 2021/22. Cases for 22/23 are mainly in the categories of worker safety, inappropriate attitudes and behaviours, patient safety and bullying and harassment is the lowest reported category. 4 anonymous and 2 cases of detriment are noted. Promotional materials were delivered to all wards across the Trust in October 2022 as part of speak up month. Visits have taken place to community teams in the year. Training has been delivered to care certificate individuals. FTSU Guardian attends Trust welcome event. FTSU Guardian attends operational management group (OMG) on a quarterly basis. Laminated posters have gone up in staff toilets across the Trust. Screensaver has been developed to help promote the role on laptops and computers. A new freedom to speak up (FTSU) steering group has been set up to oversee the FTSU process in the organisation. The Trust FTSU policy has been reviewed in line with the new national template that has been produced. The new board reflection and planning tool is being progressed and this will set the new action plan for 2023/24. Mandatory Speak up training is at 93.67%.
Recommendation:	**Trust board is asked to APPROVE the freedom to speak up annual report and subsequent publication.**

Freedom to Speak Up (FTSU) – Annual report 2022/23

1. Introduction

This annual report provides an overview of the governance, systems and processes the Trust has in place for FTSU; this report presents an annual review of the number, and types of cases that have been dealt with and provides information in relation to the latest cases that have been brought to the attention of the FTSU Guardians between 1 April 2022 and 31 March 2023.

2. About the FTSU Guardian

The Guardian role supports individuals who raise concerns and co-ordinates case management as appropriate, acting as a cultural ambassador to promote and develop an open and transparent culture in the organisation. The role provides confidence and trust enabling staff to raise concerns, carries out the triangulation of data, and looks at areas for improvement and learning whilst continually looking at ways to increase awareness of the role. The Guardian for the Trust also chairs the Yorkshire and Humber regional Freedom to Speak Up network.

3. Governance Systems and Processes

NHS England (NHSE) have produced a new Speaking up Policy template. The template is expected to be adopted as a minimum standard by all NHS Trusts and primary care providers by January 2024. The Trust speaking up policy, including the new template, has been through Trust processes and was approved by the extended management team (EMT) in April 2023.

In addition, a new Freedom to speak up reflection and planning tool has also been developed by NHSE and the Trust is required to report on the outcome and associated action plan by January 2024. This work is currently being undertaken and is on track for submission to Trust Board in November 2023.

There continues to be strong organisational commitment to supporting staff to raise concerns. This has been further evidenced during 2022/23 with the following work streams:

- A review of the structure to support Freedom to Speak Up was undertaken and as a result the reporting line for the full-time Guardian was changed from the Chief People Officer to the Deputy Director of Corporate Governance. This is to ensure that FTSU is independent and separate from any other Trust process and therefore

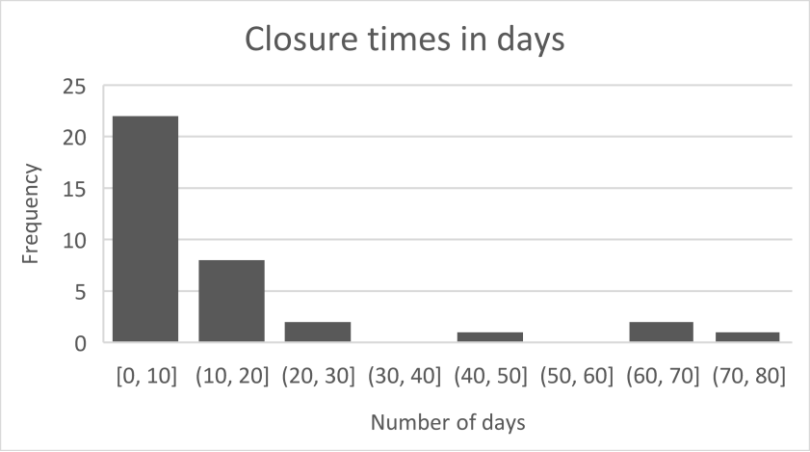
independent, transparent and open. In addition, the Guardian has a direct reporting line to both the Chief Nurse and Director of Quality & Professions and Chief Executive. Further oversight and independence is provided by the Senior Independent Director (SID) who holds Board level responsibility for Speaking Up.

- Every six weeks, meetings are held with the SID, Deputy Chief People Officer, Chief Nurse, Deputy Director of Corporate Governance and the FTSUG to review cases and themes, as well as support with case management.
- Half yearly reports on strategy and action plans are provided to the People and Remuneration Committee and assurance is provided to Trust Board through the Committee via the Alert, Advise Assure (AAA) report.
- Governance has been further strengthened in 2022/23 with the establishment of a steering group, reporting into the People Renumeration Committee. The first meeting of this group was held in March 2023. Membership includes senior clinical staff, Equity Guardians, Learning and development and safeguarding. Early work has included, review of the self assessment tool and review of learning from 2022/23 cases.
- A new process has been developed for complex cases to immediately convene an assessment meeting including the FTSUG, safeguarding team, and the people directorate. The purpose of the assessment is to formulate a plan for co-ordination of investigation, to ensure that there is clear ownership and oversight of the process.

4. Data and Benchmarking Information, including 2022/23 activity

The graph below shows that closure timescales for cases during 2022/23 have improved, with only 2 cases open over 70 days, (compared to 21 in 21/22). The majority of cases are dealt with on the same day. This evidences that most concerns raised are required to be signposted elsewhere, when they are not suitable for the FTSU process e.g., staff side.

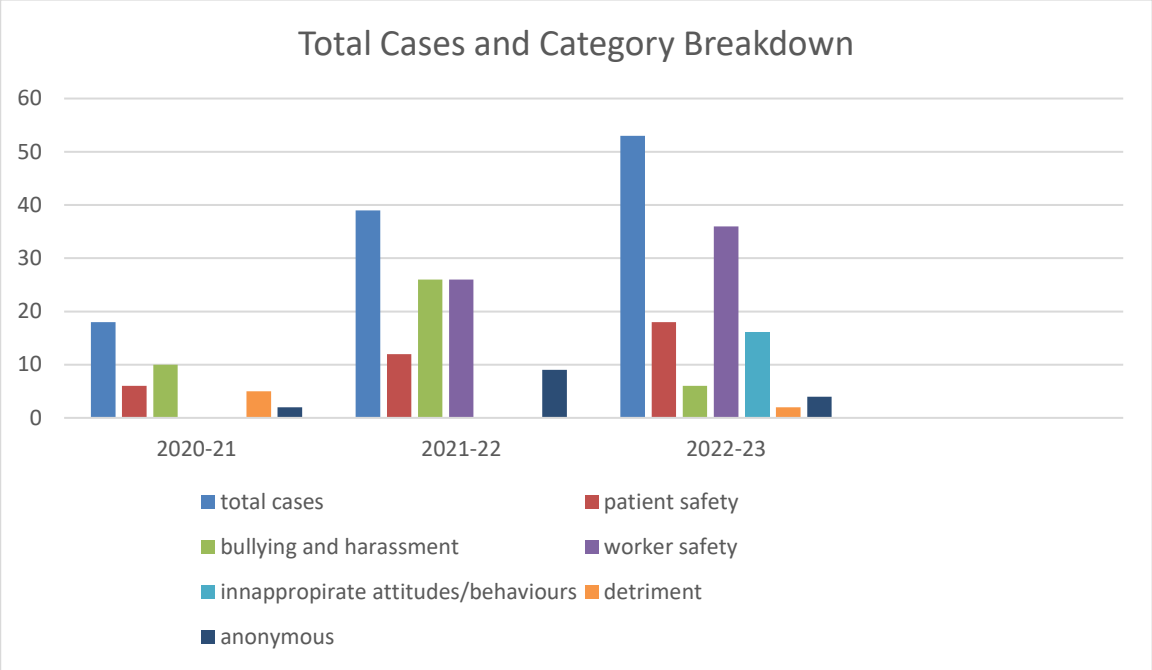
The graph below, also shows the majority of cases during 2022/23 were closed within the stipulated 35-day timescale:



Model Hospitals data

The full year national and regional data is not available at the time of the writing of this report and will be presented in November 2023 as part of the bi-annual update report.

The nature of the concerns and cases



A new category was added in for 22/23 of other inappropriate attitudes or behaviours. Figures for this are included in this graph.

During speak up month in October 22/23 there was a minimal increase in cases.

The prevalent categories in descending order are worker safety, patient safety, inappropriate attitudes and behaviours, and bullying and harassment. Four anonymous cases were received in year.

Patient Safety Related Cases

During 2022/23 it has been identified that cases relating to patient safety have increased as the year has progressed. It can be seen from the graph above that cases relating to patient safety are higher than in previous years.

Public Interest Disclosure at work (PIDA) cases

During 2022/23 no cases have met the definition of disclosures of public interest at work. (therefore not included in the chart above)

Detriment

In 2022/23 two individuals have reported suffering a detriment as a result of speaking up. One case has been resolved internally and the second is still under investigation at the time of writing this report. Both cases relate to patient safety. The outcomes of both investigations will be shared anonymously with the steering group to ensure learning is cascaded throughout the organisation.

National data

National Guardians Office data for 2022/23 was not available at the time of the report but will be included in the bi-annual update report submitted to People and Remuneration Committee and Trust Board in November 2023.

Trust Data

Trust wide reporting

A total number of 155 cases have been brought to the FTSUG since 2016, when the role was established.

Each year the number of cases received is continuing to rise reflecting the likely increase in staff awareness of the freedom to speak up process. (It should be noted the Covid-19 pandemic effected 20/21 reporting).

Date Period	Quarter	Number of concerns
2016/17	All	0
2017/18	All	8
2018/19	All	9
2019/20	All	33
2020/21	All	18
2021/22	All	39
2022/23	All	53

Care Group reporting

2022/23 data shows that concerns came from all Care Groups with the majority in Adult and Older People Mental Health, then Learning Disabilities and Autism Services then Barnsley Integrated Services. 2022/23 National Guardians Office data is not available at the time of writing of the report to compare professional groups. The Trust moved from Business Delivery Units to Care Groups in July 2022.

For 2022/23 a new method for collecting data has been agreed in conjunction with the FTSU steering group. The new method seeks consent from staff who are completing feedback, to allow information to be shared anonymously for use in reports. An action plan is being developed to improve feedback as part of the communications and engagement plan.

The Care Groups consist of different service lines to the former Business Delivery Units, and therefore a direct comparison of previous years data is unable to be made:

Concerns per area **22/23**	Number	Number of staff in locality (FTE)
Barnsley Integrated Services	7	988.35
Adult and Older people mental health	16	1460.58
CAMHS	8	338.67
Forensic Services	3	410.92
Learning disabilities and Adult ASD and ADHS	12	186.74

Support services	4	666.41
Unknown	3	N/A

Last year 2021/22 data showed that concerns came from all Business Delivery Units (BDU's) but the majority came from forensic and inpatient areas:

Concerns per area **21/22**	Number	Number of staff in locality (FTE)
Barnsley District	5	1173
Calderdale and Kirklees District	5	844
CAMHS	3	327
Forensics	10	627
Inpatients	10	337
Support services	1	753
Wakefield	5	365

5. Communication engagement and training

One of the key activities of the Guardian is to increase visibility and promote speaking up channels for staff and the Guardian has started to do this through face-to-face visits into services, developing posters and promotional materials, one to one meetings, attending the Trust's Welcome Event and providing training to the individuals joining the trust through the care certificate programme.

In 2022/23 the FTSU guardian has visited all 30 Trust inpatient wards on several occasions and has been key trained to support ease of access to Forensic services.

As well as speaking to staff the guardian has:

- Continued to attend Trust welcome events.
- Deliver Speak up training to staff studying the Care certificate and to volunteers working in the Recovery college
- Facilitated laminated posters being placed on the back of all staff toilet doors.
- Delivered Listen up and follow up training to members of Operational Management group (OMG) and Extended Executive Management Team.
- Supported the development of the FTSU intranet page
- Supported the screensaver being continually visible on computers.
- Supported a number of initiatives as part of the October 2022 "Speak Up" month, including a video being produced by TRIO

Distribution of FTSU branded water bottles, tote bags, pens and business cards across the Trust.

6. Training figures

Freedom to Speak Up training has been developed by Health Education England and contains 3 modules, Speak Up, Listen Up and Follow Up. The trust has adopted Speak up training as mandatory and the 2 other modules are on an as required basis for managers and senior leaders.

Training figures show that Speak Up mandatory training is at 93.67% against an 85% target.

Further promotion of the training modules is required to alert managers and senior leaders, to support staff to complete Listen up and follow up modules. This will be monitored via OMG on a quarterly basis.

7. Lessons Learnt

Following feedback and evaluation of cases and learning from the National Guardians Office (NGO) the following lessons learnt have been identified and will be used as case studies with managers and senior leaders.

- Ensure staff are reminded at all team meetings that they can contact their team manager/Supervisor at any time if they have any concerns or issues. Include 'Well-being' as a standard agenda item for team meetings for staff to share what they have done to aid their well-being – or to share ideas with colleagues.
- Bank staff require support and for clear expectation of role to be set. This should be face to face where possible.
- Hybrid working is a model that employees are keen to continue due to the flexibility and autonomy it offers. However, one size will rarely fit all, and managers will need to monitor this to avoid assumptions and ensure that good communication is maintained.
- Employees value informal as well as work related connection. Social support is vital to employee resilience and wellbeing and informal interaction should be encouraged wherever possible.
- Development opportunities are highly valued and are a great way to incentivise and engage employees. However, opportunities for development are often at risk in times of high pressure; managers should seek to offer these wherever possible due to the benefits they bring.
- There is often a conflict in client facing roles between the level of interaction required and the need to get work done.
- Managers and their teams should work together to identify how best to reduce pressure and ensure that employees feel confident to perform in their roles.
- We will continue to support staff to understand the changes and always offering them the opportunity to speak up about their views and how the service progresses within the leadership team. Processes have changed and referrals are discussed with service user and the clinician can get assistance from the lead clinicians in each team. Further

discussions with the Single Point of Access Team, team are planned in the future to ensure that there is improvement in communication across all teams.
- Review of Freedom To Speak Up policy complete with Staff side for review on track for EMT approval and includes policy on a page to support staff navigation.
- At handover relevant information will be passed onto the clinician so that nothing is missed.

8. Barriers to speaking up

The following are identified from the work of the network and are a focus for 2023/24, to improve:

- Low numbers of speaking up cases, are we confident that staff able to speak up and are we using all sources of feedback effectively – numbers have increased each quarter during 2022/23 indicating increased awareness.
- Low awareness of speaking up – the awareness has increased as the latest pulse survey data shows.
- Compliance with FTSU mandatory training is now at 93.67% and numbers are low for Listen up and Follow up.
- Visibility of FTSUG and network and seen as a trusted source – more ward and team visits are planned
- Concerns take too long to be resolved – Manager Feedback form being used, timescales included lower down the report.
- Communications not sufficiently visible – board to help with publicity of speaking up through headlines
- Staff being able to see a difference and using lessons learnt effectively.

9. Summary

This annual report highlights the trust continued commitment to Freedom to Speak Up and the strengthening of the governance systems. As stated in the report the benchmarking data from the National Guardians office is not available. This will be available in the November data report, with any sign of variations reported to People Remuneration Committee and the Executive Management Team. It is further proposed that for 23/24 that the reporting timetable be brought in line with financial years to enable better comparison of data and the annual report be presented to Trust Board in June 2024.

10. Recommendation

The People and Remuneration Committee are asked to comment on this annual report. The report will be presented to the Executive Management Team and finalised for presentation to the Committee on the 13 July 2023 for approval to submit to the Trust Board on the 25 July 2023.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 July 23
Agenda item 9.5

Private/Public paper:	**Public**		
Title:	**PLACE scores 2022 and summary of actions**		
Paper presented by:	Adrian Snarr - Director of Finance and Resources		
Paper prepared by:	Nick Phillips - Deputy Director: Estates and Facilities Karen Hinch - Head of Facilities		
Mission/values:	We improve and aim to be outstanding		
Purpose:	To provide the Trust Board with an overview of the Trust PLACE scores		
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 inequality in health outcomes or life expectancy Risk 4.3 - Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	To ensure that the Trust services meet the required standards for PLACE supporting the delivery of high-quality care across the places we serve.		
Any background papers / previously considered by:	Submitted to Operational Management Group, Executive Management Team Audit Committee on 11 July 2023		
Executive summary:	The Trust is required to assess itself annually against a strict set of criteria in the PLACE (Patient Led Assessment of the Care Environment) the domains assessed are in the matrix supplied at appendix 1. Whilst the Trust organises the assessment it is not undertaken purely by the Trust employees it involves volunteers who must be trained to undertake an assessment. During Covid the assessment changed to be less invasive. As we return to business as usual the volunteering role will return in full. The timeline		

	for undertaking the surveys and submitting data this year was extremely short this meant that we had to use just a portion of previous independent volunteers in the process. This meant we used our existing fully trained volunteers only, next year we plan to revert to using the wider pool including non-executive directors and governors. The Trust scores very favourably against national averages which does give assurance around the environment, cleanliness, and standard of food we supply for service users. The only exception to this is the Dales where we have two indicators slightly below the national average, these are in two areas where we receive services through the PFI provider (Private Finance Initiative) steps have been taken to improve this with the provider. This year has seen another change in the scoring matrix so there is no comparison with previous years.
Recommendation:	**Trust Board is asked to RECEIVE the report**

Trust Board July 23 - PLACE (Patient-Led Assessments of the Care Environment) Results 2022

1. The purpose of PLACE assessments

PLACE assessments are an annual assessment of the non-clinical aspects of the patient environment, how it supports patients' privacy and dignity and its suitability for patients with specific needs, e.g., disability or dementia.

The assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia or with a disability.

PLACE assesses several non-clinical aspects of the healthcare premises identified as important by patients and the public, known as domains:

- Cleanliness
- Food and hydration
- Privacy, dignity and wellbeing
- Condition, appearance and maintenance
- Dementia: how well the needs of patients with dementia are met
- Disability: how well the needs of patients with a disability are met

The criteria for each domain represent good practice as identified by professional organisations whose members are responsible for the delivery of these services:

- HEFMA – Healthcare Estates Facilities Managers Association
- HCP – Healthcare Cleaning Professionals
- HCA – Hospital Caterers Association

The PLACE assessment aims to promote the principles established by the NHS Constitution that focus on areas that matter to patients, families and carers:

- Putting patients first
- Active feedback from the public, patients and staff
- Adhering to basics of quality care
- Ensuring services are provided in a clean and safe environment that is fit for purpose

PLACE encourages the involvement of patients, the public and both national and local organisations that have an interest in healthcare. The 2022 assessment teams consisted of:

- PPI (Patient Public Involvement) representatives
- Healthwatch England - Wakefield, Barnsley and Calderdale teams
- IPC (Infection, Prevention and Control)
- Estates
- Facilities
- Ward managers and staff

The scores awarded must reflect what is seen on the day of the inspection. In this way the

inspections attempt to replicate the environment as patients and visitors see it when accessing our services.

The final scores are aggregated into percentage scores and are not based on pass/fail criteria overall.

The 2022 PLACE results have now been published as required on the NHS Digital website, link below:

https://digital.nhs.uk/data-and-information/publications/statistical/patient-led-assessments-of-the-care-environment-place

2. Results

a. National Headlines

- 936 assessments were undertaken by 222 organisations in 2022. Of these, 179 (80.6%) were NHS Trusts and 43 (19.4%) were voluntary, independent or private healthcare providers.
- Overall, the highest national average (1) domain score in 2022 was for cleanliness, at 98%.

((1) Averages are means and are weighted for bed numbers)

b. Trust Headlines

Overall, the scores are incredibly positive, a quote from the assessors (volunteers) is provided below:

“The Trust should be very proud of all its sites; they are exceptionally clean and well maintained. After 2 years of covid-19, to maintain these standards is an amazing achievement when we honestly expected standards to have dropped slightly. A very big well done to everyone”.

The table attached details the Trust’s PLACE percentage scores for 2022 against national averages; they cannot be compared to previous years due to the refined and revised questions introduced in 2022 following a national review between 2018-19 to ensure the assessments were relevant and delivered its aims with additional focus added around covid-19.

Overall, the scores achieved are excellent and are generally higher than national averages with all but 2 out of 40 domains being above the national average.

Some areas of note are:

- **Cleanliness**

All the inpatient units except for The Dales, (who achieved 97.38%, only marginally below the national average of 98%,) were above average, with 2 areas (Enfield Down and Poplars) scoring 100% and the remaining areas scoring over 99%.

- **Food**

The food domain includes a range of organisational questions relating to the catering service e.g., choice of food, 24-hour availability, mealtimes and access to menus.
It also includes an assessment of food at ward level including the taste, texture and appropriateness of serving temperature.

All Trust areas scored higher than the national average (90.2%), achieving between 92.24% and 98.45%, positive comments around food choice and quality were received from the assessment teams.

- **Condition, appearance and maintenance**

Except for The Dales, all areas achieved above national average % (95.8%), with 3 areas being scored above 99%. It was noted that The Dales is currently in the process of being redecorated and work being undertaken to review the flooring in several in-patient areas.

- **Privacy and dignity**

3. Key Actions for 2023/24

Overall, the scores are incredibly positive with a general quote from the assessors (volunteers):

All qualitative information is captured during the assessments and this data is used in the development of an action/improvement plan as well as good practices being identified and shared. A detailed action plan by service is being developed and will submitted to the via the Estates Task and Finish Group (TAG) by August 2023, who will provide monitoring and oversight.

- **Food**

An additional question was introduced into this year's assessments – '*Are you currently using a digital ordering system.'*

The Trust is currently in the process of introducing a new digital food ordering system which is being trialled on the Kendray site and will be fully implemented by quarter two 2024/25 and this will contribute to supporting menu choice, waste etc.

- **Privacy, dignity and wellbeing**

All areas achieved above national average (86.1%) for this domain although the introduction of a new organisational question – '*Is information available to indicate participation in a scheme which allows people with identified or registered carers to visit at any time, including mealtimes,'* identified there is work to be done to raise awareness in this area.

The links below give more details on what this question relates to:

- https://johnscampaign.org.uk/
- https://carerspassport.uk/hospitals

- **Disability**

This area scored well above average, with overall good accessibility for all disability types. One area of action is it was identified that a couple of areas within the trust have lifts without audible message facility, this will form part of the action plan.

4. Conclusion

Overall the Trust performed very well in the 2022 PLACE assessments and the action plan will ensure we continue to improve during 2023.

Nick Phillips
Deputy Director of Estates & Facilities

July 2023

	CLEANLINESS			FOOD			PRIVACY, DIGNITY & WELLBEING			CONDITION, APPEARANCE & MAINTAINANCE			DEMENTIA			DISABILITY		
	2022		*Nat. %*	**2022**		*Nat. %*	**2022**		*Nat. %*	**2022**		*Nat. %*	**2022**		*Nat. %*	**2022**		*Nat. %*
Fieldhead	99.77		*98*	96.36		*90.2*	99.48		*86.1*	98.01		*95.8*	96.83		*80.6*	98.10		*82.5*
Newton Lodge	99.90		*98*	95.04		*90.2*	96.69		*86.1*	99.38		*95.8*	N/A		*80.6*	96.72		*82.5*
Kendray	99.79		*98*	98.45		*90.2*	97.74		*86.1*	96.70		*95.8*	95.24		*80.6*	96.67		*82.5*
Priestley Unit (Dewsbury)	99.72		*98*	93.84		*90.2*	95.38		*86.1*	96.59		*95.8*	97.18		*80.6*	95.83		*82.5*
Dales Unit	97.38		*98*	95.86		*90.2*	94.62		*86.1*	95.45		*95.8*	87.18		*80.6*	93.65		*82.5*
Poplars	100		*98*	94.08		*90.2*	93.02		*86.1*	99.14		*95.8*	96.97		*80.6*	95.28		*82.5*
Enfield Down	100		*98*	92.24		*90.2*	95.15		*86.1*	99.67		*95.8*	N/A		*80.6*	90.16		*82.5*
Overall Organisational scores	**99.47**		***98***	**95.72**		***90.2***	**96.99**		***86.1***	**97.71**		***95.8***	**94.62**		***80.6***	**96.09**		***82.5***

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 July 2023
Agenda item 9.6 – Assurance from Trust Board Committees
Audit Committee

Date	11 July 2023
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)

Key items to raise at Trust Board	**Assure:**
	• Positive assurance received from regular reporting of
	  ○ Progress with activity to protect the Trust against cyber-attack; as in previous quarters, this report was a testament to the quality of work being delivered by the Trust's IT team.
	  ○ The triangulation of risks against the performance reporting and other governance reporting. This triangulation now includes comparison to the Strategic Overview of Business and Associated Risks.
	  ○ Internal Audit and Counter Fraud activity by 360 Assurance
	  ○ In addition to the two individual Internal Audit Reports with Limited Assurance further reports were received as follows
	• Care Group Risk Management – significant assurance
	• Data Security and Protection Toolkit – substantial assurance (based on NHS assurance ratings)
	• The Committee received a full report on Health & Safety activity for 22/23. It has been a challenging year, but much has been delivered.
	• The annual report into the Trust's PLACE (Patient Led Assessment of the Care Environment) score was also presented to Committee. The Trust scores very favourably against national averages in nearly all areas with only one exception where we receive services through a PFI provider. Thanks for all those involved in achieving those scores were noted by Committee.
	
	Advise:
	• The Committee was taken through the Trust's Declaration of Interest Annual Update. Alongside application of fit and proper persons' testing and annual declaration exercises for Directors. Non-Execs and Governors, there is an annual process for receiving declarations of interests from 413 staff identified as decision-making. The Committee was pleased to note that since April 1st, 2023, declarations have been received from all identified staff. This is a significant improvement on previous years.
	• The Committee ratified the Trust's Treasury Management strategy which currently retains all funds within the Government Banking Service. The opportunity for alternative investment is regularly reviewed but not considered appropriate at this stage.
	
	Alert:
	• The Committee received the reports of two Internal Audit Review with outcomes of Limited Assurance
	• E-Rostering
	• Risk Assessment and Care Planning
	• Executives responsible for both these areas attended Committee and gave assurance regarding the implementation of the

	recommendations in the Internal Audit reports; further updates will be brought back to future Audit Committee meetings. • Updates regarding actions to mitigate the risks assigned to the Committee were discussed; further consideration was requested from management with regard to the risk re the lack of capacity to deliver the Trust's strategic objectives in that the current delivery date for completion of actions has been set at March 2024 which is after the anticipated delivery of the current year's objectives. • The regular report on Procurement activity was presented by the new Head of Procurement. The Committee has requested that the content of ongoing reporting is reviewed to provide further context and insight. • Additionally, the Committee discussed the need for more consistent application of the Trust's tender waiver policy/processes.
Approved Minutes of previous meeting/s for receiving	Nil

Clinical Governance & Clinical Safety Committee

Date	13 June 2023 / 24 July 2023 (verbal update)
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**13 June 2023** **Alert:** • Risk 1757: This risk relates to medical devices and their maintenance and monitoring. The committee were advised that a paper is going to EMT and agreed that there will be a more in-depth discussion on this risk at the next CGCS Committee on 24 July. • Complaints responses continue to be an area of focus around both the quality and timeliness. The committee have asked for ongoing updates until they can be assured. • The Care Group and Quality report (executive trio) continues to demonstrate concerns being raised about the Horizon Centre through the Freedom to Speak Up process and the committee were advised of the executives making an unannounced visit and positive feedback from this. Leadership remains a focus and the committee was advised that the People Directorate are supporting this work. **Advise:** • The committee were pleased to hear that Darryl Thompson has been appointed to the Council of the National Mental Health and Learning Disabilities Nurse Directors Forum. • The committee discussed the draft Patient Experience/Customer Services Annual Report and provided comments. This will be coming to the board in September. • The committee is seeking approval to change its name to the Quality and Safety Committee and will be seeking board approval. • The Complex Case Review and Serious Incident Update were received and discussed in the private committee to maintain confidentiality. **Assure:** • The committee received and discussed in the private section of the meeting the Quality Regulatory and Oversight Papers with a focus on the recent CQC visits. This will be discussed with the board and key areas highlighted whilst awaiting the final report.

	• The committee received the Clinical Audit and Service Evaluation (CASE) plan for 2023-24. The plan will include an audit of out of area placements and compliance with the criteria in response to discussions at the committee previously and the ongoing risk around the level of usage. This is to provide assurance through audit that they are being used appropriately and in line with our own compliance and criteria. • The committee received an update on the Care Planning and Risk Assessment Improvement work and noted that it is continuing to move in the right direction. • The committee received the Incident Management Annual Report 23/24 which included Learning from Healthcare Deaths and the Q4 report. 97% of all incidents reported resulted in no harm or low harm. The committee noted the continued high prevalence of violence and aggression being experienced by our staff and the trauma informed work is one approach. Pressure ulcers have increased although the committee noted that it has undertaken deep dives regularly and been advised of the rationale including the impact of COVID on older people and more inactive along with the impact of the warm weather. • NICE Annual report was approved by the committee. • The committee recommended the approval of the Infection Prevention and Control Annual Report. **<u>24 July 2023</u>** A verbal update will be presented in the Board meeting in relation to the meeting held on 24 July 2023.
Approved Minutes of previous meeting/s for receiving	Nil

People and Remuneration Committee (extraordinary)

Date	13 July 2023
Presented by	Mandy Rayner, (Chair of Committee)
Key items to raise at Trust Board	**<u>Alert:</u>** • Nil **<u>Advise:</u>** • The Deputy CPO will be covering the CPO's period of absence and has increased their working hours to support this. • The renumeration package for the Newly appointed Director of Strategy and Transformation was agreed. • The committee received the Annual Freedom to Speak up report, this will be received by the BOD on the 25 July. **<u>Assure:</u>** • Nil **<u>Risks discussed:</u>** • No risks were discussed. **<u>New risks identified:</u>** • None

Approved Minutes of previous meeting/s for receiving	Nil

Finance, Investment & Performance Committee

Date	17 July 2023
Presented by	David Webster, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert** • Agency cost continues to be in excess of target, with an increase month on month to highest level in recent history, with substantive whole-time equivalent worked going down also in the same time period. There appears to be some correlation in these movements. **Advise** • Small commercial opportunity with AI tool has fallen through due to investor withdrawing. Lessons learnt investigation ongoing, with pace being highlighted as one of the frustrations of the investor. • ICB capital network have mutually highlighted concerns regarding the inclusion of an accounting standard change within available capital. The group are supporting each other in requesting a review of this policy, which is purely an accounting adjustment. • Able to split and review collaborative spend from own (collaborative ~25% of income) so now able to see accurately underlying performance. • Collaborative finance is currently on forecast overall for SWYPFT, with West Yorkshire in surplus (distributed across partners through risk/reward share), and South Yorkshire in deficit (wholly absorbed by SWYPFT) • MHIS – contract delays not currently impacting anything but may become an issue if not resolved in near future. **Assure** • Financial performance in line with plan – working hard to keep as such through recruitment to offset agency increase. • 22/23 non-recurrent investments have proved successful. With 90% of those who have responded noting positive impact. Of the 10% who have not noted positive impact, the main issues are recruitment and sickness causing delays. • Opportunities to bid on tenders show tightening financials, review ongoing to set principles for future tenders. • Capital continues to be on plan. Now working with new Head of Procurement to improve success and cost efficiencies on tenders.
Approved Minutes of previous meeting/s for receiving	19 June 2023

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

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Minutes of the Finance, Investment & Performance Committee held on 19 June 2023 (Virtual meeting, via Microsoft Teams)

Present:	David Webster Kate Quail Natalie McMillan	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director (Deputy Chair of the Committee)
Apologies	Julie Williams	Deputy Director of Corporate Governance
In attendance:	Adrian Snarr Rob Adamson Carol Harris John Laville Sean Rayner Jane Wilson	Director of Finance, Estates & Resources Deputy Director of Finance Chief Operating Officer Lead Governor (observing) Director of Provider Development (item 12) Note taker

FIP/23/17 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, David Webster (DW) welcomed everyone to the meeting, he extended his welcome to John Laville, Lead Governor who was observing the meeting today. Apologies were noted as above, and the meeting was deemed to be quorate and could proceed.

DW 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.

FIP/23/18 Declaration of interests (agenda item 2)

There were no further declarations of interests to declare.

FIP/23/19 Minutes from the meeting held on 17th April 2023 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the Finance, Investment & Performance Committee meeting held on 17th April 2023

AS remarked that whilst he appreciated the minutes had been circulated late he wanted to make the committee aware that a lot of time has been spent between meetings to ensure the minutes did not disclose commercially confidential information into the public domain.

FIP/23/20 Matters arising and action log from the meeting held on the 17th April 2023 (item 4)

AS provided the update:-

<u>Action 147 – Vacancy factor</u>

AS confirmed there was an action around the workforce plan for himself, CH, and GM to embed this into our ways of working, and this is captured in all of the financial work that is currently being done. There was a clear action from EMT for a refreshed workforce plan, which includes key milestone dates in 2023/24.

DW remarked that it sounds like the action is going to be more linked with People Remuneration Committee (PRC) when it comes to the longer-term planning.

AS replied that it is going to require overview of both committees as this will be a significant part of the 2024/25 planning, which will also go through Board as it will be key to our medium-term plan.

<u>Action 150 - Agency</u>

AS confirmed this action relates to the Agency Scrutiny Group and that Julie Williams (JW) was checking this from a governance perspective. It has been agreed that this will go through the People Remuneration Committee (PRC) as Greg Moores (GM) is the executive lead. AS confirmed that FIP will continue to pick up the financial implications through the finance report and that it was good that Natalie McMillan (NM) will get to see the financial progress as well as the actual detail that sits behind this.
DW agreed that this action could be now closed.

Action 151 – CIPs
AS confirmed there is a paper being presented today on the efficiency programme. He confirmed that the primary vehicle for oversight is the Organisational Management Group (OMG) which is chaired by Carol Harris (CH) and that we will be looking to put some project management resources into structure that programme. He confirmed Rob Adamson (RA) would provide a further update on this when we get to that section of the agenda.
It was agreed this action could be closed as this item will remain part of the standing cycle.

Action 152 - Benchmarking
AS confirmed there will be a couple of updates later in the meeting around this. He said there had been a couple of challenges around benchmarking and performance over the past couple of weeks, which has resulted in some slippage as to what he intends to bring to this committee. AS stated that he would like to explain this further when we get to that section of the agenda. DW confirmed he was happy with this. It was agreed this action can be closed.

Action 153 - Capital
AS confirmed that a request had gone through to the NEDs for a training session, and the preference that had come back was that they would like this to be at the end of a Board meeting. He stated as Nick Phillips is on leave for the June Board, the plan is to arrange this for the July meeting. AS confirmed that NP is looking into the kitchen issue to see if there is anyway this can be built into the plan. DW commented that from his point of view the kitchen was just an example that he gave, and it was more about understanding how the capital is working. He felt that now that the NEDs training around capital is in hand this item can be closed.

FIP/23/09 Benchmarking Update
CH confirmed that the referrals were broadly correct, but she felt there was more work required in relation to demand. It was agreed to close this action and that an update on the broader demand work would be provided to the committee later in the year.

FIP/23/13 Artificial Intelligence ADHD Commercialisation
AS confirmed there were quite a number of actions from the previous meeting relating to this.
He confirmed that there had been good feedback from committee members last time and since then a separate conversation has taken place with Kate Quail (KQ) between the public and private board sessions last month, with all of these actions having been recorded through the working group. He confirmed there had been lots of ongoing discussions with the Trust specialist legal team and the University of Huddersfield and Investors with no firm commitment yet being made as we work through all the comments and everything else we need to do. AS confirmed that he planned to bring a paper back through this committee once they are ready for the next steps. He advised that Subha Thiyagesh (ST) Medical Director had confirmed last Friday that the Journal papers had been published which he said is a big step to allow us to move forward.
AS confirmed that a progress update would be provided at the July meeting.

ACTION: Adrian Snarr

It was RESOLVED to NOTE the updates in relation to the action log.

FIP/23/21 Consideration of items from the Organisational Risk Register allocated to the FIP Committee (agenda item 5)

AS presented the review of committee related risks stating there were no real changes since the last update and that the two significant risks remain.

Risk 1114 Capital

AS confirmed the Capital position remains really tight across the NHS, across our system and for this Trust. He confirmed we have a plan for this year, but we will have some challenges around some of our strategic options, particularly what come out of the Estates Strategy. AS confirmed we have work that we need to do to support the older people's strategy, he explained that there is a need to plan for the capital, but we should not attempt to prejudge the outcome of a public consultation He said for planning purposes we have a multi-year plan in place as to how we will deliver that scheme.

AS confirmed there is going to be a broader conversation across the system about how, or if we can carve out some strategic capital from the overall resources and that for now the risk remains as it is, but that it will definitely require continual review.

Risk 1585 - Revenue

AS confirmed this risk remains as is, and that when RA presents the finance report the committee will see a highlighting of the financial trend, and some of the things that he has been flagging for a little while. He stated this does not pose a risk to the delivery of this year's plan, but it is something we need to be mindful of when we look into future years. AS confirmed he was comfortable with the risk level as it is at this point in time.

DW remarked that his only comment on these would be, have we got a date of completion, and he envisages they may never be complete, and certainly not by the end of July.

AS confirmed that the executive team review all of their risks every month and in that summary of risk actions where the key dates are, we check whether the actions are still current, still ongoing, or complete, as some do complete but many are continuous,

DW asked if these ones will remain continual. AS replied yes and the version presented here will get refreshed in time for the next Board meeting.

NM commented that when she looks at the risk scores, for her it does not correlate with some of the conversations that have taken place at Board around how we feel that finance is going to be a significant risk and our biggest challenge within the next financial year.

AS replied that he completely agreed with NM in that it does currently feels like a monthly balancing act, as he is trying to ensure that the profile of the financial risk is kept sufficiently high. He felt that as a risk for this financial year likelihood of possible seems okay, but if we start to take a longer-term view on this risk he would agree that the risk score may increase next year.

DW asked is it that we need to split these out into immediate future and longer-term risks. AS replied that from a finance risk point of view, because of the high level of vacancies we have, we can control the financial risk, and if it looks like we are going to tip into an overspend position, we can put a stop on recruitment and that would manage the financial risk. He explained it would make many other risks on the risk register increase, but we could make decisions at both executive and board level that says we are not prepared to increase our level of financial exposure by continuing to recruit to roles that we cannot afford, so again there is that challenge of balance across the entire trust.

AS remarked that what makes us slightly different from other organisations is that we are trying to recruit to get our spend levels up, and many organisations that surround us are trying to do the opposite, in that they already have a level of staff they cannot afford, and they are trying to figure out how to reduce this.

KQ remarked that she wanted to add weight to the comments NM has just made around can this risk level be right. She said that whilst she appreciated the explanation AS had given around this, is it more about the longer-term risk, she felt it was very important to clock this now as a committee, as part of their role here is to provide some assurance to the Board. For her she said it is more about ensuring we have got all the risks in here and she questioned if agency was adequately enough reflected.

AS replied that if members were happy he was quite willing to take away an action to have a further discussion via EMT, and also reflect on the BAF which should capture the strategic risk, rather than the risk register which captures the immediate risk. DW agreed this idea made sense.

ACTION: Adrian Snarr

DW remarked that this also links heavily to the workforce action, and once we have this in place if this is a longer-term workforce strategy it will indicate when financial challenges are most likely.

It was RESOLVED to NOTE the risks, relevant to this Committee, and NOTE comments made in relation to the risk content, risk levels and risk appetite.

FIP/23/22 Annual Accounts update (agenda item 6)

RA commented that this continues to feel like a drawn-out process, as traditionally this process concludes before the end of May, and this year we are running nearer towards the end of June. He stated good progress had been made, and that an audit pre close meeting had taken place with himself AS and Deloitte. Deloitte were preparing their close reports.
RA explained that a couple of things were raised last week, and Deloitte have started to introduce some further testing, and are asking questions that have not been asked before. He confirmed finance are still working to the wire in terms of trying to get this year's audit complete and there has been nothing unusual highlighted.
RA informed the committee that one of the things that will specifically be on the IS0260 will be the West Yorkshire adult secured deferred Income which we knew about, it has proved tricky to get this definitively resolved with Audit and all appropriate conversations have now taken place with them.
RA stated that another point to flag is where we have estimates that are slightly different to the actual invoice, he explained that some of the Deloitte samplings picked up utilities this year where we make an estimate of outstanding invoices, and because they are here longer, they now get to test when the invoice comes in, he confirmed this is an estimate and the numbers are never exactly the same, but by the time Deloitte extrapolate this the number becomes larger than we would like.

RA confirmed we are still working through this process but are fully expecting everything to be fully complete in time for the scheduled Audit Committee meeting on 26th June.

AS confirmed that all audit firms across the NHS are still looking for prudence in everyone's accounts, hence the sort of sampling the RA has mentioned. He stated we have received verbal feedback from Deloitte to say that they did not think we were being overly prudent, which is positive.

DW thanked RA and AS for the update.

It was RESOLVED to NOTE the Annual Accounts update.

FIP/23/23 Month 2 Finance Report (agenda item 7)

RA presented the update stating it feels strange still talking about the old year when we are now in month 3 of the new year.

Key headlines:-

- There was not a committee meeting for Month 1, the headline there was that everything remained okay, with a positive run rate coming out of last year, month 1 run rate was also positive. Some pressure seen coming out in Month 2.
- In terms of the main KPIs, this is a green picture which is pretty much consistent with last year's messaging.
- Agency still remains as red. RA to check colour coding on this as it is 13% above plan, which would technically be amber, it is still flagging as high risk in terms of the overall position.

ACTION: Rob Adamson

- This year, and partly linked to a question from Audit, and also to provide clarity, is the overall income and expenditure position that has always been presented, there is now a supplementary tab which shows the core trust business which now excludes the provider collaborative. RA stated the intention is to provide a clearer picture for the Board and committee members as we try to differentiate between the Trust performance and the Collaboratives. RA remarked he would welcome any comments on the presentation from the committee.
- Overall, I&E position – key numbers to pick out this month are, after a positive start in M1, we have shown an in-month deficit for M2, the main driver of this is the fact that we are now reflecting the agenda for change pay award at the 5% which is what has been agreed nationally, rather than the 2% that we agreed as part of the planning assumptions.
  RA stated that as we explain each time we have a pay award coming through, these are never fully funded. We have had to increase our expenditure, also our income, which then creates a pressure. For M2 we are forecasting a £2.5m unplanned pressure, which equates to about £417k for the first two months of the year.
- Year to date £44k surplus overall.

AS remarked that for clarification, the £2.5m cost pressure that RA referred to is the pay award and therefore it is recurrent, and we have non-recurrent flex available to cover that this year, but that only works for this year. He explained that as part of the modelling we are doing for the medium-term financial plan this is where we start to see the stretch coming through in 2024/25 because we have built in a fairly significant cost pressure.
AS remarked that this is where the workforce plan becomes ever more critical because this is the recruitment plan we need to be working to now that the pay levels have been reset at 5% higher.

DW remarked, could we check on forecast figure as a budget for pay costs, as that it not showing £2.5m greater, and is that what we should have expected to see.
RA replied no it is still an unidentified CIP, so we as a Trust are still challenged to break even, which was our plan, and this is what is modelled in the forecast, that we will deliver, albeit non recurrently this year.

AS explained that he is comfortable with the forecast for this year and that we still have some non-recurrent headroom to cover that off, but it is when we start to do the medium financial plan that it all starts to crystalise. The West Yorkshire system is now starting to do some work collectively on

medium term plans so we will feed that underlying position into this as we have been doing for a month or two now already.

- Forecast is showing break-even, month 3 is key milestone.
- Income – nothing major to report, usual reporting, no real risks coming out of this. Working with commissioners re CQINS for this year, already received confirmation from two of them that they are not applying penalties, so we are working to mitigate risks on these, along with working through the contract agreements.
- Pay - Overall the trend of increased worked WTE has continued in May. The main increase is in bank WTE; returning inpatient levels to previous levels with April being lower than normal. Substantive staff, including payment for additional hours worked, has reduced by 14 in month and this will continue to be monitored.
- Agency spend for 2023 / 24 is planned to reduce from £10.0m to £8.7m. This is in line with national, and ICB reduction targets and caps. Spend in May is £908k and year to date is 13% above the plan trajectory.
- Non-Pay pressures. Some due to timing (establishment), some due to increased usage above rebased planning assumptions (travel) and some due to inflationary cost increases (supplies & services)
    - Acute & PICU out of area beds remains a pressure. Bed days similar to plan but less costs for additional nursing, travel and average bed day rate is less than plan. Report includes breakdown of purchase of healthcare non-pay category which is wider than this.
    - Re starting non-pay review group which will pick up some of these areas.
- Out of area beds. RA confirmed this page in the report still remains draft at present and they are working towards getting this complete for Board next week. The action outstanding is confirming the number of bed days in May, and this is being picked up jointly with P&I. Overall, the costs of acute and picu are still under budget, usage seems to be roughly in line with the plan, the reduction appears to be because we have less additional nursing, less travel costs, and we are paying less as an average bed day rate.
- RA confirmed they have also reincluded the Value for Money (VFM), Financial Sustainability and efficiency page. The schemes have been summarised into a number of headings and categories showing that actually for the year to date we are ahead of plan. RA stated the table shows that out of area placements is ahead of plan along with workforce costs, although these are currently showing as non-recurrent, work will continue to move these to recurrent if possible.

  DW asked does this target need increasing now given the extra £2.5m gap in pay. RA replied yes recurrently definitely, there is a question mark as to whether it is non-recurrent, and this is all still currently evolving.

  AS remarked it is a good question, and one of the challenges is we cannot change the plan once it has been signed off and submitted. He stated every organisation deals with some variation in year, but this is a rather big variation early in year. He stated we will have to find a way to ensure that it is clear and visible through finance board papers, as it might be rather tricky to change the overarching £12m CIP target from plan. AS stated that RA and himself will take away an action to figure out the best way to report this through to board. DW remarked that it is important we track this and show that we are dealing with this.

  ACTION: Adrian Snarr/Rob Adamson

  :

- Cash Balance sheet - Accruals remain as they were at year end, with the largest factor relating to estimated pay award payments to be made June 2023. This includes the centrally funded 2022/23 and also April and May 2023 relating to the 2023/24 pay award. This is expected to significantly reduce in June which will have an impact on the Trust cash position. RA confirmed there is a specific member of the finance team who focuses on this area.
- Capital - Spend to date is ahead of plan. This relates to significant progress made on the door replacement programme and continued costs on 2022/23 schemes. Changes implemented under IFRS16 (leases), mean that these costs are now included within the NHS England Capital Departmental Expenditure Limits (CDEL) but is separate from the ICB capital allocation.
  The Trust is still forecasting we will deliver the £8.8m in total.
- Cash remains healthy and is expected to remain around the £80m value. The Trust is looking at investment options to maximise interest received.
- 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.

NM commented that as a Non-executive Director she sits in committees and gets to hear some of the conversations about the complexities, one of which AS has just shared around IFRS16, there are others around non funded pay. She felt as a committee we need to think about how we report this into board.

NM explained that the Clinical Governance & Safety Committee (CG&CSC) have moved complex incidents into the private part of the committee, and this is then shared in the private board, obviously for reasons around confidentiality those service users. She felt there was something here about the sensitivity on a political level, around what gets shared around the pressures we feel are in the system and AS has articulated this really well previously at board and here, how we balance that tension.
AS stated that it is a continual challenge to get the balance right, he said RA attended OMG last week and gave a fairly full and frank assessment of what we have just been through. He said previously we have had a softer approach, but we are now starting to provide them with evidence, and this is where we might want to take the Board. He remarked this month's performance should not cause alarm, but you can start to see the trends, we knew the pay award would be short funded, within the next month we can quantify this and say this is what it does to our underlying pay bill, and pay is fundamental to everything we do.
AS stated he was happy to take this through board and provide some of this context in the private session. He did not feel there was anything that they needed to take action on at this point in time, it was more a case of keeping them informed of the context.

RA remarked that we are developing the medium-term financial plan which he thought would be appropriate for private board, also some updates on the adherence to SFIs, and providing reports and information on those care groups that are overspending, and what is being done about this.
RA commented that during Covid the grip and control stuff was not as tight as it was prior to this as the focus had been more on operational, he stated it is now a case of getting back into that rigour, and this was the conversation that had taken place in OMG last week.

AS stated this is a really good point RA has made, he said both of them need to think about taking a medium-term financial plan through the board that does not cause them undue alarm but does start to flag the medium-term stretch within the finances.

NM commented that just thinking and learning from previous boards it is more around the grip and us questioning and making sure we are getting the governance right, also flagging early any issues and making them aware of what we forecasted was going to happen is starting to happen, so the board do not feel any surprises. NM felt it was a good habit and discipline to be asking ourselves here.

DW suggested that it might be that we add an extra 5 minutes standing item on the private agenda for any financial updates that need to be made. He asked AS & RA to take away an action from today's meeting around speaking with the rest of the executives at EMT and figuring out how best to keep everybody up to date.

ACTION: Adrian Snarr/Rob Adamson

AS replied that was fine, and something else he would like to do in this committee is once the system starts to share the financial positions of other provider organisations he would like to share that here for context. AS gave an example of 2 acute trusts in our patch that are delivering cost improvement programmes in excess of 6%, and ours is 3.4%, he said whilst it might sound tough and a big challenge for us, this is what other organisations are already doing. He said hopefully they can provide us with some evidence that they are delivering, and we can learn from them.

It was RESOLVED to NOTE the Finance Month 2 update.

FIP23/24 Financial forecast (agenda item 8)

RA clarified that himself and AS were working on some key numbers with a view to reintroducing this report in Month 3.

It was RESOLVED to RECEIVE the update on the financial forecast.

FIP/23/25 Financial sustainability (agenda item 9)

RA confirmed there was a paper within the pack that was originally shared and discussed with OMG on 14th June 2023. This has been updated to reflect those discussions and provide an update for FIP on the current status and progress, and it provides additional narrative and context to the VFM overview included within the main finance board report.

RA explained that OMG have oversight of sustainability and there are currently lots of individual workstreams already happening, not necessarily finance focussed, but they have a finance element within those, and it will be up to those workstreams to report into OMG and then escalate to EMT as appropriate.

RA stated that he has changed the terminology slightly so that it aligned with the board report itself, in terms of green, amber, and red indicators. He explained we have flagged that there is a level of CIPs that are green that are delivering and that do not present any risk for this financial year. He stated he has also tried to describe the schemes that he believes are amber at the moment, so we are saving money currently, but there is no guarantee we will continue to save money going forward. He remarked there are a whole raft of schemes that he is flagging as red at the moment, that have been identified as areas where we are going to push and explore. He stated as it stands he has not seen any evidence or information that confirms we have made a

saving or not, these have definitely happened, we are just not seeing the financial impact of these yet. RA felt we would definitely see an improvement in Month 3.

AS stated that part of getting that grip and making sure these schemes are properly documented also includes an equality impact assessment for each one of these, and it is making sure this discipline is put back in place before we sign off any finance efficiency programmes.
RA commented that this is the reason we wanted to keep the oversight within OMG because everyone around that table is involved, which enables us to get a rounded view of things.

CH commented that we did not do a quality impact assessment on the short-term incentive payment because it was only ever designed as a short-term incentive payment, and this has just stopped.
RA remarked that in theory once the work goes through we will do one on the overall pay savings /pay premiums scheme as a whole.
CH replied she did not identify this one as a scheme and this was something that should have stopped earlier, and it was stopped mid-summer.

NM stated are we saying we will continue to see that detail here at FIP.
RA replied yes, there will be regular updates on this to supplement the page that will remain in the public board paper, his intention is to feedback on progress, risks, and new schemes as we get them.

KQ asked RA if there was an inpatients versus non inpatient split within this document, as she felt that some service lines are more overspent than others, yet it is going to be the inpatient services where we are more overspent and where it is going to be tougher to make those savings. She asked do we need to clarify between inpatient and non-inpatient.

CH replied it is always inpatients, and prior to us moving into the care groups, this sometimes got a little bit lost in the overall rounding, and because of the difficulties in recruiting to the area and then the high use of temporary staff along with the acuity, that is where the overspend has always been against the budget. CH stated this is not something we accept, and we work really hard to try and get the establishment and environment right, but it is something we have been struggling with for years pre Covid.

KQ remarked that it is obvious this is going to be our costliest bit and where we are going to struggle most, and therefore the need for the QIA is vital.

AS stated that we do have financial pressures in inpatients as CH has described but that does not necessarily mean we then disproportionately try to take funding back out of inpatients. He explained we have not set a financial plan that says we need a 3% CIP, so it is 3% off every budget line, what we have said is we need a 3% CIP, and how can we deliver that, and you can see there are some differentials in there. He remarked that those differentials are particularly taken into account at OMG, as there are some things we may need to manage at care group level, rather than at cost centre level, or budget holder level.

KQ thanked AS for the update which explained clearly that the main focus is to genuinely look and maintain quality and safety, whilst also trying to make those savings.

CH commented that when we have vacancies or gaps in inpatients we have to cover them because of safer staffing and we have to keep the environment safe, and we do not do the same in the community, so we would run with vacancies in a community team, which is how we end up overspending. She stated we do try hard to monitor the impact in the community but again this may be something we need to cover more in CG&CSC.

NM remarked that although it is worth us considering, she did not want to get into a great amount of detail here, as it raises the issue about safer staffing and how we do that in the community, which we have as a regular conversation at Board. She said she is not dismissing it and it might be a good prompt for 'are we really pushing around this enough'.

KQ stated this is a really helpful paper, she asked if there was a broader sustainability piece which is about productivity that uses our internal/external benchmarking.

AS replied yes and this is it, but we are not there yet, He explained that in this financial year we have gone from zero to 50% and we need to get back up to 100%, and all of these things will have been considered previously pre covid. He stated the way funds have been distributed over the last 3 years, service lines have changed, and we now need to review them all.

It was RESOLVED to RECEIVE the update on the Financial Sustainability

FIP/23/26 West & South Yorkshire Collaborative Financial Updates (agenda item 10)

RA stated this is a regular standing item, he apologised for the paper being incomplete at the time of finalising is. He stated he is now in a position to share with the Committee accordingly the information on CAMHs and the Adult Eating Disorders.

RA stated that the West Yorkshire Adult Secure Collaborative financially is fine and is forecast to deliver a surplus this year, which will then flow out into the risk reward share.
He stated the other ones however look like they are going to be financially challenging this year, so CAMHs and Eating Disorders both have deficits for the year to date and are forecasting continued deficits throughout the course of the year, driven by activity, exceptional packages of care and basically being able to deliver the services that they are trying to deliver. He stated there are lots of operational/staffing issues, closures of beds, in cases linked to all of this and these will remain challenging and will become more explicit as we go through the year.

RA stated that South Yorkshire Collaborative is showing as a surplus as at year to date, but following further review it should have shown a bigger surplus, but it is actually forecasting to be a deficit. RA remarked there are pressures in the system, and we just need to keep validating the numbers.

AS stated that on the South Yorkshire collaborative, there is quite a bit of variability, and to provide some assurance, they do have an investment reserve for the community pathway, which may result in them having to scale back their aspirations if we cannot get it to balance.

It was RESOLVED to RECEIVE the update on the West & South Yorkshire Collaborative Financial Updates

FIP/23/27 Costing Update (agenda item 11)

RA stated that normally by this time of year we would be getting ready to take an update to Audit Committee on where we are with the National Cost Collection. Currently as it stands we do not have definitive plans, timescales, information for the 2022/23 cost collection, neither do we have a final result for the 2021/22 cost collection. He said we would normally be submitting late summer, this year it may be nearer Christmas, which will then roll us into another year.

RA remarked there has been no noise nationally that they are going to cancel it, but it does feel like it is a significant challenge. He confirmed the team are involved in all the national forums and checking on progress and he will keep the committee updated.

DW commented that other than just delays are there any other real impact on us. RA replied that the problem for us is that we have not got the outputs from 2021/22 to be able to start to compare,

and the versions that have been shared have had such considerable swings it is not useable information as it stands.

AS confirmed there are two impacts, one is on the costing team, as mentioned before we have a big project underway on Patient Level Costing (PLICS) and this uncertainty on national guidelines is impacting on that. The other area is, understandably all our Place based leads are interested in our costing information, and that is probably going to be most relevant in Barnsley, as it sits outside the West Yorkshire ICB and has a financial challenge, and it wants us to reconfirm that the funding they give us is expended in Barnsley. He stated it is not causing a huge problem at the minute, as they are being patient, but some robust costing submissions would help with this, failing that, we will share the internal work we have been preparing for them.

DW thanked RA for all of his updates.

I**t was RESOLVED to RECEIVE the Costing update.**

FIP/23/28 Commercial decision on Calderdale Talking Therapies (agenda item 12)

A detailed conversation was had relating to the financial and service elements of this potential tender submission.

I**t was RESOLVED to RECEIVE the update on the Commercial decision on Calderdale Talking Therapies, and the Committees RECOMMENDATION to support further investigation to bring to Board.**

FIP/23/29 Monthly Performance Review (agenda item 13)

AS provided the update stating the Committee may recall that when we set out the plan for the IPR development we had a particular challenge around workforce data, in as much as it did not flow through the data warehouse within the organisation, and it was dealt with exclusively within the People Directorate. As part of that transition, it was agreed we would start to feed information into the data warehouse and start to look at the standard operating procedures.

AS stated that following further work with GMs team it was also identified that we had a single point of failure, whereby nearly all of the workforce information extraction was being done by one individual. He explained that we were putting plans in place to improve resilience but this identified some immediate challenges so we have spent the last couple of weeks reacting to ensure all necessary submissions could be made.

AS stated that we had 6 benchmarking reports in the pipeline, a couple of NHS England survey reports around staffing, and our monthly NHS England workforce stats. As an organisation we are really committed to benchmarking so we did not want to miss any, but when some of those benchmarking reviews close, they close, and therefore you cannot participate if you have not sent your data through.

AS explained that in support of GMs team we have taken the work into the P&I team on a reactive basis, which we have successfully managed to submit all the benchmarking reports that were due, we had a few challenges around validating and quality assuring, but we got them all to a good standard for the deadlines. This has started to impact on the day-to-day work of the P&I team, so it has put them off plan slightly, we now just need a couple of weeks stabilisation, mainly because we need to do the IPR for the Board which has a huge amount of workforce data in it. He said once we get this out of the way Mel Wood and her team are going to come up with a sustainability plan for the next 6-9 months, which will involve the transition to the data warehouse, and a clear sign off process with GM and the People team as to what the key milestones are.

AS remarked that he has also asked MW to assess whether there is any impact on the IPR development work, there has not been to date but there could be in the next month or so, so we may need to get some resources to get this back on track.

AS remarked we are a bit on the back foot with some of this at the minute, but we have an improving situation, he felt it was important to flag it here because we have a key role in performance and benchmarking, and he is aware we have been very finance heavy with the agenda today. We have also had to look at the risk and business continuity associated with this, and although we have stabilised it now, it has been a tricky couple of weeks for the P&I team. AS commented that we are due to move to the new IPR for national indicators, which will still to flow through to the Board this time, but we also need to make sure that the next phase has not been knocked back because of this.

AS remarked that he partly wanted to apologise for today because we were due to give a more substantive update on benchmarking, and hopefully for the committee to support us to stabilise and then build again. He said what it should mean as part of this recovery plan is that we just have to re-sequence, because transferring this workforce data was always part of the plan, we have just had to do it slightly quicker than we intended to.

DW commented that single points of failure are always tricky, but it does create that forced challenge and change at times.

AS commented that the good news is because we got the benchmark returns in, once the Benchmarking Network process them we can put them in the annual plan, he said we will add this to the workplan for next month.

ACTION: Adrian Snarr

AS commented that on the monthly performance review, the committee will see in the actions that himself, CH and MW have a scheduled catch up so they can agree what we want to deep dive on, we will bring a proposition back on this next month also.

I**t was RESOLVED to RECEIVE the update on the Monthly Performance Review**

FIP/23/30 Waiting List Report (agenda item 14)

CH provided the update stating that this is the report that CG&CSC used to see and was recommended to bring to this committee. She stated we need to work on the timescales as this is the April data report, as the team had planned them out around CG&CSC meetings, so it was due to go to the last committee. CH confirmed this is the latest version that we have, and that the team publish it alternative months now.

CS explained that the quality impact will still go through to CG&CSC and there is some work ongoing in the Clinical Governance Group around how we support people that are waiting so that we can bring some assurance back through CG&CSC.

CH stated in relation to this report work is still ongoing around the following improvements:-

- Still reviewing the numerator and denominators for each of the waits
- Working on better analysis in each of the services which will then support a better narrative that starts to come through to committee. Started to use the AAA style within the report but there is still more work required.
- Recently included deprivation data alongside ethnicity monitoring, and we need to understand more about the disproportionate impact on people that are waiting, we also need some improved assurance around what we do when people are waiting.

CH stated the specific areas to note in this report from the services are:-

- Adult ADHD continue to see a higher rate of referrals than commissioning cases, much higher than the rate NICE have estimated would need to be commissioned for.

  Where 2 waiting lists are noted, it is a risk prioritisation, which has been agreed with commissioners. Although there seems to be no disproportionate impact for people who wait, deprivation data shows that there is a slightly lower representation of individuals from the most deprived areas being referred for assessment. This may indicate that there is a greater level of awareness of ADHD in less deprived areas. The service will give this further consideration.
- Improvement has been maintained in Barnsley CAMHS and most children are seen within 3 months. CH stated she would like to caveat this by saying we would like to see them sooner, but in terms of improvement they have been sustained.
- Calderdale and Kirklees core CAMHs are each seeing a large proportion of children within 3 months and most children within 6 months.
- Wakefield has seen a sudden increase in the number of children waiting and although they see the majority of children within 6 months. Staff absence due to sickness has stabilised recently and this will help to address waits.
- Both the total number of individual children waiting and the average length of wait for the CAMHS neurodevelopmental pathway in Kirklees are increasing. Demand and capacity modelling is taking place as part of the improvement work to ensure that the pathway from referral to a completed assessment is efficient and effective as possible. CH stated that board members will be aware that we have some support from an external provider to help us to address these waits.
- The measure for learning disability is that service users have been assessed, have a completed care package, and commenced treatment within 18 weeks. Performance for the assessment is generally very good with the assessment being completed within 2 weeks for almost everyone. Staffing capacity then impacts the care package being delivered. Improvement work alongside recruitment is underway to improve this position. Welfare checks are made to ensure that people are supported as they wait.
- All patients on the core psychology waiting list have already received the 6 weeks psychology induction / assessment and exceptionally long waiters are waiting for a specific, longer term treatment modality (for example eye movement desensitisation and reprocessing - EMDR).
- Patients awaiting psychology remain on the core team caseload and have access as appropriate to support in a crisis and mental health outpatient care. A digital appointment may have been offered but patients may prefer face to face therapy.
  Support from a private provider has been secured to address waits for secondary care psychology.
- The integrated performance report has reported pressures on waits for paediatric audiology. This has recently been included in the waiting list report and further work is taking place on the reported data and the narrative. The service has confirmed that a plan is in place to address the waits by October 2023.

NM thanked CH for the update, she asked in relation to the ongoing work around the referrals around deprivation, when can we expect that to come back and where.

CH replied this is a really good question and it is something we need to look at wider, she said she was happy to have a think about a date and then report back to the committee.

ACTION: Carol Harris

CH stated she was confident that the Adults ADHD team will be able to put some narrative in next

month, but this is a bigger issue we have probably not considered.

NM commented that for context, the development of this report has been to CG&CSC before it has been brought here, and it is great that we are now managing to monitor around ethnicity and deprivation and this is a step in the right direction, if we are going to measure it then we need to be clear what our learning is. She said it is likely that if we manage to find some learning around referral rates and deprivation that we will be able to learn this on a broader footprint, so this makes sure we capture it, and it does not get lost.

KQ stated this work is really important and she wondered what the role of Equality, Inclusion & Involvement (EI&I) committee has in this, and as their role is so big there is always a danger of things slipping, so for her it was about the links with other committees.

CH commented that she agreed with KQ in that we do not want to lose this and although she does not attend that EI&I committee they do look at the overall dashboard. She wondered if we start with either the waits or the demand information, so for each stream look at the referral demand so we make sure we can clearly break this down by the inequalities data. CH asked if that data was brought back to the committee do they think that would help, and further discussion could take place.

KQ replied yes this would be helpful.

KQ remarked that in relation to deprivation CH had mentioned that this data shows a less take up from certain individuals in the 20% most deprived, yet there is another table that shows there is a higher representation from people in the 20% most deprived. CH said she would check this.

ACTION: Carol Harris

NM remarked that as this report is getting more developed, the executive summary left her asking more questions, it talks about it as a risk prioritisation around the Adult ADHD, and what does that mean, in terms of what we could expect to happen as a result of that. She said there are a few comments like this that are there as reassurance rather than assurance about what we are doing, she said she appreciates this is a report that is still being developed.

NM commented there was also another example around conversations with stakeholders and discussions around referrals, and again what does that mean then for us as a committee, is there anything happening as a result of this. She said it is that extra layer of what exactly does that mean and what is happening that will really help strengthen the executive summary of the report. NM remarked that she hopes her comments have been helpful.

CH thanked NM for her comments, she said she will think about this and try and balance it better next time.

DW commented that the only thing from his point of view is the increase in waiting lists and is this picked up on a risk register. CH replied that it is.

DW asked does this require FIP oversight of this.

NM stated that there is an action at CG&CSC, which is with Marie Burnham (MB), Chair, as there was a lengthy discussion at the May meeting around risks and where do they sit, and is it across more than one committee, and it led to a broader view for MB to take that discussion to Board.

NM says there is an action around how do we get a bit smarter about being able to see the risks and where do we align them specifically to different committees.

DW stated it is worth keeping as an action, and although there is nothing specific for this committee it is more for awareness.

DW stated this was a very helpful report and he thanked CH for sharing this.

I**t was RESOLVED to RECEIVE the Waiting List Report update.**

FIP/23/31 Workplan (agenda item 15)

DW commented that the only thing he would ask is that AS & CH build the waiting lists update into the work plan on a recurring basis.

ACTION: Adrian Snarr/Carol Harris

FIP/23/32 Any other business (agenda item 16)

NM commented that she had sent DW an email around appraisals that she wanted to raise at the meeting today. She said she appreciated DW had probably not got round to looking at this yet due to annual leave. There had been a discussion at CG&CSC around appraisals and there was a specific action for her to pick up with DW at FIP around appraisal data.

NM stated this is around finding out that there were 2 wards that had 0% appraisal compliance and the question is, how has that happened from a data reporting point of view. She said it is not to talk about at length here but more to ask can we have more scrutiny around how we report appraisals, as when it has been aggregated it has been missed, so there is something around learning here, and how did we not know through our reporting systems that we had 2 wards that had 0% appraisal completion.

AS commented that there have been several conversations about this and the data does exist, it is how do we draw it out to people's attention that can take some actions on it. He said we did stray into a slightly broader conversation of aggregation of targets. Appraisals was central to this because of the CQC data request but there could be other areas where if we over aggregate we might look like we are okay, but we are masking pockets of challenge. AS confirmed there is work ongoing with CH and the care groups, and we need to figure out how best to flag this.

DW asked if it was worth bringing this back as an action to this committee in a couple of months time to understand how we are going to manage this and get visibility in the right way.

ACTION: Carol Harris

Significant issues to report to the Board of Directors

Alert

Pay award agreed nationally was in excess of what we had put in budget which has created £2.5m cost pressure. Will need to find savings which is likely to come from nonrecurrent items this year.

Assure

- Review financial risk rating, yes, it is low and feels strange, this is because it is looking at the shorter term where we are okay this year. There is certainly a longer-term potential challenge. There is an action as to how we keep the Board alert of future challenges.

Revise

- Capital training to be conducted at the end of the July Board meeting.
- Agency working group oversight being reported into PRC.
- Mostly on track with CIP programme, and all items are receiving equality impact assessments.

- Delays on national costing collections
- Waiting list brought to committee for first time.

Action

- How we manage the risk scores in terms of short/long term etc
- How are we going to report that £2.5m cost pressure without changing forecast.
- How are we going to keep board aware of the risks and issues in the private session.
- Inequalities analysis on the waiting list report
- Any actions that cross over
- Data drill downs

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 25 July 2023
Agenda item 10.1

Private/Public paper:	**Public**		
Title:	**Integrated Performance Report (IPR)**		
Paper presented by:	Adrian Snarr - Director of Finance & Resources		
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance		
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for June 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 reporting provides the 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, the report 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 June 2023. Trust Board have reviewed all priority programmes and how they should be reported in the 2023/24 IPR.		

	Key milestones have been updated with full reporting to commence from the end of quarter one (reported in August IPR). Further developments of the IPR are ongoing in line with the development plan, with the updated Care Group section to be included as part of the August report. **Strategic Objectives and priorities** • 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 96.9% against a target of 90%. For the Trust derived indicators, as at June 2023, disability 44.3%, sexual orientation 44.0% (both slightly increased from 43.5% and 43.4% reported in the previous month) and postcode 99.8% of service users have had their equality data recorded. 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, the Trusts Equality, Inclusion and Involvement Committee monitor this work. • The Trust is taking specific actions 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. • Timely completion of equality impact assessments (EIA) for service and policy remains a key metric and currently 67.4% of service EIA's have been reviewed within 12 months (This has increased from 53.7% reported in May). 100% of services have an EIA in place and work is taking place to ensure they are reviewed within the 12-month timescale. • Referral to assessment within 2 weeks for mental health single point of access (SPA) continues to be impacted by demand and capacity, particularly in the Barnsley service, however, the overall Trust position increased to 80.5% against a target of 75%. 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. Rapid improvement work in SPA together with some progress in recruitment has contributed to an improved performance this month. **Quality**

	NHS England Indicators (national) The Trust continues to perform well against the majority of national metrics. The following under-performance should be noted: • Inappropriate out of area bed days continue to be above trajectory with 441 days in June. This is a decrease compared to the previous month, but this remains high and has exceeded the threshold for quarter 1 (455 days, reported a total of 1472 days). The need for use of these beds mainly relates to increased acuity and challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 16 people placed in out of area beds at the end of June. 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 increased to 82.5% in June from 53.3% reported for the previous month, this continues to remain below the national threshold of 99%. The Trust's Paediatric Audiology service 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 2023 with additional pressures related to the increased number of referrals also having an impact. The service are also reporting a number of appointments being cancelled by parents/carers, or children not being brought to their appointments. **Local Quality Indicators** The Trust continues to perform well against the majority of quality indicators; however, the following improvements/exceptions and actions should be noted: **Care planning and risk assessments** Although the focus has been on performance against target, the main driver for change is the quality of care plans and risk assessments, therefore the care plan and risks assessment improvement group are monitoring whether improvements in performance are linked to an increase in quality, recognising there is more to do to reach full assurance. The June data for care planning shows performance of 86.6% which is a further improvement from 85.7% reported in May and remains above threshold. For risk assessments, the June data shows a slight decline in performance from the previous month within inpatient services

	(86.6%) however community services (92.3%) have shown a sustained performance. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality. A trajectory for improvement has been set based upon the current and projected performance to allow for sustainable and impactful improvement actions to be implemented. **Waiting Lists** • Children and Adolescent Mental Health Services (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 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 73.1% (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 June 2023 resulted in no or low harm or did not occur whilst under the care of the Trust, an overview of key indicators is below: • The number of restraint incidents has increased slightly to 201 from 186 in May. 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. • 89.5% of prone restraint incidents were for a duration of three minutes or less which is a deterioration on the previous two months performance, there were two incidents out of nineteen over the 3-minute threshold and these were complex cases and appropriate measures were taken and support was given to both the service users and staff involved in the incident.

	• There were 14 information governance personal data breaches during June 23. No hotspot areas were identified as they were spread across care groups and services. Most incidents related to information being disclosed in error. An improvement plan continues to be implemented to reduce the higher numbers of incidents, which includes training, communications and some data quality activity and the Data Protection Officer (DPO) is working with communications colleagues on the development of a poster campaign which highlights the impact on individuals of data breaches. • The number of inpatient falls in June was 46, which is a decrease from last month. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated. **<u>Our People</u>** • Our substantive staff in post position continues to remain stable and has increased slightly in June. The number of people joining the Trust outnumbered leavers in June. Year to date, we have had 164.1 new starters and 135.5 leavers during the first quarter of the year and focus remains on recruitment and retention. • Overall turnover rate in June was 13.1% which has increased slightly from last month (12.2%). • Sickness absence in June was 4.6% and below local threshold, with a rolling 12-month position of 5.3%. • Rolling appraisal compliance rate for June saw a small increase, from 74.9% to 78.5% and achieved the improvement trajectory to reach 78% set by the Executive management team (EMT). The improvement trajectory will be reviewed monthly in EMT to be clear on how the Trust will achieve the 90% target in year. 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 92% compliance which exceeds the Trust target of 80%, this has increased from 90.9% reported in May. Reducing restrictive practice and interventions (RRPI) training is the only area in month below the Trust target. Targeted actions are in place and compliance is reported monthly to the EMT with hot spot reports reviewed by the Operational Management Group (OMG). • The Trust position for information governance data security training saw a further increase in June to 96.8% from 95.9% reported at the end of May and remains above the 95% threshold. • Cardiopulmonary resuscitation also achieved the 80% threshold during June, reporting at 81.3%.

	Care Groups Staffing vacancies and absence 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 June, these are as follows: • Mental health acute wards have continued to manage high levels of acuity and continued high occupancy levels across mental health wards and capacity to meet demand for beds remains challenging. • Workforce challenges have continued, and this has resulted in the increased use of agency staff. 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 continue to be supported through Trust wide recruitment and retention programme. • Demand into the Single Point of Access (SPA) and capacity issues have led to ongoing pressures in the service, workforce challenges are continuing to compound these problems and have been increasing with a significant number of vacancies despite active recruitment. This increases the risk of routine triage and assessment being delayed. 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 June. • The 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. • During June, there was an increase in the overall number of cases that were clinically ready for discharge, increasing from 2.1% to 4.6%, this has been identified as a risk and is being developed for inclusion on the organisational risk register, due to the continued 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. • 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 • Agenda For Change pay awards, relating to 2022 / 23 (for which an estimate was made in the last financial year) and 2023 / 24, were paid in June 2023. The year-to-date expenditure is broadly in line with plan although this is modelled to move to an underspend position in year with workforce growth forecast to be behind that included in the plan (although still growing). • Agency spend in June was £1,002k which is a slight increase on Mays position which was £908k. • Actions are in place to address agency spend, which is being overseen by the Trust's agency group. • The Trust cash position remains strong at £82.1m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive. • In June the costs for out of area placements were £252k over budget however the year-to-date position is breakeven against plan. The forecast is expecting that a break-even position will be delivered. • Performance against the Better Payment Practice Code is 96%.
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

June 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 June 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 2023/24 IPR, these will be presented to the Finance, investment and performance committee and implemented on approval. Metrics for 2023/24 have been identified and were reviewed by Trust Board in May and will be implemented from July 2023.

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
- Strategic Objectives & Priorities
- Quality
- People
- National metrics
- Care groups
- Finance
- Systemwide monitoring

The Strategic Objectives & Priorities section has been updated to reflect the Trust's priorities and associated metrics for 2023/24. 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.

Strategic Objectives & Priorities

• 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 96.9% against a target of 90%. For the Trust derived indicators, as at June 2023, disability 44.3%, sexual orientation 44.0% (both slightly increased from 43.5% and 43.4% reported in the previous month) and postcode 99.8% of service users have had their equality data recorded. 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, the Trusts Equality, Inclusion and Involvement Committee monitor this work.

• 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.

• Timely completion of equality impact assessments (EIA) for service and policy remains a key metric and currently 67.4% service EIAs have been reviewed within 12 months (This has increased from 53.7% reported in May). 100% of services have an EIA in place and work is taking place to ensure they are reviewed within the 12-month timescale.

• Referral to assessment within 2 weeks for mental health single point of access continues to be impacted by demand and capacity, particularly in the Barnsley service, however, the overall Trust position increased to 80.5% against a target of 75%. 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. Rapid improvement work in Single point of access (SPA) together with some progress in recruitment has contributed to an improved performance this month.

Quality

NHS England Indicators (national)

The Trust continues to perform well against the majority of national metrics. The following under-performance should be noted:

• Inappropriate out of area bed days continue to be above trajectory with 441 days in June which is a decrease compared to previous month but this remains high and has exceeded the threshold for quarter 1 (455 days, reported a total of 1472 days). Need for use of these beds mainly relates to increased acuity and challenges to timely discharge. Workforce pressures also impact the successful management of acuity. The Trust had 16 people placed in out of area beds at the end of June. 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 increased to 82.5% in June from 53.3% reported for 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 service are also reporting a number of appointments being cancelled by parents/carers, or children not being brought to their appointments.

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 and risk assessments

Although the focus has been on performance against target the main driver for change is of care plans and risk assessments, therefore the care plan and risks assessment improvement group are monitoring whether improvements in performance are linked to an increase in quality, recognising there is more to do to reach full assurance.

The June data for care planning shows performance of 86.6% which is a further improvement from 85.7% reported in May and remains above threshold.

For risk assessments, the June data shows a slight decline in performance from the previous month within inpatient services (86.6%) however community services (92.3%) have shown a sustained performance. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality. A trajectory for improvement has been set based upon the current and projected performance to allow for sustainable and impactful improvement actions to be implemented.

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 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 73.1% (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 June 2023 resulted in no or low harm or did not occur whilst under the care of the Trust, an overview of key indicators is below:

• The number of restraint incidents has increased slightly to 201 from 186 in May. 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.

• 89.5% of prone restraint incidents were for a duration of three minutes or less which is a deterioration on the previous two months performance, there were two incidents out of nineteen over the 3-minute threshold and these were complex cases and appropriate measures were taken and support was given to both the service users and staff involved in the incident.

• There were 14 information governance personal data breaches during June 23. No hotspot areas were identified as they were spread across care groups and services. Most incidents related to information being disclosed in error. An improvement plan continues to be implemented to reduce the higher numbers of incidents, which includes training, communications and some data quality activity and the Data Protection Officer (DPO) is working with communications colleagues on the development of a poster campaign which highlights the impact on individuals of data breaches.

• The number of inpatient falls in June was 46, which is a decrease from last month. 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 June. The number of people joining the Trust outnumbered leavers in June. Year to date, we have had 164.1 new starters and 135.5 leavers during the first quarter of the year and focus remains on recruitment and retention.

• Overall turnover rate in June was 13.1% which has increased slightly from last month (12.2%).

• Sickness absence in June was 4.6% and below local threshold, with a rolling 12-month position of 5.3%.

• Rolling appraisal compliance rate for June saw a small increase, from 74.9% to 78.5% and achieved the improvement trajectory to reach 78% set by the Executive management team (EMT) have agreed an improvement trajectory of 78, the improvement trajectory will be reviewed monthly in EMT to be clear on how the Trust will achieve the 90% target in year. 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 92% compliance which exceeds the Trust target of 80%, this has increased from 90.9% reported in May. Reducing restrictive practice interventions training is the only area in month below the Trust target. 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).

• The Trust position for information governance data security training saw a further increase in June to 96.8% from 95.9% reported at the end of May and remains above the 95% threshold.

• Cardiopulmonary resuscitation also achieved the 80% threshold during June, reporting at 81.3%.

Care Groups

Staffing vacancies and absence 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 June, these are as follows:

• Mental health acute wards have continued to manage high levels of acuity and continued high occupancy levels across mental health wards and capacity to meet demand for beds remains challenging.

• Workforce challenges have continued and this has resulted in the increased use of agency staff. 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 continue to be supported through Trust wide recruitment and retention programme.

• Demand into the Single Point of Access (SPA) and capacity issues have led to ongoing pressures in the service, workforce challenges are continuing to compound these problems and have been increasing with a significant number of vacancies despite active recruitment. This increases the risk of routine triage and assessment being delayed. 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 June.

• The 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.

• During June, there was an increase in the overall number of cases that were clinically ready for discharge, increasing from 2.1% to 4.6%, this has been identified as a risk and is being developed for inclusion on the organisational risk register, due to the continued 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.

• 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

• Agenda For Change pay awards, relating to 2022 / 23 (for which an estimate was made in the last financial year) and 2023 / 24, were paid in June 2023. The year to date expenditure is broadly in line with plan although this is modelled to move to an underspend position in year with workforce growth forecast to be behind that included in the plan (although still growing).

• Agency spend in June was £1,002k which is a slight increase on Mays position which was £908k.

• Actions are in place to address agency spend, which is being overseen by the Trust's agency group.

• The Trust cash position remains strong at £82.1m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.

• Out of area bed costs - in June the costs for out of area placements were £252k over budget however the year-to-date position is breakeven against plan. The forecast is expecting that a break-even position will be delivered.

• Performance against the Better Payment Practice Code is 96%.

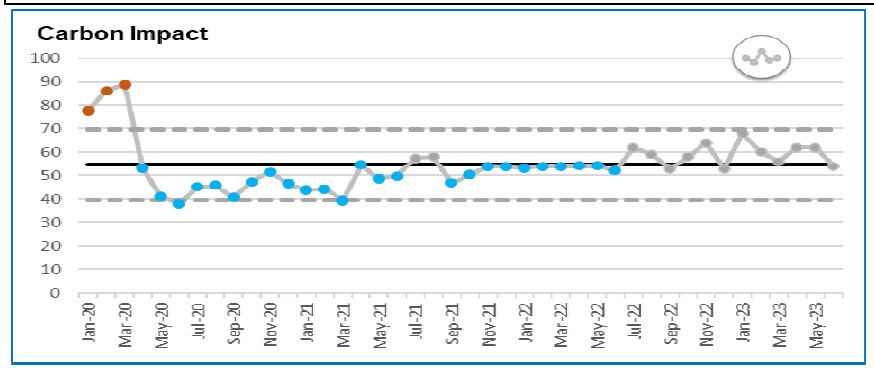
The following section highlights the performance against the Trust's strategic objectives and priority programmes for 2022/23.
For some metrics, we have identified when we anticipate this data to be available. Some of the identified metrics will be reported quarterly.
We will also incorporate statistical 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

Metrics	Threshold	Apr-23	May-23	Jun-23	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	*90%*	96.6%	96.6%	96.8%		
Percentage of service users who have had their equality data recorded - disability	To be determined for 23/24	43.2%	43.5%	44.3%		The threshold for 23/24 is being developed by the equality inclusion and involvement sub committee and will be discussed at the August meeting. Further update to be provided next month.
Percentage of service users who have had their equality data recorded - sexual orientation		43.3%	43.4%	44.0%		
Percentage of service users who have had their equality data recorded - deprivation (postcode)		99.8%	99.8%	99.8%		
Timely completion of equality impact assessments (EIAs) in services and for policies	95%	53.3% Service 94.6% Policy	53.7% Service 96.1% Policy	67.7% Service 96.1% Policy		EIAs for services are reviewed annually. This means all services have an EIA in place. Work is being undertaken to support services with the reviews within the year.
Completion of equality mandatory training	>=80%	96.0%	96.2%	97.0%		
Number of people who sustain 26 weeks employment via Trust Individual placement support service	Trend monitor	0	1	1		2023/24 to be used as a baseline
Carbon Impact (tonnes CO2e) - business miles	76	62	62	54		Data showing the carbon impact of staff travel / business miles. In June staff travel contributed 54 tonnes of carbon to the atmosphere.
Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks), by ethnicity, disability, sexual orientation and deprivation	55%	Due August 2023				Q4 - 63.3% Reported 6 weeks in arrears. A weighted average is used given there are different targets in different places.

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 June 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 have been removed 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 a more blended approach to working is expected going forward. The performance against this measure will continue to be monitored.

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)

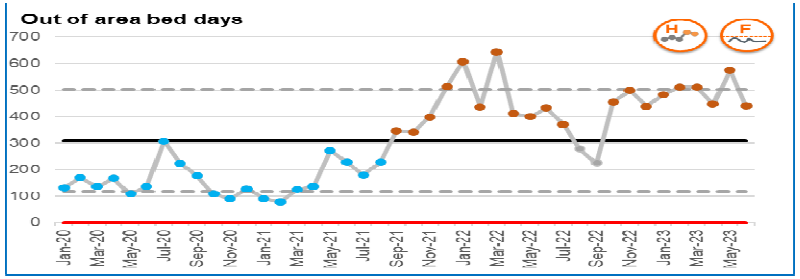
Work in partnerships at System & Place to improve the health of our communities	Community Mental Health transformation: Develop internal and external communication messages to raise awareness and promote understanding of SWYPFT role in next phase of transformation.		This work is being aligned to place based and ICS messaging via weekly programme meetings and is a workstream of the newly formed internal Community Transformation (MH) steering group, with governance now established.
	Address inequalities involvement and equality in each of our places with our partners		It has been agreed by EMT that in 23/24 there will be a priority programme to address inequalities, involvement and equality in each of our places with our partners. This programme is currently being scoped to ensure that it builds on existing work and complements the actions in the equality, engagement, communication and membership strategy. In the meantime, work continues with partners. EMT supported the proposal for Equality, involvement and addressing inequalities to be a Golden thread throughout all strategic change priority programmes in 2023/24.

Improve Care

Metrics	Threshold	Apr-23	May-23	Jun-23	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95% Improvement trajectory: June 90%, July 92%, Aug 94%, Sept 95%	90.6%	87.7%	86.7%	H F	June data shows a slight decline in performance from the previous month within inpatient services, however community services have shown sustained performance above improvement trajectory. All areas are working to improve performance and quality of risk assessments. Risk assessment completion is based upon completion within a set timeframe but does not account for a robust and high quality risks assessment which might take a little longer. Issues with data capture, service pressures and data quality continue to be addressed but are 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. A trajectory for improvement is in place from May 23 which was set based upon current and projected performance to allow for sustainable and impactful improvement actions to be implemented.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		80.7%	92.9%	*92.3%*	H F	
% Service users on CPA offered a copy of their care plan	80%	85.0%	85.7%	86.6%	H F	The care plan and risk assessment improvement group continue to look at performance as well as quality of care planning and risk assessments. Part of the improvement work is to identify how we measure the quality (co-production, outcomes, timeliness)as well as the quantity (completed and shared), this may require a change to the way in which we report through the IPR. Currently we measure the number of service users who have been involved in, or have received a copy of their care plan, this informs us of an important but limited set of assurances. Although focus has been on performance the main driver for change is quality and we are monitoring that any improvements in performance are linked to an increase in quality, recognising there is more to do to reach full assurance.
Registered substantive staff in post mental health and learning disabilities services	Establishment	Due July 23 (August report)				
Staff in neighbourhood teams	Establishment					
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	23	41	17		Any increases are monitored by the Patient Safety Team.
Inappropriate out of area bed placements (days)	Q1 - 455, Q2 - 368, Q3 - 276, Q4 - 0	457	574	441	H F	See statistical process chart below for further detail.
% service users clinically ready for discharge	<=3.5%	2.4%	2.1%	4.6%		A new risk related to delays in discharge has been identified and has been added to the organisational risk register.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	694	296	774		Children are prioritised according to need. Average wait, in days, is an average of the length of wait for children who have had an appointment in the month. The monthly average is impacted by very long or very short waits. Measures are in place to monitor and contact children whilst they are waiting. The longest wait for those seen in the month was 808 days, the shortest was 740 days. Number on waiting list at end of June - 252. The longest waiter on the waiting list had waited 827 days. Waiting list initiatives are in place.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	492	479	493		Children are prioritised according to need. Average wait, in days, is an average of the length of wait for children who have had an appointment in the month. The monthly average is impacted by very long or very short waits. Measures are in place to monitor and contact children whilst they are waiting The longest wait for those seen in the month was 819 days, the shortest was 100 days. Number on waiting list at end of June - 1614. The longest waiter on t he waiting list had waited 1037 days. Waiting list initiatives in place.
Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	72.9% 43/59	85.7% 60/70	73.1% 57/78	L ?	Wakefield at 100%. Barnsley 10 of 17 not met target: 6 are outstanding recording issues being resolved; 2 are occupational therapy waits - 1 patient now seen, 1 being prioritised; 1 speech and language therapy breach due to bank staff focus on priority cases, and; 1 psychology case - autism assessment waiting staff capacity. Calderdale 3 of 9 cases breached: 2 in psychology - both due to staffing issues, on waiting lists, regular welfare contacts; 1 breach in nursing - welfare contacts made. Kirklees 8 of 27 breached: 3 in nursing due to incorrect calculation made for 18 week target - staff have been reminded, patients received welfare contacts; breaches also in occupational therapy, psychology and physiotherapy due to staffing/capacity, and; 2 recording issues to be resolved.
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	92.5%	90.6%	92.6%	H ?	
Community health services two hour urgent response standard	70%	87.3%	86.6%	86.2%		
Referral to assessment within 2 weeks (external referrals)	75%	60.4%	68.6%	80.5%	?	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 with a significant number of vacancies despite active recruitment. 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, and remains below target performance in Barnsley, improvements have been seen in Calderdale and Kirklees and this has had a positive impact on the overall Trust position for the month.

Improve Care

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)

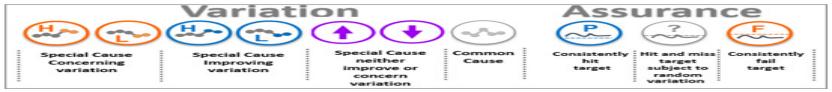


Improve Care

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 16 people placed in out of area beds at the end of June 2023.



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 completed Phase three: governance and quality monitoring by 31/5/2023 Complete/ Under Review Phase four: patient safety response planning by 30/06/2023 In Progress Phase five: Curate and agree patient safety policy and plan by 31/8/2023 In Progress Go Live: Develop comprehensive improvement plans by Autumn 2023 (NHS England have revised the go live date)		PSIRF Phase four: patient safety response planning by 30/06/2023 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.
	Care Planning and Risk Assessment		It has been agreed by the Executive Management Team (EMT) that in 23/24 there will be a priority programme of improvement work with the focus on Care Planning and Risk Assessments. This programme is currently under rescoping, building on the existing work that has been undertaken and setting an improvement plan for 2023/24. There are 3 programme groups now established: 1. Legislation & Policy; 2. Quality 3. Performance.
	Personalised Care (Moving on from Care Programme Approach (CPA))		It has been agreed by EMT that in 23/24 there will be a priority programme of improvement work with the focus on personalised care (moving on from CPA). This programme is currently under rescoping, building on the existing work that has been undertaken, alignment to community mental health transformation, and setting an improvement plan for 2023/24 with governance and terms of reference to be reviewed and established in July 2023.
Continually improve the care we provide, ensuring it is responsive, inclusive & timely	Improving Access to Care (IATC): Update on improvement work to reduce waits		• Community LD services (LD): The design of SystmOne waiting list functionality with the Calderdale team has been approved. Configuration team and training team are aiming to complete build and have this rolled out to wider localities in a collaborative approach and teams using the System by end of July. The Equality and Involvement and Business Intelligence teams provided an awareness session with Calderdale team to support in data recording and understanding of importance of data capture of protected characteristics to improve data collection. • Children's and Adolescent Mental Health Services (CAMHS) neurodevelopmental services in Kirklees and Calderdale - outcomes from adult attention deficit hyperactivity disorder (ADHD) and CAMHS workshop on 19th June include agreement to develop a standardised Trustwide pathway for transition including training for staff, children and young people, and families and carers, and referrers. Agreement made to transfer young people who reach 18 years whilst on CAMHS neuro waiting list to adult ADHD/autism services. Referrals have plateaued at around 160 per month for last 3 months, work continues to monitor waiting list data, and ways to manage referrals such as working with highest referrers and to look at how we can support those schools to make appropriate referrals. • Adult community services – core psychology: SystmOne waiting lists have gone live in all core psychology localities. Service level data analysis work has begun as this will help identify potential areas of improvement. A rescoped project plan and driver diagram have been developed. • SystmOne waiting list project: The project continues to support services in using the functionality correctly, supporting solving of data quality issues, and concentrating on the remaining services trained/setup to begin feeding data from the high-level reporting tool/become "live". • Review of waiting times report: This is a collaborative piece and work continues to develop the report to the agreed plan, in line with the scheduled clinical governance and safety meetings. • Work has commenced on scoping the programme of work for 2023/24 aligned to other priority programmes under the improving mental health portfolio.
	Improving Mental Health portfolio		It has been agreed by EMT that in 23/24 there will be four priority programmes of improvement work covering Care closer to home, Inpatient Improvement, Community transformation (mental health) and Improving Access to Care. These programmes are currently under rescoping, building on the existing work that has been undertaken and setting improvement plans for 2023/24.
	Out to public consultation on older people's inpatient services by summer 2023 – Now autumn 2023		Work continues on finalising the business case and draft consultation documents. Complexities linked to agreeing finances for transformed options and governance processes has led to some delay and consultation is now anticipated to commence in autumn.

Improve resources

Metrics	Threshold	Apr-23	May-23	Jun-23	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	£32k	(£358k)	£19k		A surplus £19k greater than plan has been recorded in month; overall the surplus was £879k. Pressures in pay and non-pay have been offset by additional income and interest received.
Capital spend against plan (monthly)	£8.8m	£218k	£347k	(£442k)		The year to date position is £105k ahead of plan with spend of £993k. This is due to prior year schemes and a door replacement programme being undertaken earlier than planned.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	£939k	£908k	£1,002k		The monthly run rate of agency spend continues to be higher than plan trajectories. The run rate has increased in month with spend greater than £1m.
Financial sustainability and efficiencies delivered over time (monthly)	£12m	£568k	£1,497k	£1,812k		The cumulative savings to date are £1,812k and form part of the overall financial position.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	9				Six of these incidents related to physical violence (contact against staff by patient), with other incidents relating to slip, trips and falls, injury/concern following restraint and physical aggression (no physical contact by patient).
Estates Urgent Response Times - SLA	95%	93.8%	96.8%	98.9%		SLA 1 & 2 are the priorities given to Emergency and Urgent work which has a 2 day response time
Premise Assurance Model (PAM)	Good	Good	Good	Good		PAM is a report measuring how well the Trust is run and includes Estates, Facilities, Governance, Patient Safety, Efficiency & Effectiveness
Statutory Compliance	100%	100.0%	100.0%	100.0%		Includes Water, Gas, Electricity, Refrigeration, Pressure, Lower and Asbestos
% of ligature jobs completed within timeframe	100%	50.0%	76.0%	93.8%		For June, this relates to one job outstanding waiting for a part on the water mist system. The issue is in a corridor and mitigation is in place until works are completed

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	Financial Improvement plan		Financial Improvement plan established and scope agreed by EMT. Reporting into OMG in place. Non recurrent funding for project management secured and possibilities for filling this post being explored. Value for money conversation commenced on i-hub to encourage ideas from across the whole Trust
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 go live has been rescheduled to w/c 17 July 2023 (planning for 18 July 2023) to account for subsequent remediation testing which includes end-to-end test of the data transfer process.
	Implementation of a Trust wide approach to digital dictation submission for Board approval July 2023.		Tender submissions evaluation activities concluded and final evaluation report currently undergoing internal governance/approval processes.

Make SWYPFT a great place to work						
Metrics	**Threshold**	**Apr-23**	**May-23**	**Jun-23**	**Variation/ Assurance**	**Notes**
Turnover external (12 month rolling)	>12% - 13%<	13.0%	12.2%	13.1%		Rolling turnover increased by 0.9% to 13.1%
Registered workforce growth	3% (by March 24)	0.77%				
Sickness absence - rolling 12 months	<=4.8%	5.3%	5.3%	5.3%		Absence rate in month remained at 4.6%.
Workpal appraisals - rolling 12 months	>=78%	74.4%	74.9%	78.5%		For the month of June, the percentage rate increased by 3.6.% to 78.5% and is now above threshold
% staff recommending the Trust as a place to work	65%	Due Aug 23				Quarterly reported, next survey July '23.
% staff recommending the Trust as a place to receive care and treatment	65%	Due Aug 23				Quarterly reported, next survey July '23.
Staff supervision rate	80%	Due Aug 23				Supervision data is currently excluded due to a review of the supervision policy, recording and reporting. An improvement approach is being taken to this work. The supervision database will be live from end June and it is anticipated reporting will be available from August with planned trajectory for improvements.
Complaints - Number of responses provided within six months of the date a complaint received	100%	27% (4/15)	38% (3/8)	17% (2/12)		Improvement programme is established to address backlog reviewing the processes, including sign off to optimise response times. Investment in the customer services team made to reflect the demand and capacity and support quality improvements.
Mandatory training - Cardiopulmonary resuscitation	80%	75.5%	79.2%	81.3%		
Mandatory training - Reducing restrictive practice interventions	80%	73.8%	73.8%	76.7%		Actions being taken to address the compliance rate include use of third-party providers to increase capacity to deliver, the introduction of an e-learning suite to increase accessibility and reduce the need for face-to-face training and a project plan being delivered in close partnership with the Nursing, Quality & Professions directorate. Executive management team have approved a business case for recruitment of additional training capacity.
Mandatory training - Fire	80%	90.2%	91.2%	92.8%		
Mandatory training - Information governance	95%	90.6%	95.9%	96.8%		

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 priority programmes are under development.		Inclusive recruitment, retention and wellbeing: Scoping out work in local places to identify and prioritise where to commence this work with the resources available. Talent management framework conversations have commenced including an Extended EMT workshop held. Living our values: Agreement to hold an engagement event to bring all people who are working on culture related activity together to work on alignment of activity and establish a collaborative joined up approach. This work will be led by the new Head of People experience who commences with the Trust in August.

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 NHS Talking Therapies (formerly Improving Access to Psychological Therapy (IAPT)) services received training on delivering ‘Transcultural Therapy' combined with a focus on providing culturally sensitive supervision.
- NHS Talking Therapies 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:

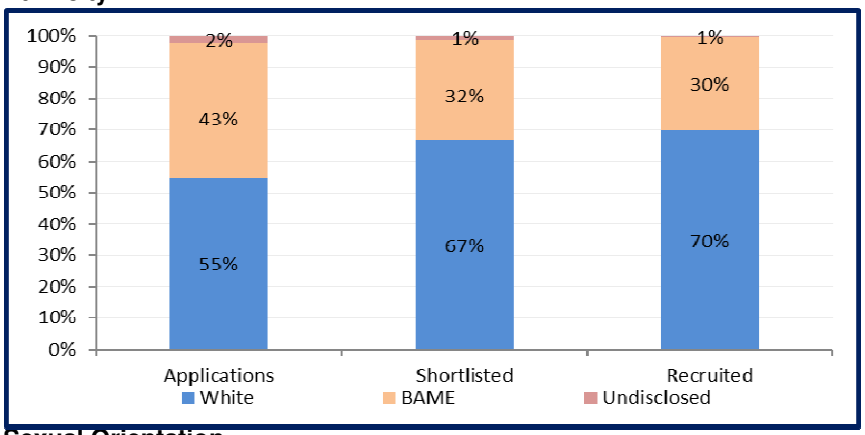
• Perinatal pathways include peer support workers as key members of staff within the new pathway design
• The Trust has an updated Transgender policy and Accessible Information Policy. Both policies have been co-designed with the voice and views of staff, lead managers, staff side, staff networks and 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.

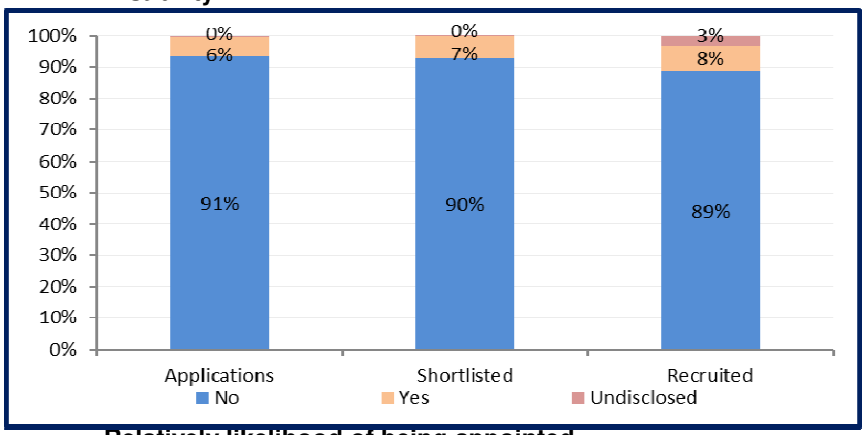
Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 1 2023-2024

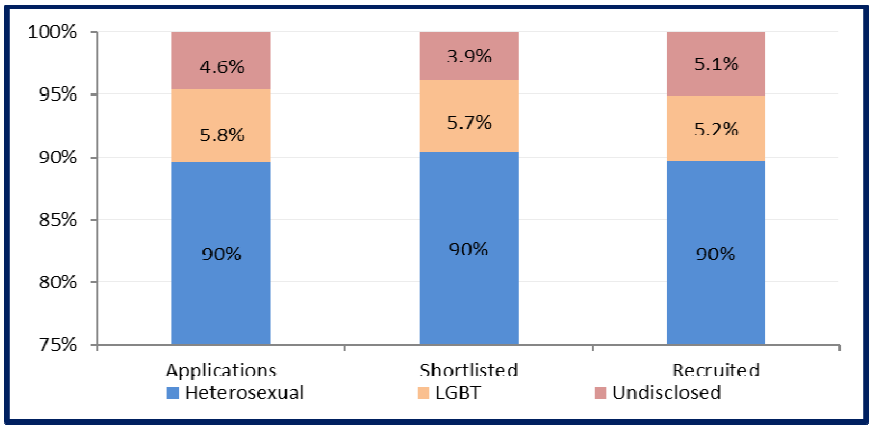
Ethnicity



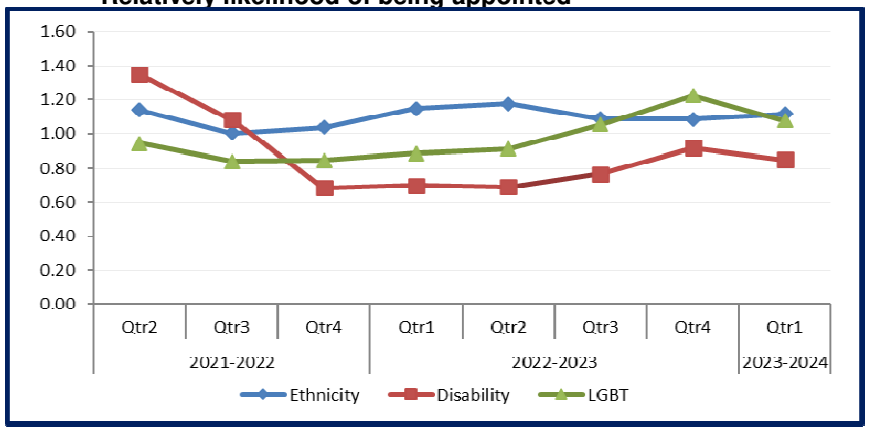
Disability



Sexual Orientation



Relatively likelihood of being appointed



Relative Likelihood YTD Quarter 1 2023-2024:	BAME:	Disability:	LGBT:
	1.11	0.85	1.08

Reducing Inequalities

Recruitment - rolling 12 months to end of Quarter 1 2023-2024 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.

Please note, data includes any records where the relevant date (application submitted, applicant shortlisted, applicant recruited) falls within the rolling 12 months to the end of the reporting quarter

Undisclosed data is not used in the relative likelihood calculation for any of the three categories.

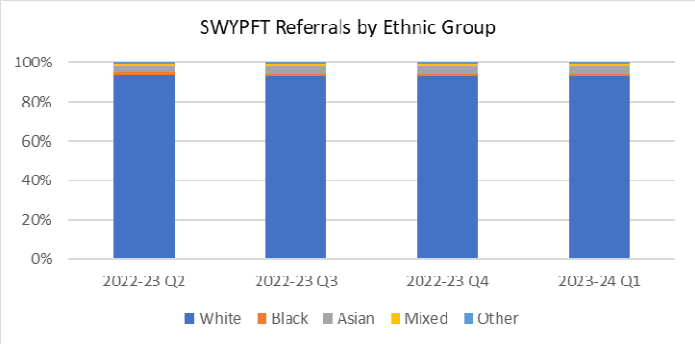
BAME - relative likelihood of being appointed compared to white applicants this quarter = 1.11
Disability - relative likelihood of being appointed compared to non-disabled applicants this quarter = 0.85
LGBTQ+ - relative likelihood of being appointed compared to heterosexual applicants this quarter = 1.08
NB Relatively large proportions of undisclosed could unintentionally skew the data

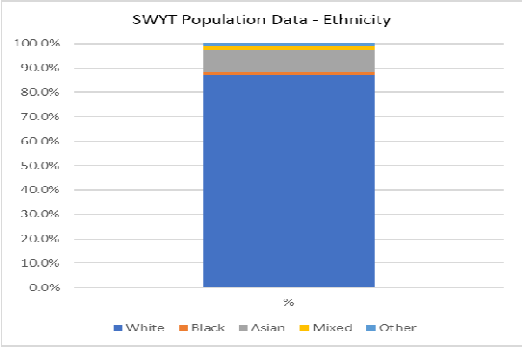
Relative likelihood key
1.00 = target figure, equally as likely to be appointed.
Greater than 1.00 = less likely to be appointed
Lower than 1.00 = more likely to be appointed

Action
Recruitment & Selection policy in the process of being reviewed
Review Recruitment & Selection training
Work with staff networks around action planning

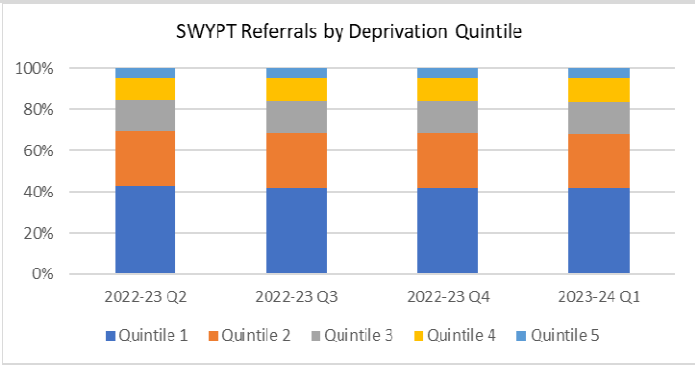
Reducing Inequalities

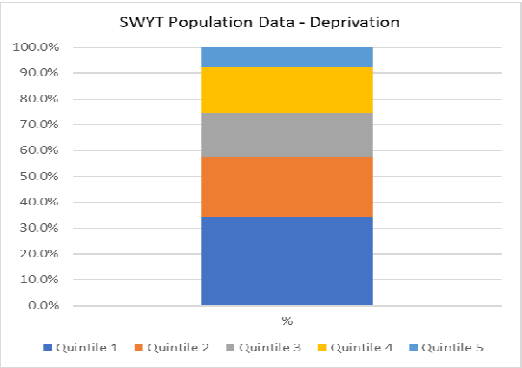
Referrals - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
White	97.7%	93.1%	93.2%	93.1%	87.1%
Black	1.1%	1.0%	1.2%	1.3%	1.4%
Asian	3.3%	3.8%	3.5%	3.4%	8.9%
Mixed	1.0%	1.1%	1.2%	1.2%	1.6%
Other	0.9%	0.9%	0.9%	0.9%	1.1%



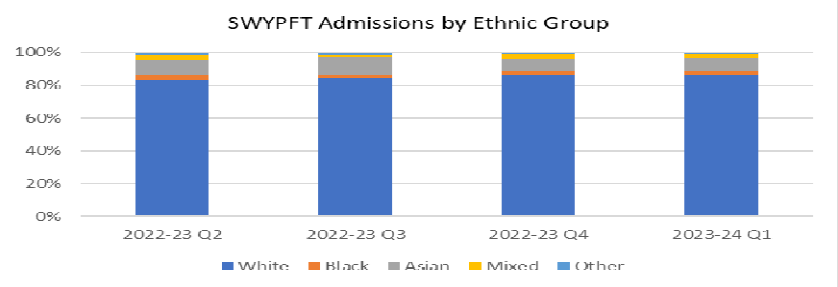


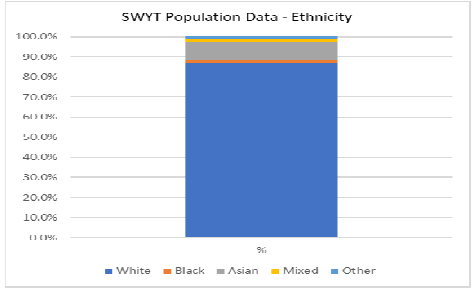
Quintile	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
Quintile 1	42.8%	41.7%	41.8%	41.9%	34.1%
Quintile 2	26.4%	26.5%	26.6%	26.1%	23.4%
Quintile 3	15.2%	15.6%	15.2%	15.5%	17.0%
Quintile 4	11.0%	11.5%	11.6%	11.8%	17.8%
Quintile 5	4.7%	4.7%	4.8%	4.7%	7.8%

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.

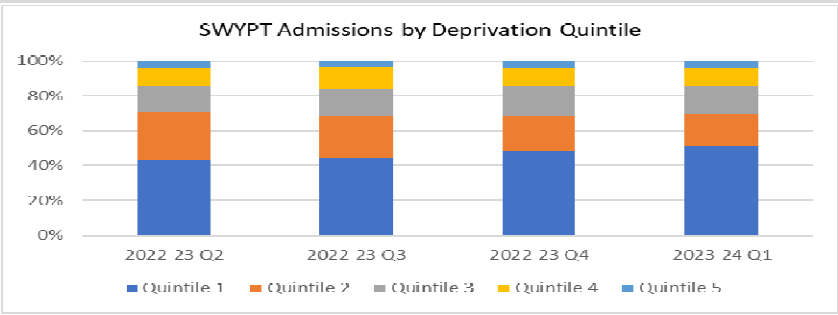
Reducing Inequalities

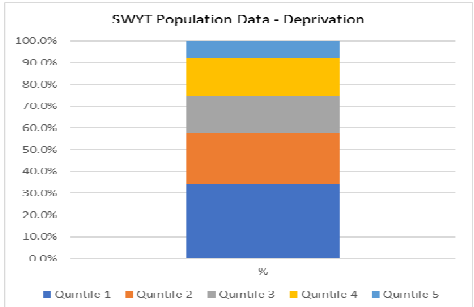
Admissions - (Includes physical health, mental heath, learning disability and forensics)





Ethnic Group	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
White	83.6%	84.4%	86.1%	86.6%	87.1%
Black	3.2%	1.7%	2.5%	2.2%	1.4%
Asian	8.6%	11.1%	7.6%	8.0%	8.9%
Mixed	2.7%	1.5%	2.7%	2.2%	1.6%
Other	1.8%	1.3%	1.1%	1.0%	1.1%





Quintile	2022-23 Q2	2022-23 Q3	2022-23 Q4	2023-24 Q1	Local Population
Quintile 1	43.6%	44.4%	47.8%	51.3%	34.1%
Quintile 2	27.4%	23.8%	20.5%	18.1%	23.4%
Quintile 3	14.5%	16.1%	17.3%	16.4%	17.0%
Quintile 4	10.7%	12.1%	10.5%	10.5%	17.8%
Quintile 5	3.8%	3.5%	3.9%	3.7%	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
- Admissions during quarter 1 for people from a white ethnic group were in line with that of the population the Trust serves.
- Admissions for people with a mixed ethnic group were slightly higher 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. 51.3% of the Trust's admissions were for people from the most deprived areas of the population the Trust serves.
- The number of admissions from the least deprived areas (quintile 5) is in line with the previous 3 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.

Quality Headlines

Section	KPI	Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	TBC	57.2%	60.0%	53.0%	66.0%	68.0%	70.0%	72.0%	74.0%	78.0%	76.0%	81.0%	84.0%	N/A
Complaints	% of feedback with staff attitude as an issue 12	< 20%	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	17% 4/23	11% 2/17	16% 3/19	1
Service User Experience	Friends and Family Test - Mental Health	84%	88%	85%	85%	84%	86%	85%	83%	85%	83%	82%	85%	91%	1
	Friends and Family Test - Community	95%	93%	92%	93%	93%	93%	94%	93%	95%	97%	94%	97%	96%	1
Quality	Number of compliments received	N/A	31	10	13	5	28	39	83	22	26	50	66	33	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) 4	Trend monitor	31	19	35	32	33	30	40	30	35	24	34	28	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	Trend monitor	0	0	0	2	2	2	3	2	2	1	1	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	0	0	1	2	1	0	0	0	2	1	0	2	0	1
	% Service users on CPA offered a copy of their care plan	80%	36.1%	38.2%	42.8%	44.3%	43.8%	44.1%	50.5%	58.6%	75.1%	85.0%	85.7%	86.6%	1
	Number of Information Governance breaches 3	<12	10	9	13	11	13	8	12	8	13	12	9	14	2
	% of inpatients clinically ready for discharge	3.5%	2.6%	3.0%	2.8%	3.3%	2.7%	3.8%	4.3%	4.5%	3.5%	2.4%	2.1%	4.6%	3
	The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	90%	78.0%	82.0%	71.3%	71.3%	79.1%	76.6%	83.6%	87.8%	89.9%	90.6%	87.7%	*86.7%*	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	90%	54.2%	81.7%	62.9%	68.0%	69.5%	74.3%	68.2%	67.0%	79.4%	80.7%	92.9%	*92.3%*	3
	Total number of reported incidents	Trend monitor	1179	1254	1168	1243	1308	1188	1247	1196	1249	1195	1321	1217	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	27	11	32	26	30	25	34	26	35	17	34	24	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	4	3	3	3	7	6	3	3	2	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	0	5	2	3	0	2	3	2	1	5	2	1	
	Safer staff fill rates	90%	115.8%	115.6%	118.4%	117.4%	119.1%	118.1%	122.1%	121.4%	119.3%	123.5%	123.5%	123.7%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	84.7%	83.1%	87.5%	91.0%	90.8%	85.6%	90.5%	89.1%	89.7%	94.4%	95.7%	93.1%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	50	26	43	49	48	39	55	46	38	29	42	34	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	3	0	1	1	1	4	0	2	1	2	1	0	1
	Eliminating Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less 8	90%	80.0%	91.0%	100%	100%	92.0%	100.0%	95.2%	87.0%	100.0%	90.0%	86.6%	89.5%	1
	Number of Falls (inpatients)	Trend monitor	70	63	58	68	63	59	51	49	39	34	53	46	
	Number of restraint incidents	Trend monitor	171	161	160	169	223	189	212	223	203	192	186	201	
	Potential under-reporting of patient safety incidents														
	% people dying in a place of their choosing 14	80%	100.0%	85.3%	85.7%	91.7%	93.3%	78.1%	93.8%	83.3%	100.0%	87.5%	92.1%	87.8%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	0	0	0	0	0	0	1
	C Diff avoidable cases	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	E. Coli bloodstream infection rate	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0	0	0	0	0	0	0	0	0	0	0	0	
Improving Resource	NHS England Systems Oversight framework segmentation	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	Overall CQC rating		Good												
	CQC well - led rating		Good												

Quality Headlines

Quality Headlines cont…

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. 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.
11 - Number of records with up to date risk assessment - '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 NHSE 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 June increased to 201 from 186 reported in the previous month. Further detail is provided in the relevant section of this report.
• % of prone restraint with duration of 3 minutes or less remained below the 90% threshold for June 23. Further detail can be seen in the following section of the report.
• 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 - 0 in June
• The number of people with a risk assessment/staying safe plan in place within timescale remains under the local threshold of 95%. A trajectory of improvement was set last month to achieve 90% by the end of June, this has been achieved by community services but inpatient services remain slightly below. See the Strategic Objectives & Priorities 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 remains above threshold. See Strategic Objectives & Priorities section for further details.
• Clinically ready for discharge (previously delayed transfers of care) - This has increased in June and now is above threshold in June 2023 at 4.6%. 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.
• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required . In June there was a decrease to 38 from 53 in May. Further detail is provided in the relevant section of this report.
• The number of information governance breaches in relation to confidentiality breaches has increased to 14 during the month - further detail is provided in the relevant section of this report.

Patient Safety Incident Response Framework (PSIRF)
As reported in the previous Integrated performance report, 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. We are progressing through various phases of work, including discussions with our ICB and provider collaborative colleagues, mapping our services, data analysis and improvement activity, writing our draft PSIRF policy and plan. 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 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 we report Serious Incidents)
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.
We have received one upgrade to our test environment, however feedback from providers (including SWYPFT) to the national team and RLDatix Ltd was that this did not provide the functionality required to deliver this successfully. This has resulted in further work by RLDatix Ltd and the national team to develop this further, this remains underway. Consequently, this means we cannot progress with our test work or live implementation until the upgrade is received. This had been planned for 5th July but was stood down as the software was not ready to deploy. We remain on the waiting list for the changes to be made as soon as they are available. This applies to all providers using Datixweb (approximately 75% of Trusts).

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 Patient Safety Incident Response Framework
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 Executive Management Team and training is planned between July and December 2023.

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).

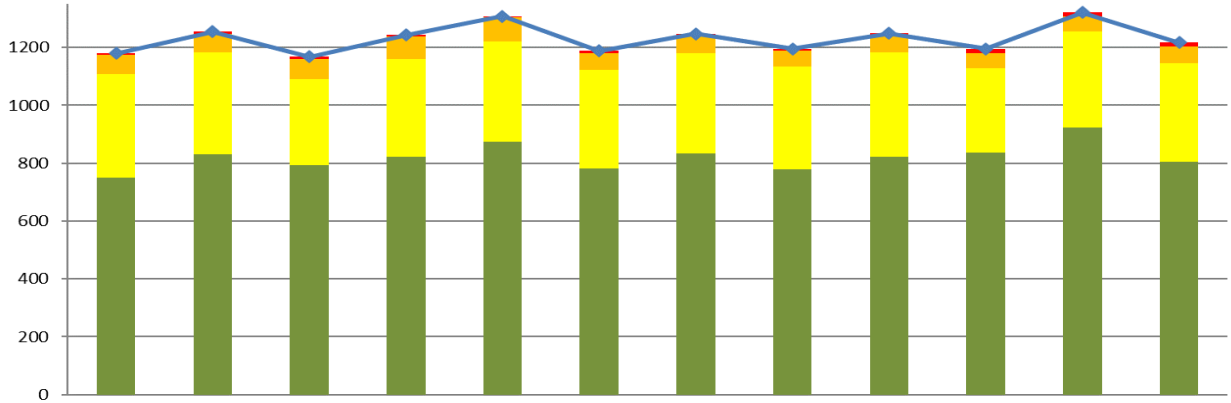
A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety).

96% of incidents reported in June 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 expected 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



	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Red (should not be compared with SIs)	5	6	8	6	3	8	8	7	9	14	13	13
Amber	65	66	68	76	85	58	59	56	56	52	54	59
Yellow	358	350	299	339	346	341	346	353	363	293	332	341
Green	751	832	793	822	874	781	834	780	821	836	922	804
Total	1179	1254	1168	1243	1308	1188	1247	1196	1249	1195	1321	1217

The Trust's 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 are regularly reviewed.

No never events reported in June 2023

Safety First cont…

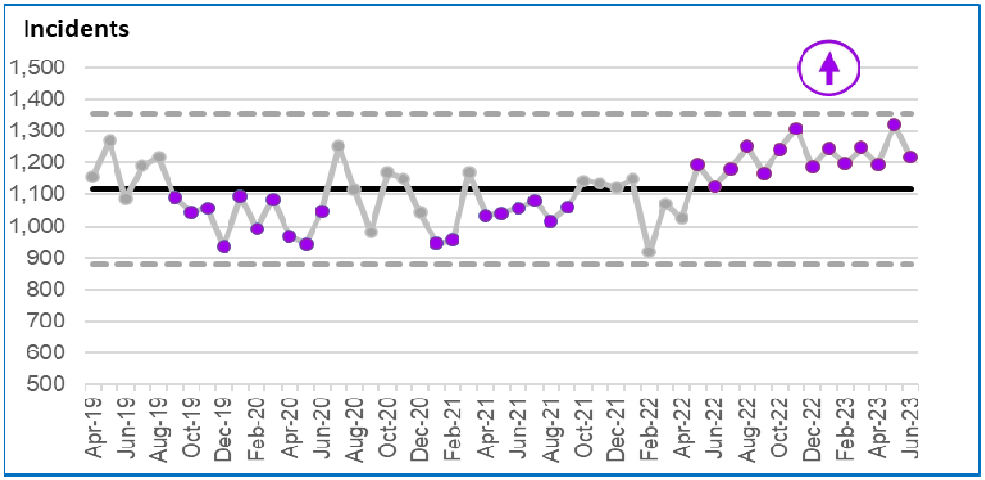
Summary of Patient Safety Incidents resulting in moderate or severe harm or death

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 expected range, any areas with higher or lower rates than normal are explored further.

Breakdown of incidents in June 2023:
24 moderate harm incidents
3 severe harm incident s
1 patient safety related death

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 3 May 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.

Content, including presentations, is available on the intranet.

The next event is on Wednesday 9th August at 1:30pm - 3:30pm. If you would like to attend or share your learning from experience, please email learninglibrary@swyt.nhs.uk.

Bluelight alerts

Bluelight alert 68 - 16 May 2023 - potential to create an anchor point for a fixed ligature within doorframe

Bluelight alert 67 - 9 May 2023 - Identification of incorrect hypodermic needles for drawing from glass ampules

Bluelight alert 66 - 3 May 2023 - Tampering of seclusion, bedroom and bathroom environments

Patient Safety Alerts

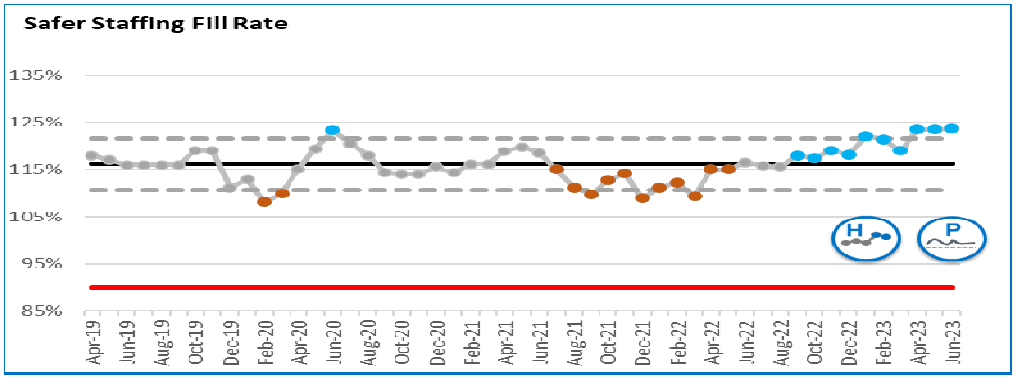
Patient safety alerts issued in June 2023

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 review and 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.

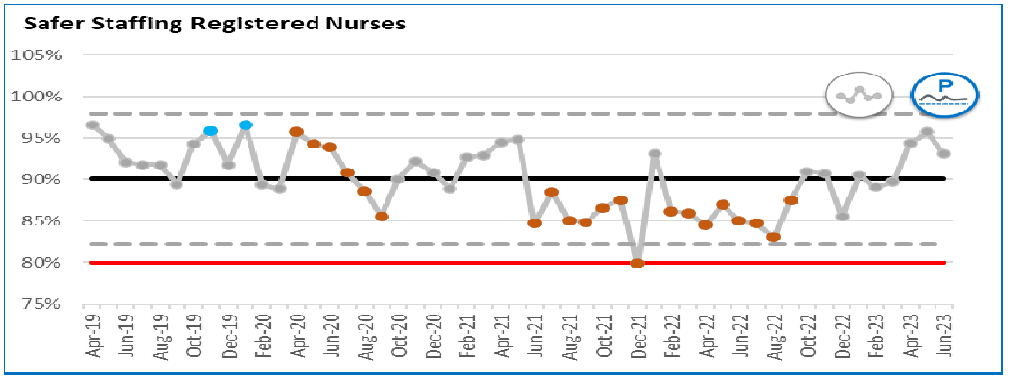
There were no patient safety alerts not completed by the deadline of June 2023.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2023/007/MHRA	Potential risk of underdosing with calcium gluconate in severe hyperkalaemia	27/06/2023	No - alert not applicable to Trust	01/12/2023	27/06/2023

Safer Staffing Inpatients



The chart above shows that as at June 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 June 2023 we remain in a period of common cause variation. Further information about staffing levels can be found on the previous page.

During June there has been an increase in demand of the flexible staffing pool with a total of 261 more shift requests. The number of shifts filled has increased by 24 shifts to a total of 5,004 and fill rates increased overall for inpatients however two care groups decreased slightly. The continued high fill rate of requested shifts (86.55%) is due to the availability of staff, increasing the bank resource, continued engagement with our master agency partner and the ongoing flexibility and contingency planning of the operational colleagues. The cancellation of shifts that have not been filled by wards has had a negligible impact on the number of unfilled shifts.

A reduction or increase in requests does not equate to a reduction or increase in acuity. This should not be seen as achieving our requirements as this describes our fill rate compared to our budgeted figures (capacity) and not our acuity (demand). Historically June has shown an increase in fill rates as staff look to banks shift to supplement their wages over the holiday period. We continue to monitor staffing related Datix, 12 in June (6 less than the previous month) and looking at hotspots and trend analysis of staffing deficits where possible.

Both bespoke adverts and centralised recruitment continues and there are 3 assessment centres throughout July/August for band 5 substantive and bank, as well as band 2 substantive and bank. We have flattened the recruitment process for students both on bank and external. We are reviewing all agency block bookings to replace with bank if feasible.

We continue with bespoke band 5 registered nurse (RN) adverts as well as the international recruitment. To date we have had 64 internationally recruited band 5 nurses with 54 being on the wards throughout the Trust, including on the neurological rehabilitation unit. We have received financial support from NHSE through to Q3 and are awaiting the outcome of the new NHSE funding bid.

Escalation and continuity plans are followed 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.

Project plans for the continued roll out of SafeCare and getting all teams onto the health roster system have been agreed by EMT and are ongoing.

Although we continue to sustain the overall fill rate, we continue to fall short of the RN fill rate for day shift and will continue to look at ways of improving this. This has meant that 19 wards, an increase of one on the previous month, have fallen below the 90% RN day fill rate. 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, as well as being safe, however this 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).

In June no ward fell below the 90% overall fill rate threshold which is a decrease of one ward on the previous month. Inpatient areas continue to experience high acuity as identified above. There is ongoing interventions, projects, and support in place when a ward has been identified as having ongoing and sustained staffing issues to improve the situation. A decrease of two on the previous month, there were 24 (76.8%) of the 31 inpatient areas who achieved 100% or more overall fill rate. Of those 24 wards, 15 (an increase of three on the previous month) achieved greater than 120% fill rate. The main reason for this being cited as increased acuity, observation, and external escorts.

Safer Staffing Inpatients cont…

Although safe and effective staffing remains a priority in all our teams, and the systems wide increase of acuity, the focus for the flexible staffing resources has been Poplars and Crofton within older people's services and the Oakwell Centre. 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 decreased by 0.9% to 87.8% in June compared with the previous month.
Registered Nurses Nights: Overall registered Night fill rates have increased by 0.1% in June to 102.8% compared with the previous month.
Overall Registered Rate: 95.3% (decreased by 0.4% on the previous month)
Overall Fill Rate: 123.7% (increased by 0.2% on the previous month). Health Care Assistants showed an increase in the day fill rate of 2.1% to 141.2% and the night fill rate decreased by 0.9% to 150.3%.
Unfilled shifts: An unfilled shift is a shift that has been requested of the bank office, flexible staffing, and could not be covered by bank staff, agency or Over Time. 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	Unfilled Percentage			
Registered	395	(+57)	4287.08	32.62%	(+4.04%)	**832**	**(-2)**
Unregistered	391	(+59)	4308.75	8.60%	(+0.62%)	**4210**	**(+36)**
Grand Total	**786**	**(+116)**	**8595.83**	**13.45%**	**(+1.70%)**		

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.
These figures allow us to monitor an increase on the flexible staffing resource and look at what appropriate resources are required from the Trust bank flexible staffing resource.

Information Governance (IG)

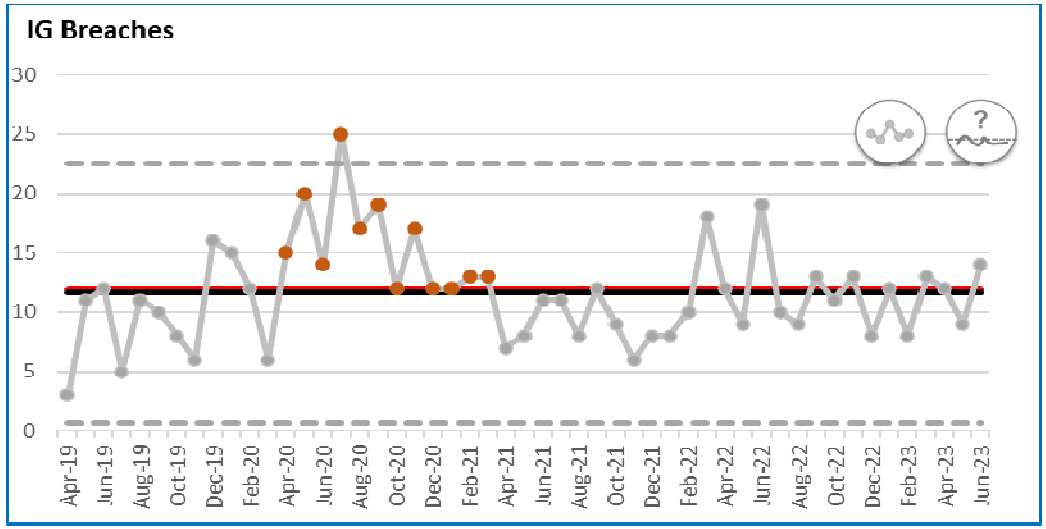
14 personal data breaches were reported during June, which is an increase on recent months and over the threshold of 12. These incidents were spread across all care groups. An improvement plan continues to be implemented to reduce the higher numbers of incidents, which includes training, communications and some data quality activity.

Nine breaches involved information being disclosed in error i.e. due to post and emails being sent to the wrong recipient, correspondence being sent without patient consent, patients supplied with another's patient's data, wrong person being given access to a shared folder and confidential papers being put in general waste.

Two incidents were reported by inpatient services involving patients accessing secure areas and being party to other patients' data. A further incident involved the loss of paper data and the lost record process being invoked.

The Data Protection Officer (DPO) is working with communications colleagues on the development of a poster campaign which highlights the impact on individuals of data breaches.

The Trust does not currently have any open cases with the Information Commissioner's Office.



This SPC chart shows that as at June 2023 we remain in a period of common cause variation. Though we are over the threshold of 12 breaches.

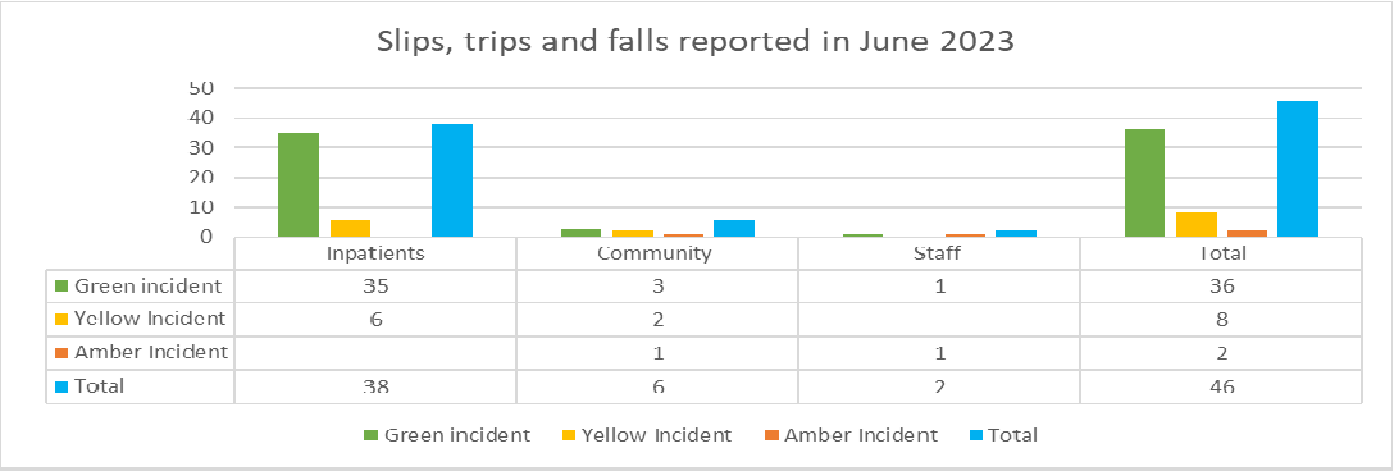
Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes are now in place for 2023/24 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.

There are some new indicators in this years scheme and the Trust's CQUIN leads group are monitoring progress against the thresholds as we come towards the end of quarter one. Submission is due towards the end of august and therefore further update around associated risks and forecast achievement can be expected in next months report.

Trustwide Falls

June 2023 has seen 46 slips, trips and falls related Datix reports. Below is a breakdown of falls and if they occurred in the community, inpatients, or staff group. 25 of these reports are still waiting final approval.



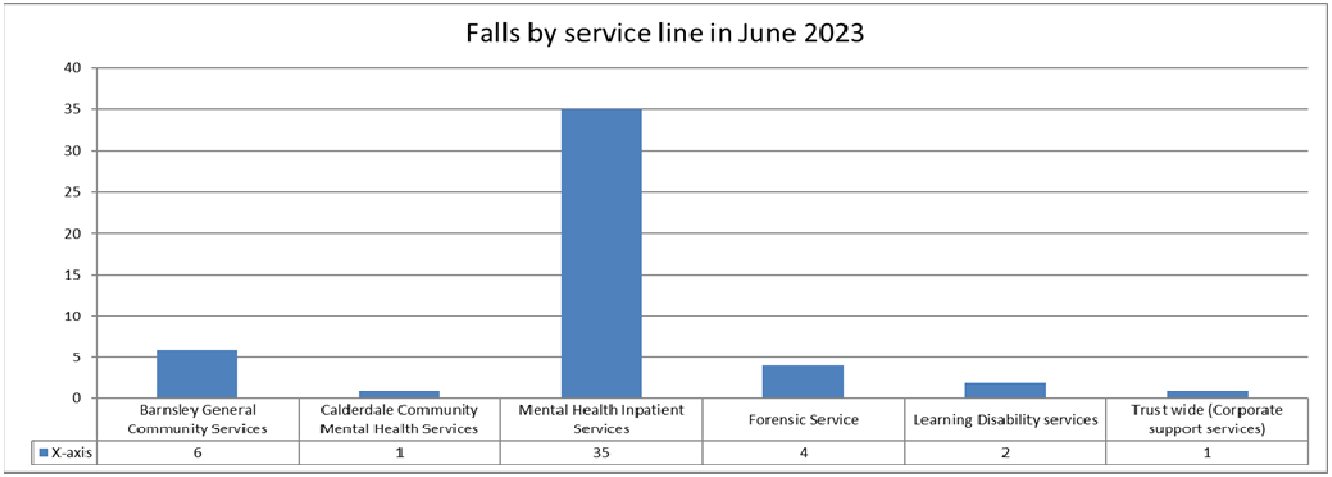
	Inpatients	Community	Staff	Total
Green incident	35	3	1	36
Yellow Incident	6	2		8
Amber Incident		1	1	2
Total	38	6	2	46

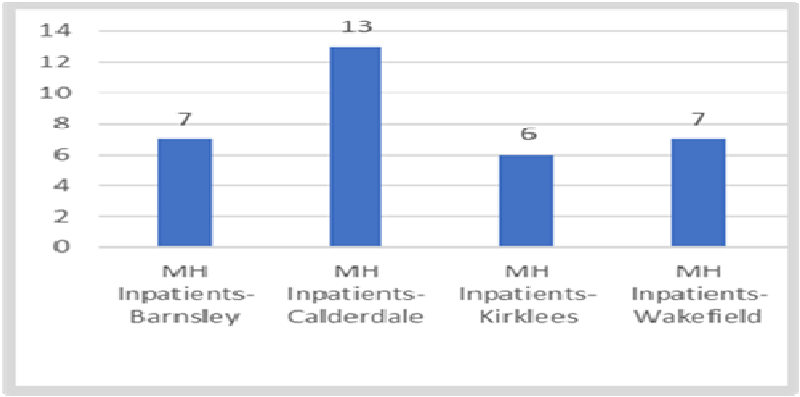
Amber incident: 2 incidents reported.
• One incident was a service user who fell in the community
• Another was a staff member who fell during training

Yellow incident: 8 incidents reported, service users who suffered minor injuries following a slip, trip or fall.
• No significant injuries were sustained, and no themes were highlighted

Green incident: 36 incidents reported, the majority of reported slip, trips or falls were graded as green, indicating no harm or low-level injury.
• Some of these Datix reports occurred whilst service users were on leave in the community or at home

Falls by care group: Most falls continue to occur on older adult inpatient wards. Falls incidents can fluctuate, these being linked with complexity of service user presentation such as dementia diagnosis, deconditioning or agitation.





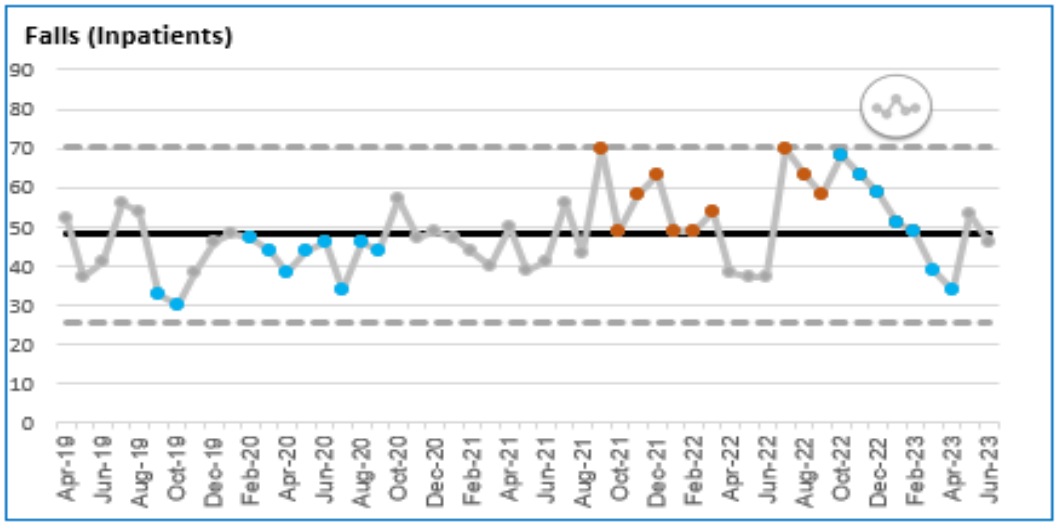
The graph opposite shows a breakdown of ward location and the amount of falls they have had.

Actions

• Datix reports reviewed by falls coordinator, providing support and insight, whist highlighting any recurrent themes or service users who have been repeatedly falling
• The falls coordinator has been completing dip checks on a small number of services user cases, reviewing the FRAT-18 falls risk screen tool, and post falls protocol. Initial findings:
    • not all tools are completed
    • no post falls protocol completed when required
    • standard and quality of completed tools varies, requiring improvement
    • falls coordinator is now reviewing and working with locality matrons to improve this
• The generic falls environmental checklist has been trialled and completed on three older adult wards this month. It has shown two wards that would benefit from having improved falls alert systems and light sensors. This data has been shared with the senior management team.
    • It has been agreed we can use this checklist Trustwide
• There has been a small increase in falls occurring on Beechdale Ward due to a service user who has an infection and also a level of deconditioning prior to admission. This was quickly recognised and treated
• The falls coordinator has visited Trust neuro-rehab ward at Kendray Hospital. Staff have been working proactively to reduce falls incidents on the ward, e.g. have a noticeboard stating how many days since the last fall.

Falls (Inpatient)

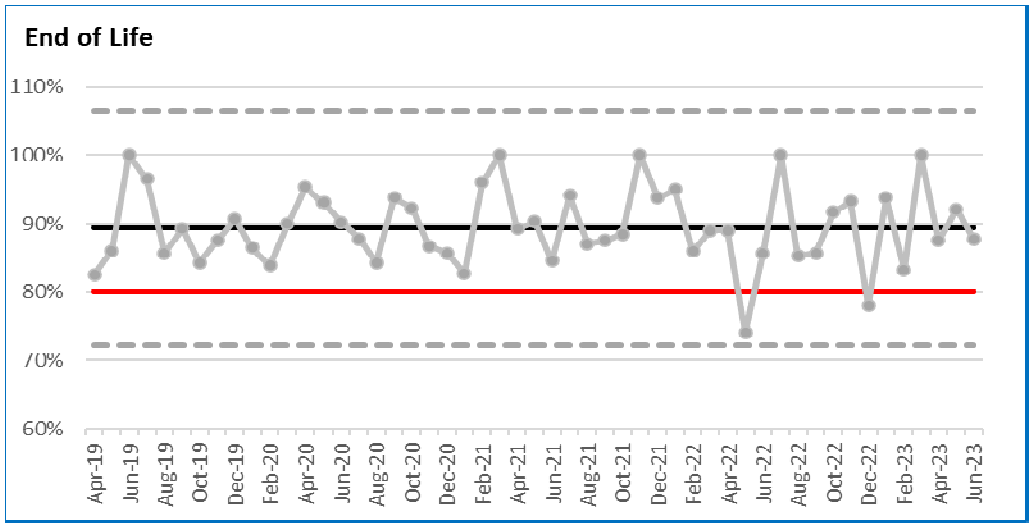
The total number of falls was 46 in June. A new falls coordinator commenced in February 2023, part of the role is to advise, review and support the clinical teams/ staff through education, policy, awareness raising, environmental reviews that may contribute to falls. This will increase staff confidence and will enhance the falls reduction work.



The SPC chart above shows that in June 2023 we remain in 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 87.8% in June.



The chart above shows that in June 2023 the performance against the metric remains in common cause variation and therefore within an acceptable range. Due to fluctuation in the performance whether we will meet the target cannot be determined.

Patient Experience

Friends and family test shows

- 96% would recommend community services
- 91% would recommend mental health services

Mental Health Friends and Family Test Results				
	Target	Apr-23	May-23	Jun-23
Community Services	85%	83%	88%	90%
Acute	85%	93%	80%	97%
Secure & Forensics	60%	100%	72%	100%
Other*	85%	82%	82%	100%
Total	**84%*** **	**82%**	85%	91%

Specialist Services Friends and Family Test Results				
	Target	Apr-23	May-23	Jun-23
ADHD	85%	44%	50%	50%
CAMHS	75%	76%	85%	97%
Learning Disability	85%	100%	100%	100%

Community Services Friends and Family Test Results				
	Target	Apr-23	May-23	Jun-23
Children & Families	95%	93%	96%	100%
Inpatient	95%	100%	100%	100%
Nursing	95%	100%	100%	97%
Other	95%	100%	100%	100%
Rehabilitation & Therapy	95%	94%	93%	97%
Specialist**	95%	95%	97%	88%
Total	**95%**	**94%**	97%	96%

*includes Insight team, perinatal, friends and family team

**includes equipment and adaptation service, neuro physiotherapy, podiatry

*** weighted for 2023/24

Patient Experience

Satisfaction has increased in mental health services and for the Trust as a whole. Satisfaction within secure and forensic services has seen an increase from 72% in May to 100% in July and acute services has increased from 80% in May to 97% in July.

Community services have seen a slight decrease in satisfaction throughout June (97% to 96%) but with notable increase in satisfaction for rehab therapy, from 93% to 97%. A decrease is noted for specialist services but it is worth noting that numbers for this service are very small and therefore a reduction of one shows as a larger decrease in satisfaction rating (2/15, nothing of note identified within the comments).

ADHD results are based on 2 out of 4 responses. Work continues to be undertaken with the ADHD team to address the response rate and feedback received.

	Top three positive themes	Top three negative themes
Trustwide	1. Staff	1. Staff
	2. Communication	2. Clinical treatment
	3. Access and waiting times	3. Access and waiting times
Community	1. Staff	1. Staff
	2. Access and waiting times	2. Communication
	3. Communication	3. Environment
Mental Health	1. Staff	1. Staff
	2. Communication	2. Clinical treatment
	3. Admission and discharge	3. Access and waiting times

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

Safeguarding Adults:
In June 2023, there were 35 Datix categorised as Safeguarding Adults. 17 of these were graded as green, 16 were graded as yellow and two were graded as amber.
The sub-categories of the Safeguarding Adults Datix were as follows:

- emotional/psychological abuse.
- financial abuse
- physical abuse
- neglect
- sexual abuse
- self-neglect
- domestic abuse
- hate crime/discriminatory abuse

Of the amber Datix, there was:

- One categorised as emotional/psychological abuse which related to a group chat that was used to share plans around self-harm, suicide and going missing. This was discussed with the service user's key workers and the police.
- One categorised as physical abuse from a service user to a friend. The reporting staff member was advised to report concerns to the police.

In addition to the Safeguarding Adults Datix, there were 11 sexual safety Datix, all of which were graded as green or yellow. In three of these Datix, a member of staff was the affected person, in one it was another resident in the care home where the service user resided, and in the remaining seven Datix, services users were the affected persons.

Safeguarding Children:
In June 2023, there were 13 Datix categorised as Safeguarding Children. Eight of these were graded as green, four were graded as yellow and one was graded as amber.
The sub-categories of the safeguarding children Datix were as follows:

- child neglect
- physical abuse
- sexual abuse of a child
- request for service
- child protection

The amber Datix categorised as child neglect was due to concerns around a parent and their mental health.
In all of the 13 Datix submitted, referrals were made to Safeguarding Children Teams and Trust safeguarding advice was sought in eight cases. Appropriate actions were taken following all incidents.

Infection Prevention Control (IPC)

Surveillance: There has been zero cases of E.coli bacteraemia, C difficile, MRSA bacteraemia and MSSA bacteraemia.

Mandatory training figures are healthy:
Hand Hygiene-Trust wide Total – 96%
Infection Prevention and Control- Trust wide Total – 94%
Remain above the Trusts 80% training compliance threshold.

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, which has a target date of March 2024. The current policies and procedures remain compliance, and there is no risk in the system.

Outbreaks
There have been no outbreaks in June 2023, however there has been one area monitored.

Complaints

- Acknowledgement and receipt of the complaint within three working days – 79% for formal complaints.
- Number of responses provided within six months of the date a complaint received – 2 (17%)
- Number of complaints waiting to be allocated to a customer service officer – 23
- 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 –11 weeks average.
- There were 19 new formal complaints in June 2023
- Of these 2 have a timescales start date, 13 are awaiting consent and 3 are awaiting allocation.
- 16% of new formal complaints (n=3) have staff attitude as a primary subject.
- 33 compliments were received.
- Customer services closed 12 formal complaints in June 2023.
- Number of concerns (informal issues) raised and closed in June 2023 – 39
- Number of enquiries responded to in June 2023 - 141
- Number of complaints referred to the Parliamentary Health Service Ombudsman this financial year to date - 0

Reducing Restrictive Physical Intervention (RRPI)

There were 201 reported incidents of reducing restrictive physical interventions used in June 2023 this is an increase of 15 (8%) incidents from May 2023 which stood at 186 incidents. This is within normal variation for this data.

89.5% of prone restraints in June 2023 lasted under 3 minutes. In June 2023 prone restraint (those remaining in prone position and not rolled immediately) was reported 19 times of 323 (5.8%) of total restraint positions, this is an increase of 4 from last month which stood at 15 of 283. There were two incidents with a duration of 3-4 minutes and this was due to ensuring the safe administration of crisis medicine management whilst exiting seclusion.

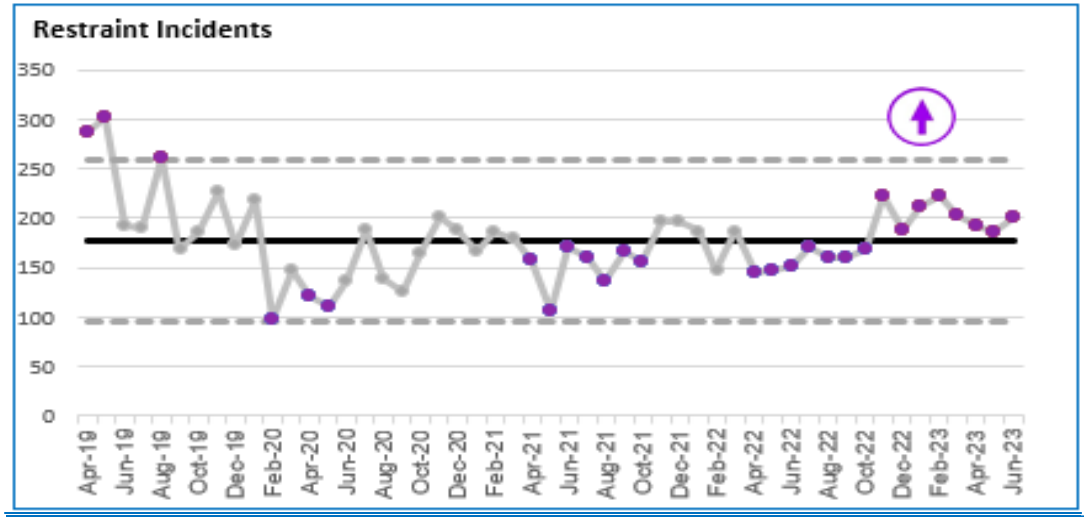
Horizon centre reported 8 incidents of prone restraint and all the incidents involved the same service user. The service user has complex needs and has experienced past trauma. The team on Horizon have worked closely with the RRPI team to explore least restrictive options. The service user has a positive behaviour support plan (PBS) and when seclusion is required it is used for the shortest time possible with staff utilising seclusion in a flexible manner as per Mental Health Act Code of Practice (2015) The 8 prone restraints are connected to when staff are exiting seclusion safely during which there is a significant risk of harm to staff. Further in-reach work continues to be provided by the RRPI team who regularly review and offer guidance on incidents reported via Datix.

Restraint Position Used	Number of restraint Positions Used	Percentage of the Type of Restraint Position Used of Total
Standing	129	40.0%
Seated	55	17.0%
Supine	39	12.0%
Safety Pod	32	9.9%
Restricted escort	20	6.1%
Prone	19	5.8%
Side	15	4.6%
Prone then rolled	8	2.4%
Kneeling	6	1.8%
Total	323	

Team Using Prone Restraint	Total
Horizon Centre Assessment and Treatment Service	8
Melton PICU, Barnsley	3
Newhaven Forensic Learning Disabilities Unit	2
Elmdale Ward	1
Hepworth Ward, Newton Lodge, Forensic	1
Nostell Ward, Wakefield	1
Stanley Ward, Wakefield	1
Walton PICU	1
Ward 18, Priestley Unit	1
Total	19

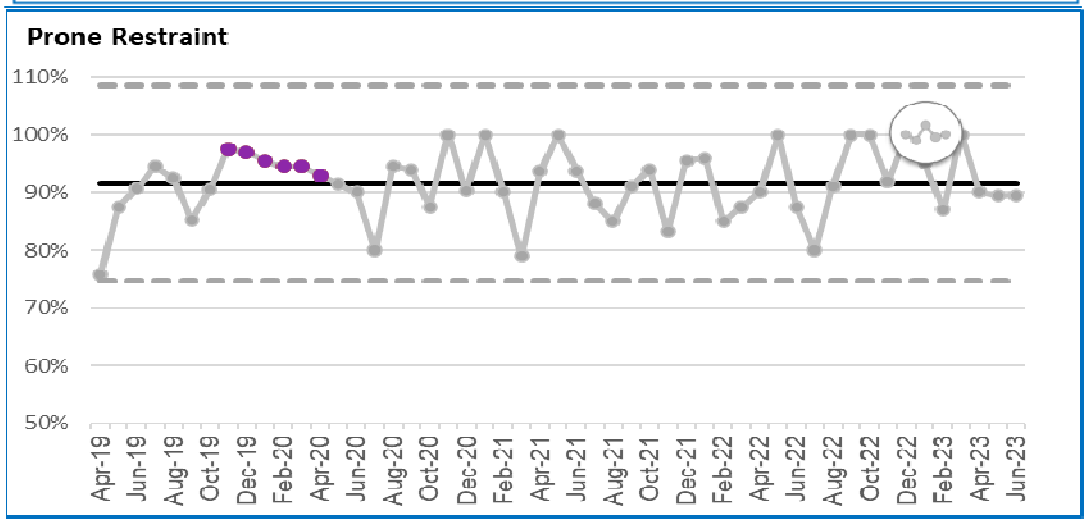
Duration of Prone Restraint Position	Total
0 - 1 minute	10
1 - 2 minutes	4
2 - 3 minutes	3
3 - 4 minutes	2
Total	19

Reducing Restrictive Physical Intervention (RRPI)



This SPC chart shows that in June 2023 we remain in a period of special cause variation (purple markers).

It should be noted that an increase in restraint incidents does not always indicate a deterioration in performance.



This SPC chart shows that due to the continued variation in prone restraint incidents in June 2023 means that we remain in a period of common cause variation.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Establishment	Improving Resources	Well Led	-	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	5,157.4	5,174.0	5,193.8
Employed Staff (ESR last day in the month)			-	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	4,257.0	4,266.2	4,273.6
Vacancies			-	723.1	795.3	816.5	881.8	895.2	942.0	936.8	944.8	926.9	818.9	822.0	818.4
Vacancy rate			<10%	14.7%	15.9%	16.2%	17.1%	17.4%	18.1%	17.9%	18.0%	17.6%	15.9%	15.9%	15.8%
Turnover external (12 month rolling)			>12% - <13%	15.5%	15.2%	14.8%	14.4%	14.4%	14.2%	14.3%	13.7%	13.5%	13.0%	12.2%	13.1%
Starters			-	46.4	58.1	69.5	56.9	50.5	26.6	65.4	70.2	58.1	47.2	59.3	57.5
Leavers			-	56.9	56.3	51.6	48.2	40.6	27.5	60.1	38.5	43.1	58.8	39.6	37.0
Sickness absence - Rolling 12 month			<=4.8%	4.9%	4.8%	4.9%	5.0%	5.1%	5.3%	5.3%	5.2%	5.3%	5.3%	5.3%	5.3%
Sickness absence - Month			<=4.8%	5.5%	4.7%	4.8%	5.7%	5.9%	6.3%	5.3%	5.3%	5.1%	5.0%	4.6%	4.6%
Employees with long term sickness over 12 months			-	-	0	2	2	2	2	4	2	2	1	0	0
Appraisals - rolling 12 months			May Trajectory>=78% Overall threshold: >=90%	55.8%	61.3%	57.3%	56.0%	60.7%	62.9%	69.8%	71.5%	71.8%	74.4%	74.9%	78.5%
Employee Relations - Suspensions (over 90 days)			-	1	2	2	2	2	3	3	1	1	0	0	0
Mandatory Training - TOTAL	Improving Care		>=80%	87.2%	90.7%	89.8%	89.5%	89.5%	89.2%	89.4%	90.1%	90.2%	90.5%	90.9%	92.0%
Mandatory Training - Reducing Restrictive Practice Interventions				73.8%	73.8%	72.0%	70.3%	68.4%	66.4%	71.9%	74.5%	74.6%	73.8%	73.8%	76.7%
Mandatory Training - Cardiopulmonary Resuscitation				74.6%	75.7%	75.0%	72.5%	72.1%	72.0%	73.0%	75.1%	75.0%	75.5%	79.2%	81.3%
Mandatory Training - Clinical Risk				96.2%	96.4%	96.6%	96.3%	96.2%	96.0%	95.7%	94.9%	95.9%	95.6%	95.4%	95.4%
Mandatory Training - Display Screen Equipment				94.3%	94.9%	95.5%	95.1%	95.4%	95.8%	96.0%	96.3%	96.4%	96.5%	96.8%	97.0%
Mandatory Training - Equality & Diversity				94.1%	93.9%	94.3%	93.8%	94.2%	94.1%	94.6%	95.1%	95.8%	96.0%	96.2%	96.2%
Mandatory Training - Fire Safety				87.4%	87.1%	86.4%	87.3%	87.7%	87.5%	88.3%	88.4%	89.4%	90.2%	91.2%	92.8%
Mandatory Training - Food Safety				79.3%	79.8%	79.2%	78.6%	79.9%	79.5%	79.6%	79.8%	79.4%	78.0%	83.4%	86.4%
Mandatory Training - Freedom To Speak Up (FTSU)				86.8%	88.2%	89.8%	90.5%	91.3%	91.7%	92.0%	92.4%	92.5%	93.2%	93.7%	94.0%
Mandatory Training - Infection Control & Hand Hygiene				87.3%	87.7%	88.2%	88.4%	88.6%	88.4%	88.4%	88.6%	90.2%	91.5%	92.4%	94.1%
Mandatory Training - Information Governance (Data Security)			>=95%	92.9%	92.5%	92.2%	91.2%	89.8%	87.6%	87.3%	84.8%	86.5%	90.6%	95.9%	96.8%
Mandatory Training - Moving & Handling			>=80%	95.7%	95.3%	95.2%	95.3%	95.8%	95.6%	93.0%	93.4%	95.5%	95.5%	94.9%	95.2%
Mandatory Training - Nat Early Warning Score 2 (New S2)				84.3%	85.6%	86.3%	87.4%	88.1%	89.6%	91.1%	92.0%	92.4%	92.5%	92.1%	93.8%
Mandatory Training - Mental Capacity Act/Dols				93.3%	93.5%	93.8%	93.5%	93.4%	93.3%	95.6%	95.3%	94.0%	91.6%	93.6%	93.7%
Mandatory Training - Mental Health Act				89.5%	90.4%	90.9%	90.7%	91.0%	91.2%	90.4%	91.6%	92.2%	91.6%	91.3%	91.2%
Mandatory Training - Prevent				94.6%	95.1%	95.3%	95.0%	94.6%	94.4%	94.7%	95.2%	95.6%	95.4%	95.5%	92.1%
Mandatory Training - Safeguarding Adults				89.1%	89.7%	89.5%	89.4%	89.5%	89.0%	89.1%	89.9%	90.0%	90.0%	89.7%	89.3%
Mandatory Training - Safeguarding Children				89.9%	89.7%	90.2%	88.7%	88.9%	88.6%	88.8%	89.3%	89.8%	90.0%	90.7%	91.1%

Notes:

• Employed Staff (Electronic 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.

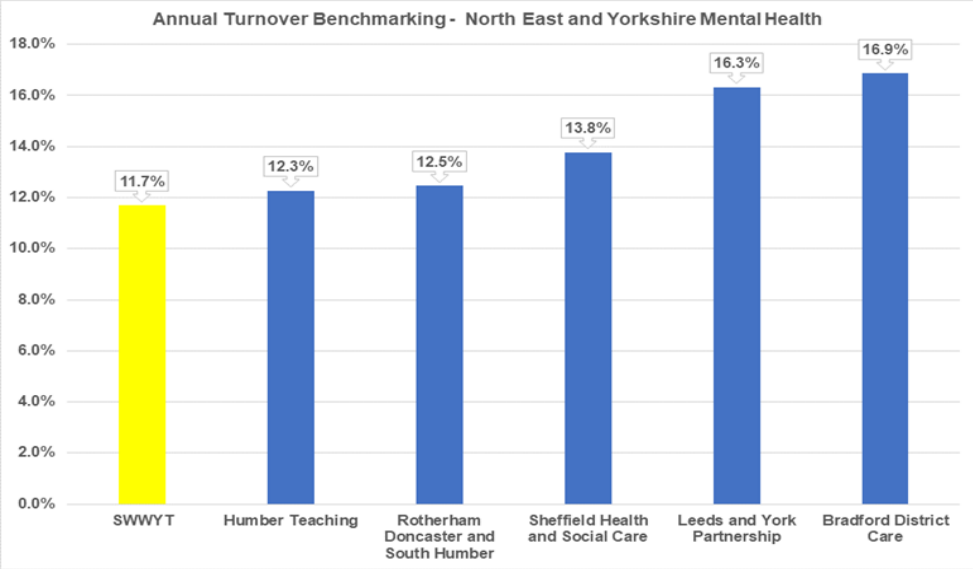
• Starters/Leavers - variation in alignment to establishment exists due to a number of factors such as, data taken as a snapshot so will not reflect any changes made on the system after the extraction date as well as changes in contractual hours that cannot be retrospectively applied.

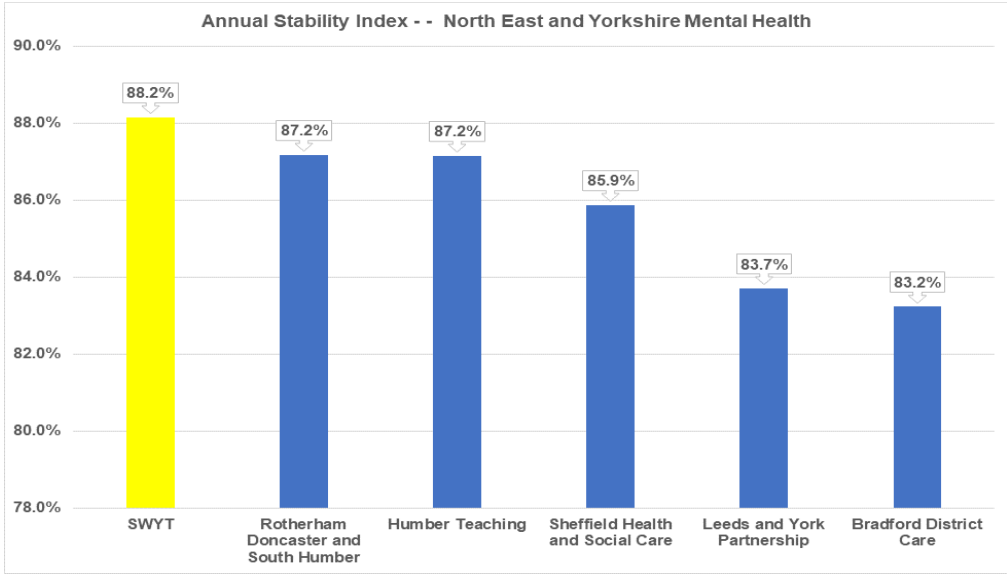
• Turnover - Quarterly reports from feedback of leavers are being appraised in the Trust's operational management group with reporting and actions from quarterly reports to care groups.

• Sickness absence - from April 23 - the reported figure is rolling 12 month. For earlier months this was year to date.

Stability of the Workforce

- Substantive staff in post has increased by 7.4 whole time equivalents (WTE) in June.
- Staff in post workforce growth since April stands at 0.77% against a target of 3% for the year (on target)
- Rolling and year to date turnover is 13.1%, which is a slight increase from last months position (12.2%). When benchmarked against the latest workforce statistics published by NHS England on digital.nhs.uk (Jan 2023) the Trust has one of the lowest rates in our region and the highest for the staff stability index (staff in post over 1 year).





Keep Fit & Well

Absence

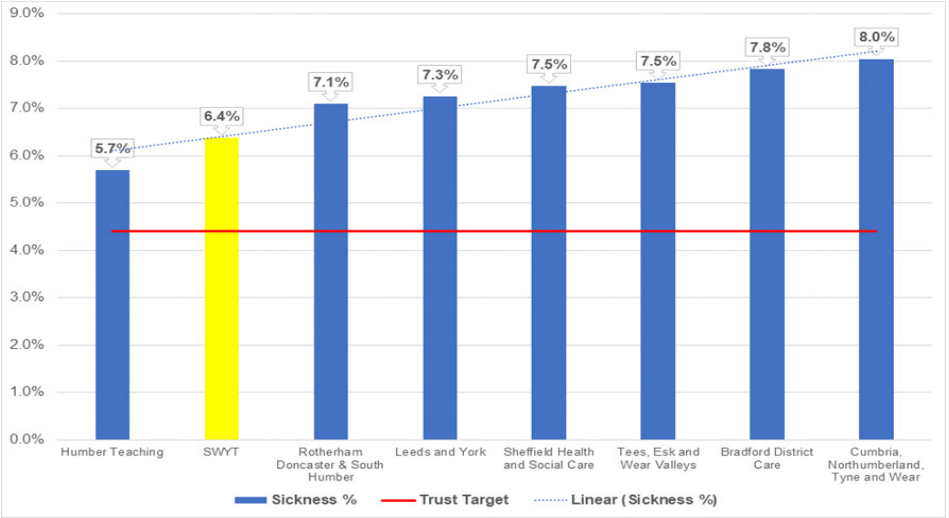
• 12 month rolling absence rate remains at 5.3%.

• Forensics absence saw a further increase in month of 1% from previous month to 7.9%. Focused support with managers on long term sickness, has been undertaken in the care group which has previously had a positive effect on the absence rate. The Forensics human resource business partner role is working closely with Forensics to identify hotspots and targeted reduction

• Estates and Facilities absence increased during June to 6.5% (6.0% year to date) - focus remains on sickness meetings, monthly reports to individual managers and increased personal development support to address this increase. This increase has been seen due to small increases in long term sickness cases (3).

• Stress related absences still accounts for the largest reason increasing to 37%. (This remains constant around 34-37% Trustwide)

• When compared to the latest figures published by NHS England via digital.nhs.uk (Dec 2022) we have the second lowest percentage in the region.



Supportive Teams

Appraisals

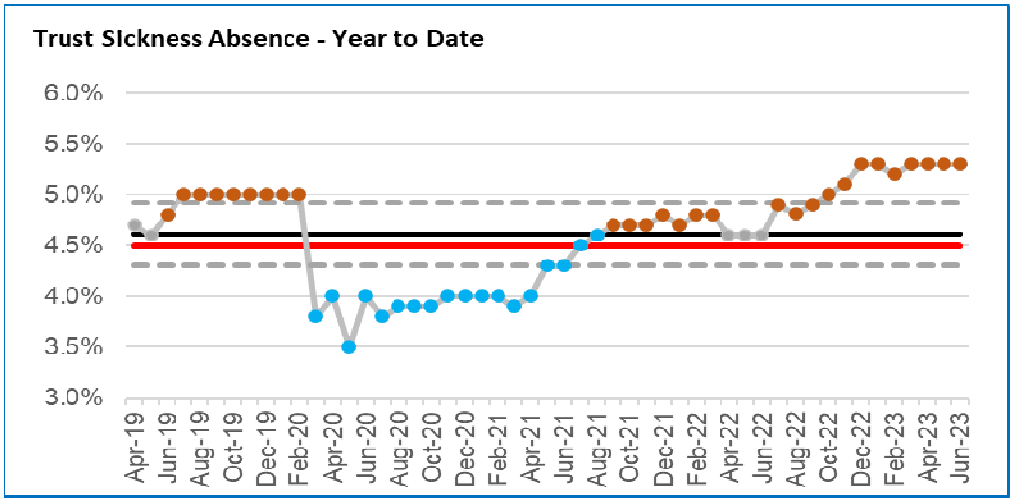
• For the month of June, the percentage rate increased by 3.6% to 78.5%.

Mandatory Training

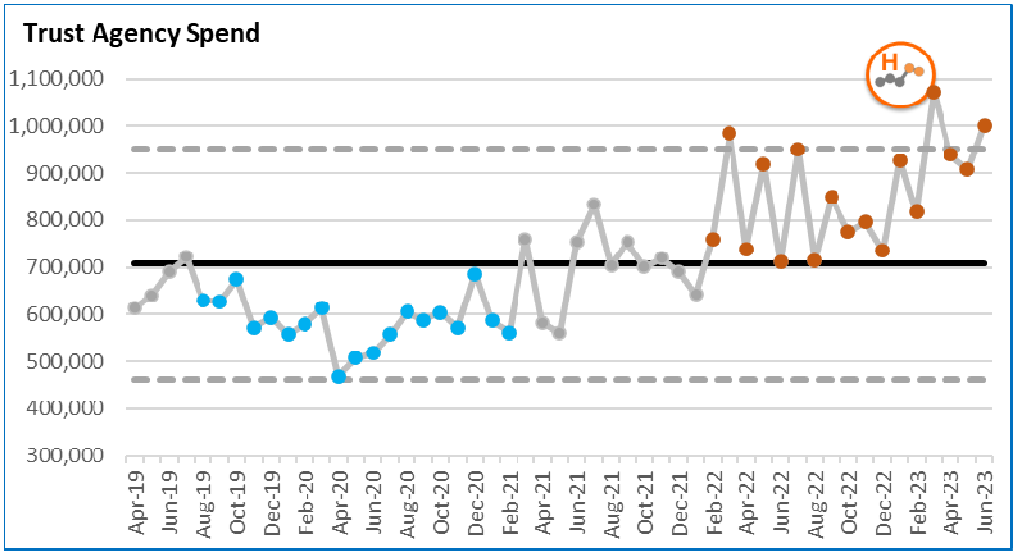
• Overall mandatory training reports 92% which remains above Trust target. Compliance by care group is reported monthly to the executive management team with hot spot reports reviewed by operational management group.

• Two subjects out of 17 reported are below the Trust's 80% target - these are resuscitation and reducing restrictive practice interventions. Actions being taken to address these areas include use of third-party providers to increase capacity to deliver, the introduction of an e-learning suite to increase accessibility and reduce the need for face-to-face training and a project plan being delivered in close partnership with the Nursing, Quality & Professions directorate.

Analysis



The SPC chart shows that in June 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 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). Monthly agency performance group established and has commence in June for all care groups to focus on individual long term agency placement.

• The Trust have been working with Liaison Contingency Workforce since April to understand our efficiency in utilisation of eRostering, bank, agency and workforce management. The outcome of that work is due on the 2nd August with following recommendations and report due into Agency Scrutiny Group on the 10th August.

• Alternative marketing campaigns to engage wider markets. Several national and local recruitment events booked between now and November and Yorkshire Pride events attended in June and July. Recent recruitment events attended in Wakefield, Calderdale and Manchester along with University fair attendance and virtual online events conducted (work with Touchstone to engage under-represented/hard to reach groups).

• Significant increase in assessment centre recruitment events – 8 since April (usually 1 per month) over 370 potential candidates into bank and substantive healthcare support worker and nurse posts. This will have a positive impact upon agency provision in future months. Further additional assessment centres planed over the next few months to cater for demand in application.

MEDICAL APPRAISALS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number expected to be undertaken in period	37			
Number undertaken in period	34			
Number not undertaken for which the RO accepts postponement is reasonable	2			
Percentage of appraisals taken place	92%			
Percentage of appraisals signed off in period as satisfactory	92%			

MEDICAL REVALIDATIONS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of revalidation recommendations due in period	5			
Number of positive recommendations	5			
Number of deferrals	0			
Number of non-engagements	0			
Percentage of revalidation recommendations made	100%			

RESPONDING TO CONCERNS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of active cases under Maintaining High Professional Standards procedures	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) were 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 was a year of transition as Integrated Care Boards ICBs were formally established and new collaborative arrangements are developed at system level. ICBs are now lead for the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate. No further update has been provided for 2023/24 to date. The Trust will continue to monitor for any changes.

• This table only includes operational metrics, there are a number of other workforce, quality and finance 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 care group performance monitoring.

• NHS Standard Contract against which the Trust is monitored by its commissioners. The below table reflect metrics included in the contracts for 22/23 work continues across provider and commissioner to conform contracts for 23/24 and once this process has been completed, metrics may be amended to ensure they reflect current year. 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 - NHS England systems oversight framework, NHS long term plan, NHS standard contract

KPI	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-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.	0	0	0	0	0	0	0		
Inappropriate out of area bed days	Q1 - 455	482	511	511	457	574	441		
Community health services two hour urgent response standard	70%	87.5%	85.0%	83.8%	87.3%	86.6%	86.2%		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	60%	92.6%	94.4%	81.3%	96.7%	94.4%	87.1%		
NHS Talking Therapies (formerly IAPT) - proportion of people completing treatment who move to recovery	50%	57.1%	53.9%	53.6%	52.7%	53.6%	*53.4%*		
NHS Talking Therapies (formerly IAPT) - Number of people who first receive recognised advice and signposting or start a course of psychological therapy within the reporting period - Barnsley	Per Quarter - 1563	500	461	480	456	500	600		
NHS Talking Therapies (formerly IAPT) - Number of people who first receive recognised advice and signposting or start a course of psychological therapy within the reporting period - Kirklees	No Target Set	978	792	886	724	929	799		
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	95.1%	95.7%	97.5%	97.9%	98.9%	99.6%		
Number of people accessing Individual Placement Support (IPS) services as a rolling total each quarter	19 per qu - Calderdale 15 per qu - Kirklees 5 per qu - Wakefield	40 Calderdale; 37 Kirklees; 31 Wakefield			45 Calderdale; 39 Kirklees; 32 Wakefield				
Number of individuals accessing specialist community perinatal and maternity mental health services	Q1 - 316	81	57	84	342	130	76		
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	99%	88.0%	91.6%	79.8%	60.7%	53.3%	82.5%		

KPI	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Data quality rating [8]	Variation/ Assurance
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	87.9%	89.6%	86.6%	90.3%	90.6%	92.6%		
NHS Talking Therapies (formerly IAPT) - Treatment within 6 weeks of referral	75%	97.7%	97.6%	98.1%	97.8%	98.6%	*99.4%*		
NHS Talking Therapies (formerly IAPT) - Treatment within 18 weeks of referral	95%	99.8%	100.0%	99.8%	99.8%	99.8%	*100.0%*		
The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week	95%	87.5%	80.0%	87.5%	33.3%	80.0%	N/A*		
The percentage of children and young people with an eating disorder designated as routine cases who access NICE concordant treatment within four weeks	95%	88.6%	100.0%	100.0%	75.0%	89.5%	100.0%		
Data Quality Maturity Index	95%	99.4%	98.2%	99.6%	*98.0%*	*99.2%*	*99.5%*		
Total bed days of children and younger people under 18 in adult inpatient wards	0	8	31	44	15	11	30		
Total number of children and younger people under 18 in adult inpatient wards	0	2	2	2	3	1	1		
Number of detentions under the Mental Health Act (MHA)	Trend Monitor	184			188				
Proportion of people detained under the MHA who are BAME	Trend Monitor	19.6%			16.5%				
% Admissions gate kept by crisis resolution teams	95%	98.9%	99.0%	98.2%	100.0%	99.0%	100.0%		
% Service users on care programme approach (CPA) having formal review within 12 months	95%	95.8%	95.4%	97.6%	97.1%	97.4%	97.4%		
% clients in settled accommodation	60%	84.4%	84.4%	84.6%	84.4%	84.0%	*84.3%*	⚠	
% clients in employment	10%	11.6%	11.4%	11.2%	11.1%	11.5%	*11.7%*	⚠	
Completion of improving access to psychological therapies (NHS Talking Therapies (formerly IAPT)) minimum data set outcome data for all appropriate service users, as defined in contract technical guidance 1	90%	98.1%	99.1%	98.9%	98.9%	98.4%	*99.0%*		
Completion of a valid NHS number field in mental health and acute commissioning data sets submitted via SUS, as defined in contract technical guidance	99%	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	90%	99.4%	99.4%	99.4%	99.5%	99.5%	*99.4%*		

KPI	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Data quality rating [8]	Variation/ Assurance
The number of completed non-admitted RTT pathways in the reporting period	18000 (1500 per month)	Reporting from 23/24			1523	1719	2335		
The number of incomplete Referral to Treatment (RTT) pathways	27900 (split 2500 p/m A-J; 2400 J-S; 2300 O-D; 2200 J; 2100 F; 2000 M	Reporting from 23/24			1933	1835	1592		
Count of 2-hour urgent community response first care contacts delivered within reporting quarter	Q1 2800, Q2 2500, Q3 3700, Q4 3100	Reporting from 23/24			3103				
Virtual ward occupancy	80%	Reporting from 23/24			82.9%	44.3%	92.9%		
Community services waiting list (report split by 0-17; 18+)	Q1 5652, Q2 5430, Q3 5469, Q4 5198	Reporting from 23/24			Due August 2023				
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed Primary Care Networks) for adults and older adults with severe mental illnesses	Barnsley (3600 per quarter, 12 month rolling)	Reporting from 23/24			3469				
	Calderdale (2400 per quarter, rolling 12 month)				2382				
	Kirklees (5100 per quarter, rolling 12 month)				4998				
	Wakefield (3800 per quarter, rolling 12 month)				3688				
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Barnsley (2000 per quarter, 12 month rolling)	Reporting from 23/24			2137				
	Calderdale (1200 per quarter, rolling 12 month)				1089				
	Kirklees (3000 per quarter, rolling 12 month)				3045				
	Wakefield (3900 per quarter, rolling 12 month)				4322				

N/A* - no applicable cases during month

Glossary			
SOF	NHSE System Oversight Framework	O	Other National Metric
SC	NHS Standard Contract	SU	Service User
LTP	NHS Long Term Plan	CPA	Care Programme Approach

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 99.6%

• 72 hour follow up remains above the threshold at 92.6%. We remain in a period of special cause improving variation 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 increased to 82.5% in June from 53.3% reported for the previous month. This remains below threshold and has now entered a period of common cause variation (please see SPC chart on the next page). This is a small service and there have been a number of staffing issues that have impacted clinic availability. Due to the continued 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. The service are also reporting a number of appointments being cancelled by their parents/carers, or children not being brought to their appointments. The Was Not Brought (WNB) figures are high and the service are taking steps to try to address this. This includes sending an additional appointment text message reminder closer to the appointment date, and also changing the wording within appointment letters that are sent out to parents/carers. When an appointment is cancelled by a parent/carer or a child is not brought, the service often have to book another appointment that breaches the 6 week wait.

• The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week - no urgent cases were referred in June 2023.

• During June 2023, there was one service user aged under 18 years placed in an adult inpatient ward with a total length of stay in the month of 30 days. 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.

• The 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 however both are above their respective thresholds.

• 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.

• NHS Talking Therapies - proportion of people completing treatment who move to recovery remains above the 50% target at 53.4% for June. This metric is in special cause improving 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 June. This metric remains in a period of special cause improving variation due to continued (more than 6 months) performance above the mean. Fluctuations in the performance mean that achievement of the threshold cannot be estimated.

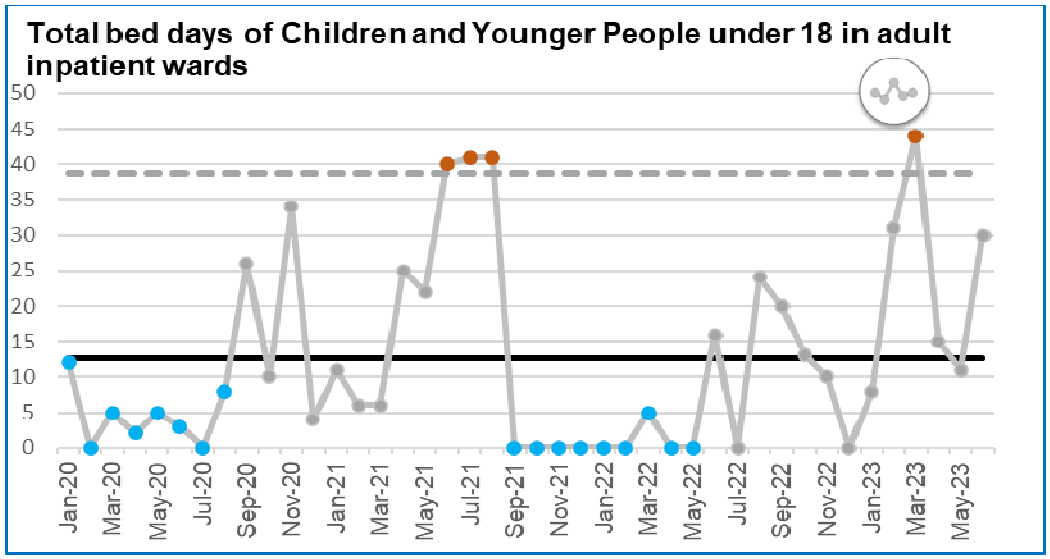
Data quality:

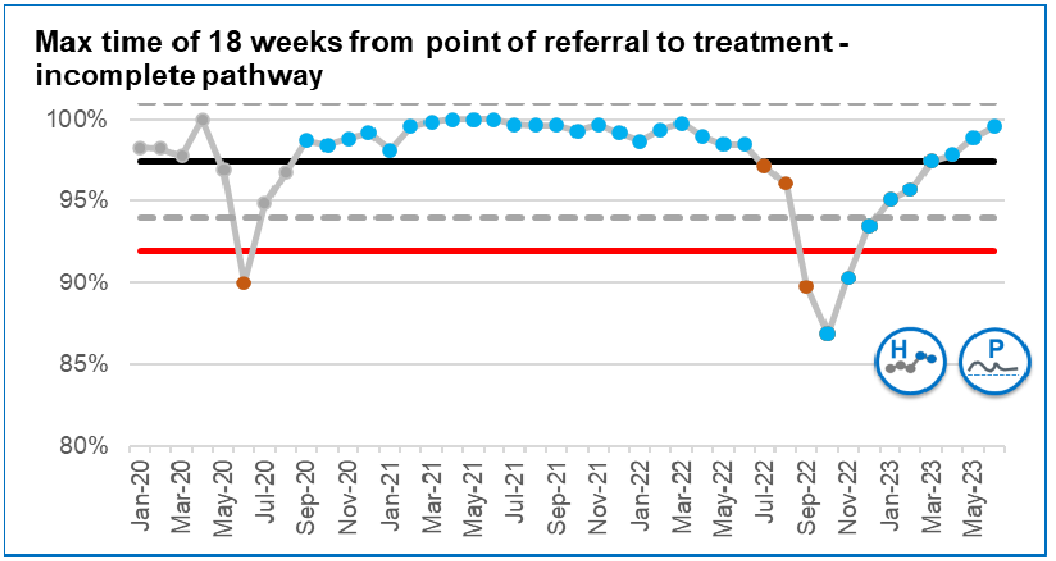
An additional column has been added to the tables on the previous pages to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.

For the month of June the following data quality issue has been identified in the reporting:

- The reporting for employment and accommodation shows 14.7% of records have an unknown or missing employment and/or accommodation status. This has been flagged as a data quality issue and work is taking place within care groups to review this data and improve completeness.

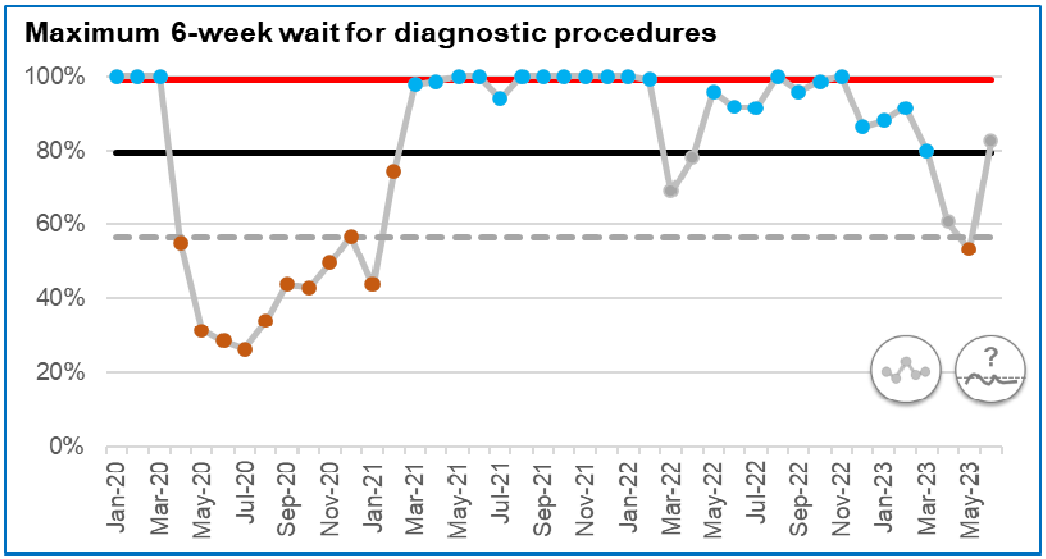
Analysis

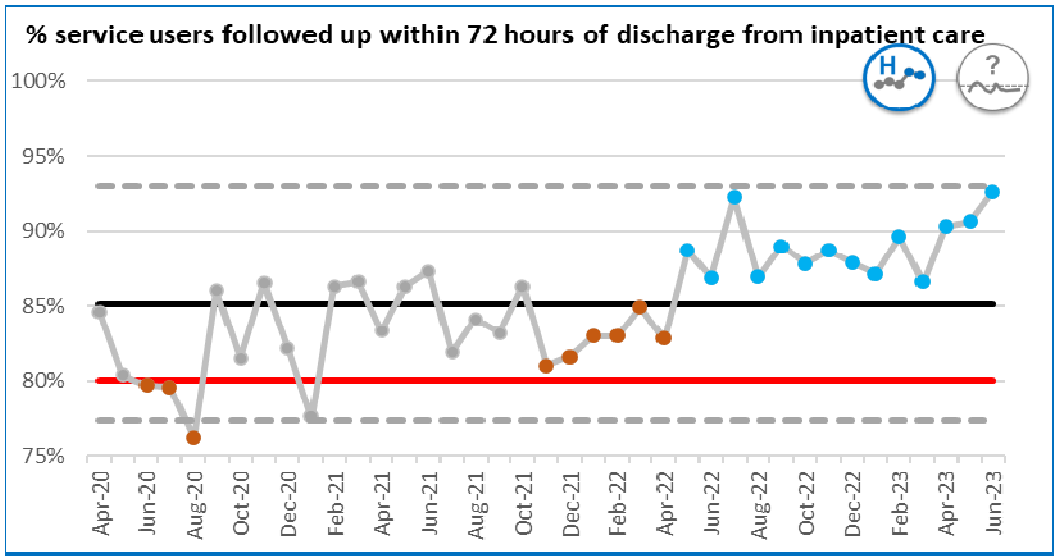




The statistical process control charts (SPC) above show that in June 2023 we remain in a period of common cause variation regarding the number of beds days for children and young people in adult wards. After consecutive periods of improvement against the referral to treatment metric we remain in a period of special cause improving variation in June 2023 and we are expected to meet the target.

Analysis





The SPC charts above show that for June 2023 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.

Current average OPEL level

2.78

Key

OPEL Level 1
OPEL Level 2
OPEL Level 3
OPEL Level 4

Mental Health Community (Including Barnsley Mental Health Services)

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	75.1%	76.6%	
% Assessed within 14 days of referral (Routine)	75%	68.6%	80.5%	
% Assessed within 4 hours (Crisis)	90%	97.5%	95.7%	
% Complaints with staff attitude as an issue	< 20%	0% (0/5)	38% (3/8)	
% service users followed up within 72 hours of discharge from inpatient care	80%	90.6%	92.6%	
% Service Users on CPA with a formal review within the previous 12 months	95%	98.5%	97.3%	
% Treated within 6 weeks of assessment (routine)	70%	98.0%	94.7%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.1%	80.5%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	92.9%	*92.3%*	
Information Governance training compliance	>=95%	97.1%	98.1%	
Reducing restrictive practice interventions training compliance	>=80%	69.5%	72.6%	
Sickness rate (Monthly)	4.5%	5.0%	3.8%	
% rosters locked down in 6 weeks				

Barnsley General Community Services

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	79.6%	81.5%	
% Complaints with staff attitude as an issue	< 20%	33% (1/3)	0% (0/1)	
% people dying in a place of their choosing	80%	92.1%	87.8%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.7%	85.2%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	
Information Governance training compliance	>=95%	95.3%	96.2%	
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	98.9%	99.6%	
Maximum 6 week wait for diagnostic procedures	99%	53.3%	82.5%	
Reducing restrictive practice interventions training compliance	>=80%	50.0%	57.1%	
Safer staffing (inpatient)	90%	114.0%	114.4%	
Sickness rate (Monthly)	4.5%	4.3%	4.6%	
% rosters locked down in 6 weeks				

Mental Health Inpatient

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	52.3%	61.9%	
% Bed occupancy	85%	88.7%	87.2%	
% Complaints with staff attitude as an issue	< 20%	20% (1/5)	0% (0/5)	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.7%	75.6%	
% of clients clinically ready for discharge	3.5%	2.9%	6.8%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	87.7%	*86.7%*	
Inappropriate Out of Area Bed days	152	574	441	
Information Governance training compliance	>=95%	94.3%	94.5%	
Physical Violence (Patient on Patient)	Trend Monitor	23	22	
Physical Violence (Patient on Staff)	Trend Monitor	42	57	
Reducing restrictive practice interventions training compliance	>=80%	79.9%	81.8%	
Restraint incidents	Trend Monitor	111	***114***	
Safer staffing	90%	128.1%	127.8%	
Sickness rate (Monthly)	4.5%	4.2%	4.2%	
% rosters locked down in 6 weeks				

Forensic

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	69.3%	72.7%	
% Bed occupancy	90%	87.8%	83.9%	
% Complaints 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%	96.3%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.1%	81.4%	
% of clients clinically ready for discharge	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%	95.2%	95.6%	
Physical Violence (Patient on Patient)	Trend Monitor	3	1	
Physical Violence (Patient on Staff)	Trend Monitor	18	12	
Reducing restrictive practice interventions training compliance	>=80%	83.6%	84.0%	
Restraint incidents	Trend Monitor	37	***26***	
Safer staffing	90%	113.5%	115.4%	
Sickness rate (Monthly)	5.4%	6.9%	7.9%	
% rosters locked down in 6 weeks				

LD, ADHD & ASD

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	72.1%	69.5%	
% Complaints with staff attitude as an issue	< 20%	0% (0/3)	0% (0/2)	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	50.0%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.6%	85.8%	
% of clients clinically ready for discharge	3.5%	25.0%	25.0%	
Information Governance training compliance	>=95%	94.2%	95.4%	
LD – First face to face contact within 18 weeks	90%	78.5%		
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	33	39	
Reducing restrictive practice interventions training compliance	>=80%	78.6%	80.8%	
Safer staffing	90%	143.2%	144.7%	
Sickness rate (Monthly)	4.5%	5.2%	5.0%	
Restraint incidents	Trend Monitor	31	***26***	
% rosters locked down in 6 weeks				

CAMHS

Metrics	Threshold	May-23	Jun-23	Variation/ Assurance
% Appraisal rate	>=90%	80.5%	76.6%	
% Complaints with staff attitude as an issue	< 20%	0% (0/3)	0% (0/2)	
CAMHS - Crisis Response 4 hours	N/A	97.1%	95.3%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.3%	80.1%	
Eating Disorder - Routine clock stops	95%	89.5%	100.0%	
Eating Disorder - Urgent/Emergency clock stops	95%	80.0%	N/A	
Information Governance training compliance	>=95%	96.7%	96.7%	
Reducing restrictive practice interventions training compliance	>=80%	72.2%	76.6%	
Sickness rate (Monthly)	4.5%	3.2%	4.6%	
% rosters locked down in 6 weeks				

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

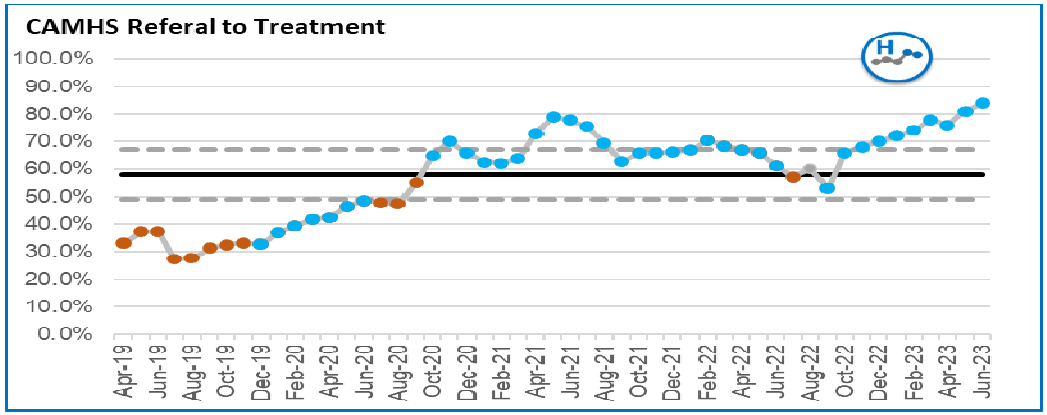
• Waiting numbers for Autistic Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. Robust action plans are in place (with Transformation Programme support) but the shortfall between commissioned capacity and demand remains.
• Eating disorder caseloads remain under pressure due to case acuity/complexity.
• There are ongoing issues with shortage of specialist residential and tier 4 places due to reduced capacity nationally and ongoing capacity issues locally. This is noted on the Trust risk register and work continues to improve patient flow.
• The focus on maintaining staffing levels in Wetherby Young Offenders Institution and Adel Beck secure children's home continues due to specific issues in relation to recruitment of band 6 nursing staff.
• Self-harm incidents/risk are a key focus of improvement work at Wetherby Youth offender institute.

Advise

• Waiting times from referral to treatment in Wakefield remain an outlier. Referral rates remain a key factor. The brief intervention and group work service offer has been strengthened, and medium term improvement is anticipated. Additional mental health support team investment has been confirmed which will enable further strengthening of the schools-based offer.
• Work in Kirklees continues as part of a Kirklees Keep in Mind programme to develop the mental health support team offer across all local schools/colleges.
• A business case is being developed in Barnsley with respect to the specialist support offer for children with learning disabilities/special educational needs.
• A work programme is underway to ensure more seamless transition to adult ADHD/ASC pathways.
• Friends and family test results are above threshold at 80%.

Assure

• Staff wellbeing remains a focus. Each CAMHS team has an agreed action place in place as a direct response to the staff survey. Staff survey results generally positive across all teams. Sickness rates remain low.
• The Trust has proactively engaged with provider collaboratives in South Yorkshire and Bassetlaw and West Yorkshire to strengthen the interface with inpatient providers and improve access to specialist beds.



As you can see in June 2023, we remain in a period of special cause improving variation. For further information see narrative above.

Barnsley general community services:

Alert/Action

Health Integration Team Urban House:
• Due to vacancies, and challenges with recruitment, there is pressure on nurse prescribing within the service. There service is currently working with Pharmacy and the Walk in Centre in Wakefield, to provide cover for the service as necessary and one of the Band 6 staff within the service is to start the Independent Nurse Prescriber course in September 2023.
• Sickness absence is causing additional pressures in the team which has been supported by staff within General Community Services.
• Following the recent positive visit by the Integrated Care Board (ICB) Quality Team, and their suggestion of a resilience review in relation to staffing levels etc, we continue to explore how we can strengthen the capacity and skills within the team.

Advise

• Neighbourhood Nursing Service (NNS) Position Paper- the Service Director is to present at Operational Management Group (OMG) / Extended Management Team (EMT) in early July.
• Referral rates to Children's Therapy have remained high – the team continue to work on solutions to this.
• Children's Speech and Language Therapy – many schools are reducing their teaching assistant staffing which have an impact for services like ours which work in schools, and where school staff carry out programmes.

Health Integration Team Urban House (UH):
• The Commissioner is reviewing current health provision for the 6 resettlement programmes in Wakefield which includes Urban House.
• Wakefield Public Health Team have raised concerns regarding the increase in the incidence of measles both nationally and locally and were keen to ensure our staff had considered vaccination. This has been discussed with the team and we are working with Occupational Health/Infection Prevention & Control.

Barnsley general community services continued:

Assure

• Live Well Wakefield have been successful in being awarded the new contract together with NOVA. The contract is from 1st October 2023, and for 4 years initially.
• Yorkshire Smokefree have been asked to be first implementors in a new initiative through NHS England to give 1 million starter kit vapes in a Swap to Stop campaign. Commissioners and service managers are discussing the viability. Calderdale and Sheffield Services have declined the offer as both services already have vapes as an offer to their clients.
• There has been increased interest in vacancies advertised on NHS jobs – the vacancy factor is reducing in the Neighbourhood Nursing Service (NNS).
• There has been a recent successful recruitment drive for NNS Band 5 nurses, appointing 18 newly qualified staff nurses to commence Sept/Oct 23. 10 are currently undertaking their final placements within the teams in which they will take up their new post. There has also been successful recruitment to 5 newly qualified Band 6 District Nurses - all commence in post mid-July.
• Neighbourhood Rehabilitation Service (NRS) are commencing a pilot to extend therapy provision to support 2-hour crisis referrals. This means the service will extend their service provision from 6pm to 8pm. The pilot commenced from 10 July 2023 and will run for 4 weeks, followed by a review.
• Connecting Care Approach – we are working in partnership with Adult Social Care to strengthen integrated partnership working between health and social care colleagues. This work has commenced in the North-East neighbourhood before being rolled out across the other five neighbourhood areas.
• There has been a successful recruitment process for a 9-month secondment opportunity to an Operational Lead post for NNS.
• 18 new hand-held doppler kits have been distributed to all District Nursing Teams and community sisters.
• Children's Speech and Language Therapy – training resources are now available for course participants digitally. This is a green approach contributing to sustainability, and also saves administrative time.

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) services:

Alert/Action

• Referrals for both ADHD and Autism assessments remain higher than pre pandemic levels.
• Friend & Family Test - 50%. The service is continuing to explore different methods of collating feedback.

Advise

• There are no waiting lists for Autism assessments.
• The waiting list for ADHD continues to reduce for those people identified as medium and high-risk cases.

Assure

• All KPI targets met.
• All training is above the threshold.
• High 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 roll learning out to all localities. Training sessions are progressing well.
• Reducing Restrictive Practice 76.7% with action plan in place.
• Work to reduce sickness absence continues, with support provided by the People Directorate.

ATU (Assessment & Treatment Unit)
• The Horizon improvement programme continues to make progress. Improvements continue to embed and staff involvement, engagement and well-being remain a priority.
• Recruitment to posts which were previously shared posts (with Bradford) is progressing.
• Clinically ready for discharge - currently 25% and reflect system challenges in provision of bespoke packages of care to meet complex needs.

Advise

Community & ATU (Assessment & Treatment Unit)
• Community Improvement Programme is planned and will follow the same format as the Horizon plan.
• Events for Learning Disabilities Week went ahead and were well received.
• Appraisal currently 71.4%
• The service is working to address a potential service gap for people with an LD who require and ADHD assessment.
• Out of hours service currently being mobilised.

Assure

ATU (Assessment & Treatment Unit)
•Complaints 0%
•Friends and Family Test 100%

Community
• Waiting list mitigations have been developed including an early alert system which will help teams to potentially avoid delays in appointments.
• Annual health check completion across all 4 localities is continuing to improve.
• Wellbeing plans are in place for both Horizon and community

Forensic services:

Alert/Action

• Bed Occupancy – Newton Lodge 84.62↓, Bretton 95.33%↑, Newhaven 87.5%↓. Work continues to address occupancy, and to ensure this is maximised to reduce out of area placements.
• Sickness absence/covid absence – this remains above the care group target but has reduced to 6.9%.
• Vacancies & Turnover – Turnover has fallen to 8.5% which is an improved position. Recruitment & retention remains a priority and projections for the number of new starters looks positive.
• Care programme approach – 100%↑ which represents a significant improvement.
• CQC – full inspection took place mid may with 9 out of 11 wards being visited. Learning from the inspection is supported by quality improvement work led by the Quality and Governance Team.

Advise

• Regular meetings continue to transition Forensic Child and Adolescent Mental Health Services (FCAMHS) to a Provider Collaborative.
• Mandatory training overall compliance:
• Newton Lodge – 92%↑
• Bretton – 91%↑
• Newhaven –89.9↑
• The above figures represent the overall position for each service.
• 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.
• Appraisal (72.7%↑) and supervision remains a priority.
• The well-being of staff remains a priority within the service. The wellbeing group have reviewed the NHS survey results and developed an action plan identifying 3 key areas to focus on. There is a strong level of engagement within the Care Group.

Assure

• High levels of Data Quality across the Care Group (100%).
• 100% compliance for HCR20 being completed within 3 months of admission.
• Friends and Family 100%
• All Equality Impact Assessments across forensic services have been completed for 23/24.

Adults and Older People mental health:

Alert/Action

• Acute wards have continued to manage high levels of acuity.
• There is high occupancy levels across wards and capacity to meet demand for beds remains challenging.
• Workforce challenges have continued with increased use of agency staff.
• The work to maintain effective patient flow continues, with the use of out of area beds being closely managed.
• 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, underpinned by the work on the 100 Day Discharge Challenge.
• Demand into the Single Point of Access (SPA) and capacity issues have led to ongoing pressures in the service, compounded by workforce challenges.
• 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 and is still considerably below target performance in Barnsley. Calderdale and Kirklees, although still slightly below target, has continued to demonstrate significant improvement this month. Action plans remain in place, with specific improvement work taking place in Barnsley.
• Rapid improvement work in SPAs together with some progress in recruitment should contribute to an improved performance in the coming months.
• 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. We continue to be proactive and innovative in approaches to recruitment and workforce modelling.
• All areas are focussing on continuing to improve performance for FIRM risk assessments, and performance is showing some progress in all areas for those on CPA who have had a staying-well plan within 7 days and those who have had a formulation within 7 days against trajectory. Inpatient performance for those admitted who have had a staying-well plan within 24 hours is working towards achieving and sustaining improvement against trajectory.
• 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, action plans and support from Quality and Governance Leads remain in place.

Advise

• Senior leadership from matrons and general managers remains in place across 7 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 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 for acute inpatient wards we are committed to a trajectory of all appraisals being completed by mid July.
• We are looking at our performance regarding Friends and Family Tests both in content of responses and numbers completed and developing actions to improve, with all areas now above threshold other than Barnsley where significant improvement has taken place.
• We continue to work towards required concordance levels for CPR 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

• We are performing well in gatekeeping admissions to our inpatient beds.
• We are performing well in 72 hour follow up for all people discharged into the community.
• Our Business Support Manager for Calderdale and Kirklees has led on the successful re-accreditation process for our One Year Review as a Veteran Aware Trust.

Overall Financial Performance 2023/24

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast 2023/24	Narrative
1	Surplus / (Deficit)	£1m	£0m	The plan for June 2023 was an increased surplus relating to the timing for Low Value Activity (LVA - as set nationally) income. A surplus of £0.9m has been achieved in month which is in line with plan. The year to date position is a surplus of £1.0m which is £0.3m behind plan. Recovery plans are being developed and the forecast remains that a breakeven position can be achieved in year which is in line with target.
2	Agency Spend	£2.8m	£10.3m	In line with national, and ICB, targets Trust agency spend for 2023 / 24 is planned to reduce from £10.0m to £8.7m. Spend in June is £1,002k which is an increased run rate and the year to date position is 19% above the plan trajectory.
3	Financial sustainability and efficiencies	£1.8m	£12m	The Trust financial plan includes a sustainability programme totalling £12.0m and is directly linked to the Trust priority of spending money wisely. Individual performance is provided within the report. This target remains challenging.
4	Cash	£82.1m	£76.9m	The Trust cash position remains strong at £82.1m; this is higher than plan. This has always been maximised however the current interest rates provide additional financial incentive.
5	Capital	£1m	£8.8m	The capital programme is made up of 2 elements. Key performance is monitored against the ICB capital allocation and excludes the impact of IFRS 16 (leases). The detail is shown within the full report. To date expenditure is £1.0m with significant progress made on the door replacement programme.
6	Better Payment Practice Code	96%		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 -

ICB Board meeting and minutes :: South Yorkshire ICB

The Trust is trying to establish a feed of data of applicable key performance indicators for each of the integrated care boards.

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 3 (2023 / 24)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

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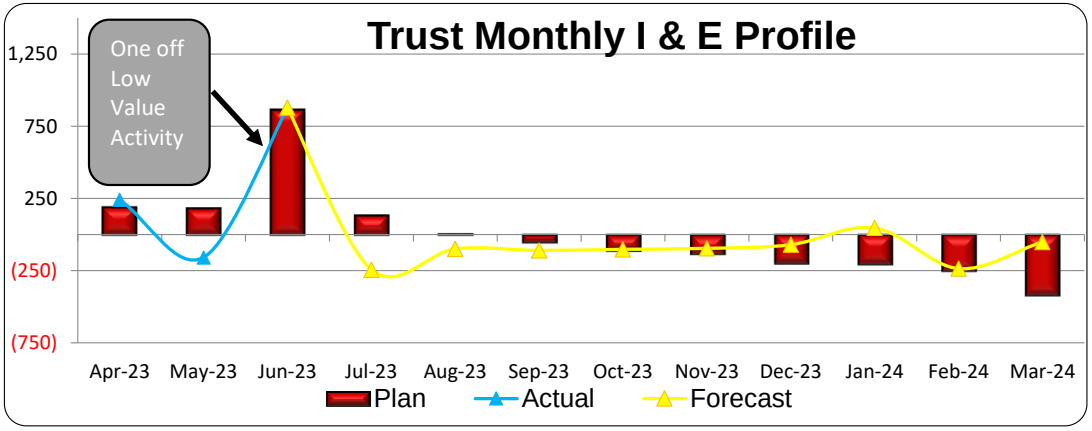
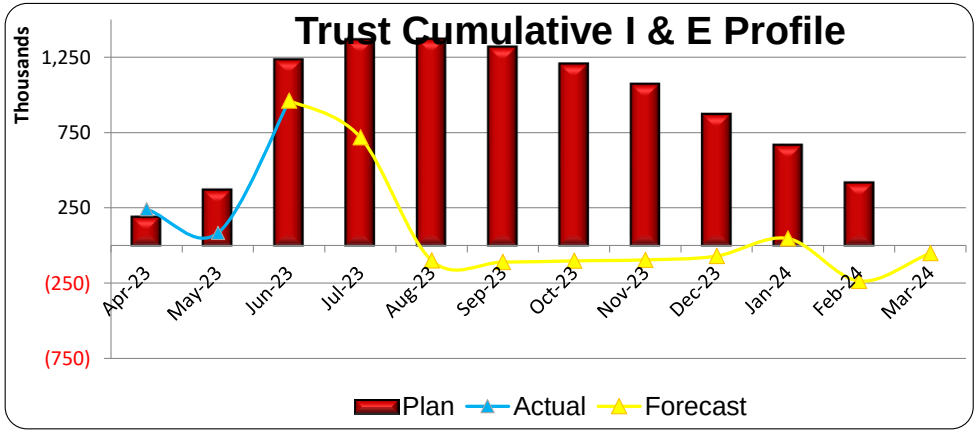
2.0 Income & Expenditure Position 2023 / 24

The table below presents the total consolidated financial position for South West Yorkshire Partnership NHS Foundation Trust. This incorporates it's role as co-ordinating provider for a number of Mental Health Provider Collaboratives but excludes it's linked charities which are consolidated into the Trust's group annual accounts. The impact of the Provider Collaboratives is highlighted separately within this report.

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	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
Healthcare contracts					34,051	34,228	177	97,740	98,140	400	388,630	390,547	1,917
Other Operating Revenue					1,199	1,202	3	3,267	3,315	47	13,187	12,720	(467)
Total Revenue					**35,250**	**35,430**	**180**	**101,007**	**101,454**	**447**	**401,817**	**403,267**	**1,450**
Pay Costs	4,830	4,803	(27)	0.6%	(20,332)	(20,495)	(163)	(60,199)	(60,101)	98	(243,739)	(243,291)	448
Non Pay Costs					(13,613)	(13,685)	(72)	(38,253)	(39,231)	(978)	(153,051)	(155,515)	(2,464)
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,830**	**4,803**	**(27)**	**0.6%**	**(33,945)**	**(34,181)**	**(235)**	**(98,452)**	**(99,332)**	**(880)**	**(396,790)**	**(398,806)**	**(2,016)**
EBITDA	**4,830**	**4,803**	**(27)**	**0.6%**	**1,304**	**1,249**	**(55)**	**2,556**	**2,123**	**(433)**	**5,027**	**4,462**	**(565)**
Depreciation					(518)	(517)	1	(1,553)	(1,551)	2	(5,949)	(5,940)	8
PDC Paid					(179)	(179)	0	(537)	(537)	0	(2,148)	(2,148)	0
Interest Received					252	326	74	764	927	163	3,070	3,627	557
Surplus / (Deficit) - ICB performance measure	**4,830**	**4,803**	**(27)**	**0.6%**	**860**	**879**	**19**	**1,230**	**962**	**(268)**	**0**	**(0)**	**(0)**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(58)	(58)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,830**	**4,803**	**(27)**	**0.6%**	**860**	**860**	**(0)**	**1,230**	**904**	**(326)**	**0**	**(232)**	**(232)**





2.0 Income & Expenditure Position 2023 / 24

The position of South West Yorkshire Partnership NHS Foundation Trust, excluding the financial impact of Provider Collaboratives, is shown below. The movement between the total financial position and the total excluding the collaboratives is reconciled below for ease.

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	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
Healthcare contracts					25,577	25,476	(101)	72,808	72,552	(256)	288,901	288,944	44
Other Operating Revenue					1,199	1,202	3	3,267	3,315	47	13,187	12,720	(467)
Total Revenue					**26,776**	**26,677**	**(98)**	**76,075**	**75,866**	**(209)**	**302,088**	**301,665**	**(423)**
Pay Costs	4,810	4,769	(40)	0.8%	(20,206)	(20,272)	(66)	(59,819)	(59,525)	295	(242,257)	(240,891)	1,366
Non Pay Costs					(5,249)	(5,063)	185	(13,650)	(14,258)	(608)	(54,636)	(56,057)	(1,421)
Gain / (loss) on disposal					0	0	0	0	0	0	0	0	0
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,810**	**4,769**	**(40)**	**0.8%**	**(25,454)**	**(25,335)**	**119**	**(73,469)**	**(73,782)**	**(313)**	**(296,893)**	**(296,948)**	**(55)**
EBITDA	**4,810**	**4,769**	**(40)**	**0.8%**	**1,321**	**1,342**	**21**	**2,606**	**2,084**	**(522)**	**5,194**	**4,716**	**(478)**
Depreciation					(518)	(517)	1	(1,553)	(1,551)	2	(5,949)	(5,940)	8
PDC Paid					(179)	(179)	0	(537)	(537)	0	(2,148)	(2,148)	0
Interest Received					252	326	74	764	927	163	3,070	3,627	557
Surplus / (Deficit) - ICB performance measure	**4,810**	**4,769**	**(40)**	**0.8%**	**877**	**972**	**95**	**1,281**	**924**	**(357)**	**168**	**255**	**87**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(58)	(58)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,810**	**4,769**	**(40)**	**0.8%**	**877**	**953**	**76**	**1,281**	**866**	**(415)**	**168**	**23**	**(144)**

To help with clarity on the position of the provider collaboratives a summary between the two tables is shown below. The individual analysis within the remainder of this report highlights the Trust only values. The collaborative financial performance is reported separately.

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	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
Total Trust Position	4,830	4,803	(27)	0.6%	860	879	19	1,230	962	(268)	0	(0)	(0)
Provider Collaboratives	20	33	14	67.9%	(17)	(93)	(76)	(51)	38	89	(168)	(255)	(87)
Total excluding Collaboratives (as shown above)	**4,810**	**4,769**	**(40)**	**0**	**877**	**972**	**95**	**1,281**	**924**	**(357)**	**168**	**255**	**87**

Income & Expenditure Position 2022 / 23

June 2023, excluding the financial impact of the provider collaboratives, is a surplus of £1.0m. This is £95k better than plan.

The Trust revised financial plan, submitted May 2023, is a breakeven position. This is profiled with a surplus in the first months of the year which reduces in line with Trust workforce, recruitment and retention assumptions. Cost reductions are profiled later in the year which help to reduce the impact of cost increases. The plan included an assumed pay award at 2% and related uplifts to commissioner tariff. The revised pay offer, and gap compared to commissioner income uplifts, presents a significant financial pressure to this plan position.

NHS England - monthly submission

The financial performance reported here is consistent with the monthly return made to NHS England and also to that reported into the West Yorkshire Integrated Care Board (ICB). The corresponding declaration is made within the return itself.

Income

The majority of income continues to be received through block payment arrangements with any variances to plan agreed by exception. Payment has been received from commissioners in June 2023 for the Agenda For Change pay award uplift; this was already reflected in budgets from month 2.

Pay

Agenda For Change pay awards, relating to 2022 / 23 (for which an estimate was made in the last financial year) and 2023 / 24, were paid in June 2023. For the year to date expenditure is broadly in line with plan although this is modelled to move to an underspend position in year with workforce growth forecast to be behind that included in the plan (although still growing).

In June 2023 there has been a reduction in sustantive worked WTE although this has been offset by increases in bank and agency resulting in an overall reduction of 1. This supports the assumptions included in the forecast position.

Recruitment and retention workstreams continue, including continued overseas recruitment for nursing and other professions.

Non Pay

The non pay analysis highlights that most categories are overspent against plan. The largest is the purchase of healthcare category with operational pressures presenting as out of area placements and other costs. Work continues to assess how much of this is due to inflationary pressures, increased usage or other reasons.

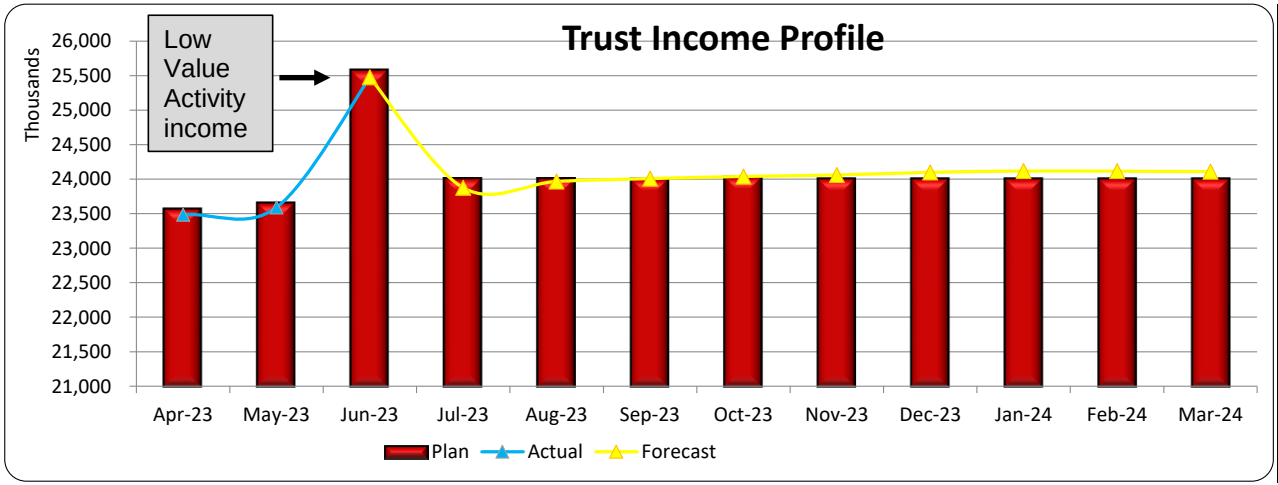
2.1 Income Information

The Trust Income and Expenditure position separately identifies clinical revenue and other revenue received as part of these significant contracts as a result of the post covid-19 financial architecture. These contracts are historically those to provide healthcare services as the purpose of this Trust. This does not include other income which the Trust receives such as contributions to training, staff recharges and catering income. This is reported as other operating income.

This excludes the income received for the commissioning role as co-ordinating provider for mental health collaboratives. This is reported separately.

The vast majority of income continues to be received from local commissioners (formerly CCGs, now Integrated Care Boards (ICBs)) and NHS England.

Income source	Apr-23 £k	May-23 £k	Jun-23 £k	Jul-23 £k	Aug-23 £k	Sep-23 £k	Oct-23 £k	Nov-23 £k	Dec-23 £k	Jan-24 £k	Feb-24 £k	Mar-24 £k	Total £k	Total 22/23 £k
NHS Commissioners	19,533	19,642	21,396	19,980	19,984	19,958	19,968	19,990	19,972	19,973	19,971	19,964	**240,331**	**220,257**
ICS / System / Covid	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**6,243**
Specialist Commissioner	2,752	2,753	2,881	2,794	2,794	2,761	2,761	2,761	2,761	2,761	2,761	2,762	**33,303**	**4,069**
Pay Award	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**9,058**
Local Authority	490	516	510	504	509	509	505	505	505	523	523	523	**6,122**	**5,311**
Partnerships	514	584	546	454	537	637	662	662	720	720	720	720	**7,474**	**5,052**
Other Contract Income	197	96	144	143	143	143	143	143	141	141	141	141	**1,715**	**2,256**
Total	**23,486**	**23,590**	**25,476**	**23,875**	**23,967**	**24,008**	**24,040**	**24,061**	**24,099**	**24,117**	**24,115**	**24,109**	**288,944**	**252,245**
2022 / 23	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**	



Contracts for 2023 / 24 with main commissioners are continuing to progress towards signature in line with national guidance. These, including the financial elements, will be updated to incorporate the revised Agenda For Change pay award and any future medical pay award. For 2023 / 24 this will flow as an uplift to commissioner tariff. Arrears relating to 2022 / 23 were paid directly by NHS England.

Additional income has been received, as planned, in June 2023 relating to the one off payment for low value activity (LVA). These values are calculated nationally and are recevied as a single payment from individual non local ICB's.

Overall income is in line with plan. Financial, and operational, risks will continue to be assessed including CQUIN performance.

2.2 Pay Information

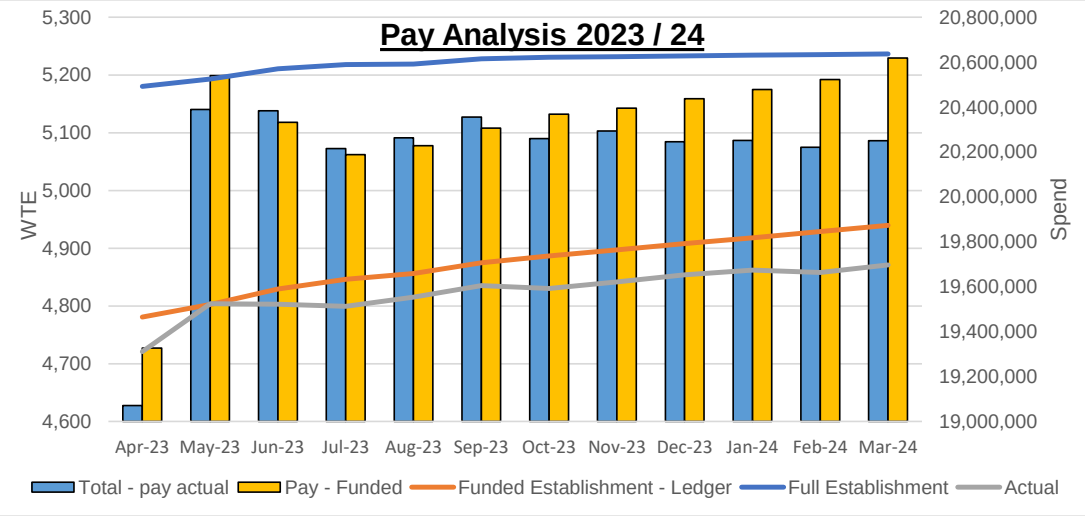
Our workforce is our greatest asset, and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities 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-23 £k	May-23 £k	Jun-23 £k	Jul-23 £k	Aug-23 £k	Sep-23 £k	Oct-23 £k	Nov-23 £k	Dec-23 £k	Jan-24 £k	Feb-24 £k	Mar-24 £k	Total £k
Substantive	17,160	18,043	17,933	17,967	18,020	18,141	18,073	18,119	18,105	18,127	18,114	18,130	**215,931**
Bank & Locum	849	1,355	1,337	1,222	1,255	1,249	1,241	1,237	1,231	1,226	1,228	1,251	**14,681**
Agency	939	908	1,002	917	878	856	835	828	800	789	770	759	**10,279**
Total	**18,947**	**20,306**	**20,272**	**20,106**	**20,153**	**20,246**	**20,149**	**20,183**	**20,136**	**20,142**	**20,111**	**20,140**	**240,891**
22/23	17,397	18,201	17,728	18,510	17,937	20,464	18,972	18,425	17,828	16,905	19,719	18,889	**220,976**

Bank as % (in month)	4.5%	6.7%	6.6%	6.1%	6.2%	6.2%	6.2%	6.1%	6.1%	6.1%	6.1%	6.2%	6.1%
Agency as % (in month)	5.0%	4.5%	4.9%	4.6%	4.4%	4.2%	4.1%	4.1%	4.0%	3.9%	3.8%	3.8%	4.3%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,343	4,329	4,312	4,342	4,358	4,382	4,383	4,398	4,411	4,424	4,420	4,429	**4,378**
Bank & Locum	222	314	326	296	302	301	299	297	297	296	297	301	**296**
Agency	157	161	164	161	155	152	148	147	146	142	141	140	**151**
Total	**4,721**	**4,804**	**4,803**	**4,799**	**4,815**	**4,835**	**4,830**	**4,842**	**4,854**	**4,862**	**4,858**	**4,871**	**4,825**
22/23	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**



The Agenda for Change pay award, both 2022 / 23 additional and 2023 / 24 year to date values, have been paid in June 2023. An accrual had been made for the 2022 / 23 element and therefore there is no financial impact shown here. Budgets were updated for the revised 2023 / 24 uplift in May 2023.

Overall expenditure, and worked WTE, are similar to last month although there has been an increase in temporary staffing offset by a reduction in susbtantive worked WTE.

The Trust workforce plan included a profile of increasing WTE worked, shown by the orange line. In June this is 27 less than plan and the forecast is that this will remain less than plan for the remainder of the year although will continue to see a general trend of increase.

2.2 Agency Expenditure Focus

Agency spend is £1,002k in June. Spend in 2022 / 23 was £10.0m with an average run rate of £834k.

Agency costs have a continued focus for the NHS nationally and for the Trust. As such separate headline analysis of agency trends, pressure areas and actions are presented below.

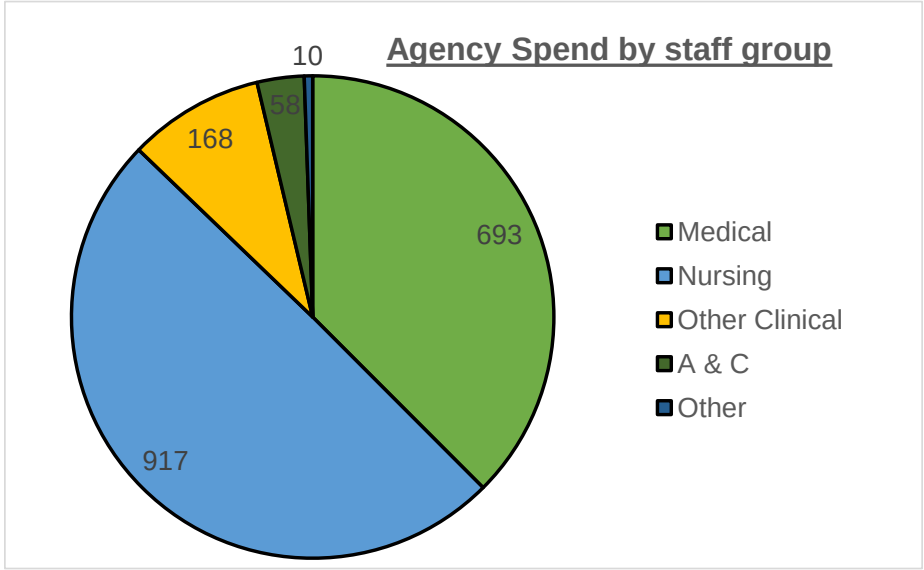
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

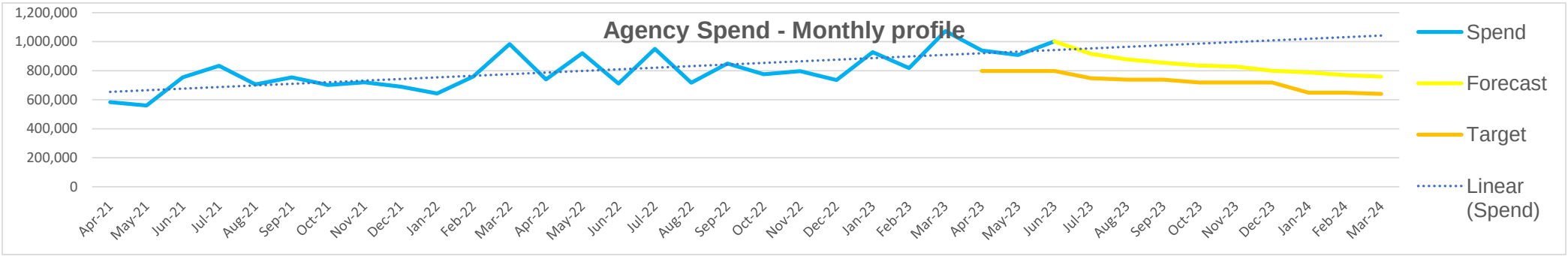
Under the NHS Single Oversight Framework expected maximum agency levels have been set for 2023 / 24. The Trust planned for delivery of this target at £8.7m. This represents a £1.3m reduction from expenditure incurred in 2022 / 23.

The Trust agency scrutiny and management group continues to provide oversight ensuring that Trust processes are followed and agency spend is appropriate and minimised. The Trust will continue to assess need based upon safety, quality and financial implications.

June 2023 spend is £1,002k which, as shown by the graph below, is higher than target. The current modelled trajectory has some reductions, as shown by the yellow line, but this is above target for each month.

As shown by the pie chart nursing staff (registered and unregistered) is the largest single category. This remains focussed in inpatient (both adult acute and older peoples) and Forensic services.



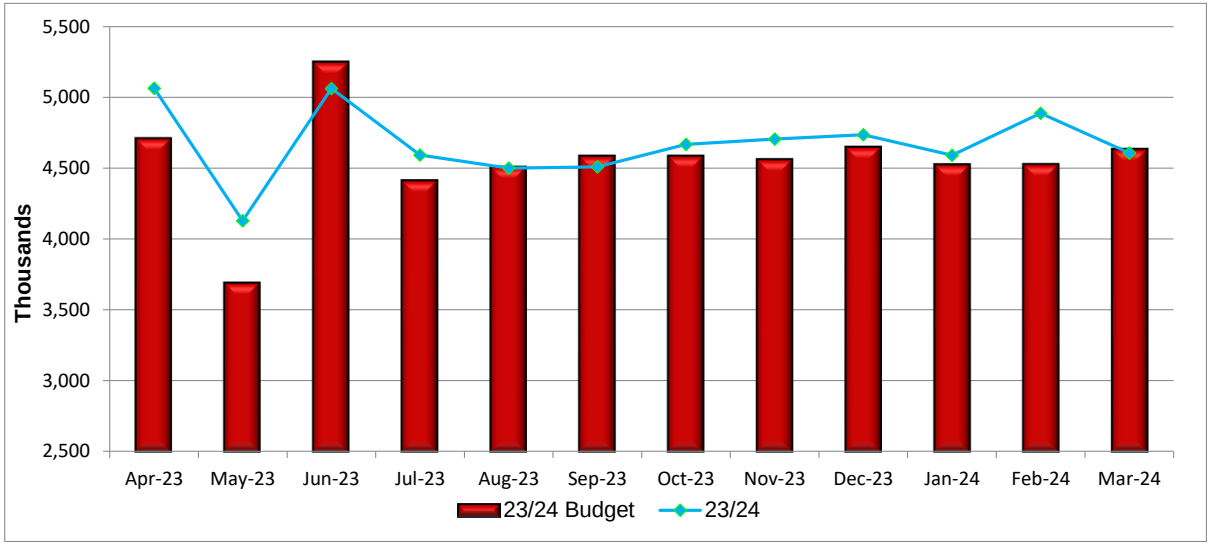


2.3 Non Pay Expenditure

Whilst pay expenditure is the majority of 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. This also excludes expenditure relating to the provider collaboratives.

Non pay spend	Apr-23 £k	May-23 £k	Jun-23 £k	Jul-23 £k	Aug-23 £k	Sep-23 £k	Oct-23 £k	Nov-23 £k	Dec-23 £k	Jan-24 £k	Feb-24 £k	Mar-24 £k	Total £k
2023/24	5,066	4,128	5,063	4,593	4,501	4,509	4,668	4,705	4,736	4,591	4,888	4,608	**56,057**
2022/23	4,213	4,350	4,271	4,080	4,917	4,694	4,130	4,767	4,010	7,142	4,797	6,931	**58,303**

Non Pay Category (per accounts)	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	1,025	934	(91)
Establishment	2,177	2,275	98
Lease & Property Rental	2,179	2,114	(65)
Premises (inc. rates)	1,343	1,448	105
Utilities	566	620	54
Purchase of Healthcare	2,351	2,747	396
Travel & vehicles	1,203	1,247	45
Supplies & Services	1,709	1,727	19
Training & Education	410	456	46
Clinical Negligence & Insurance	197	197	(0)
Other non pay	490	492	2
Total	**13,650**	**14,258**	**608**
Total Excl OOA and Drugs	**10,273**	**10,576**	**303**



Key Messages

Non pay expenditure budgets were reset for 2023 / 24 based on historical trends and estimates of inflationary price increases. Budget adjustments, and alignments, continue as normal.

Overall the purchase of healthcare, which is traditionally an area of financial pressure and continues to be reported separately, is overspent against plan. This is an increase in June and the forecast reduction for the remainder of the year continues to present an operational and financial risk.

The majority of non pay expenditure categories are now showing as overspent for the year to date. Actions are being developed to be clear on the reasons for this (volume increases, inflationary pressures, decisions made) and responses will be con-ordinated through the re-established non pay review group.

Other non pay includes all other items not categorised into the above headings. Due to the nature of Trust expenditure this can be wide ranging. Where possible costs will be allocated into the main headings above which are in line with Trust Annual Accounts categorisation.

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. In this analysis this is Trust costs only and therefore excludes provider collaboratives.

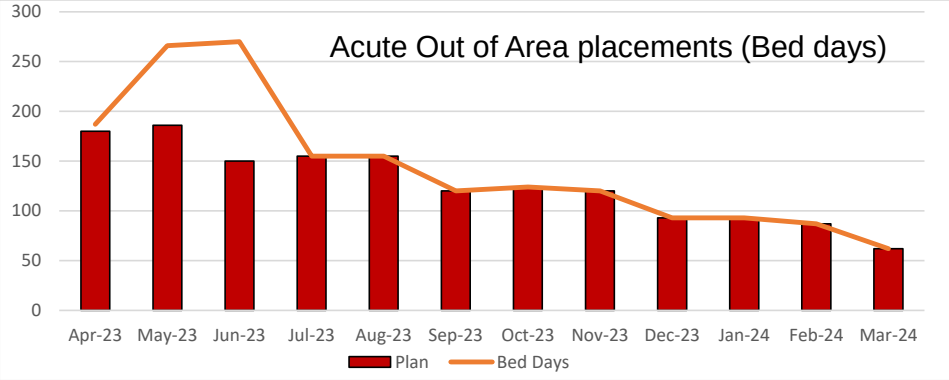
The largest value relates to out of area bed placements (split acute and PICU and the focus of this analysis) which can be volatile and expensive. The reasons for taking this action can be varied but can include:

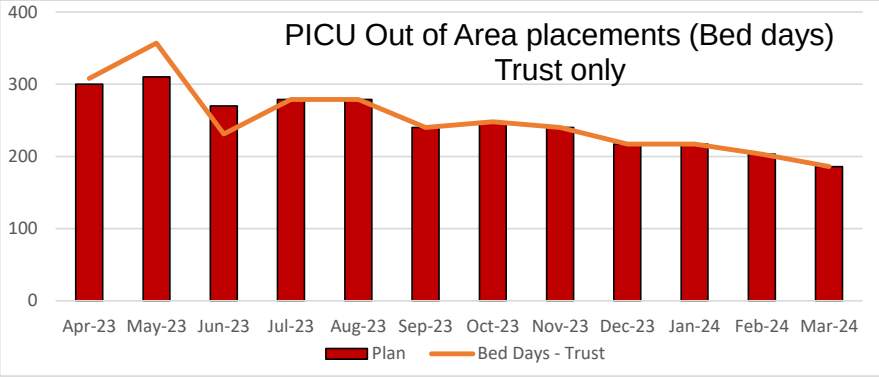
* Specialist health care requirements of the service user not directly available / commissioned within the Trust
* No current bed capacity to provide appropriate care

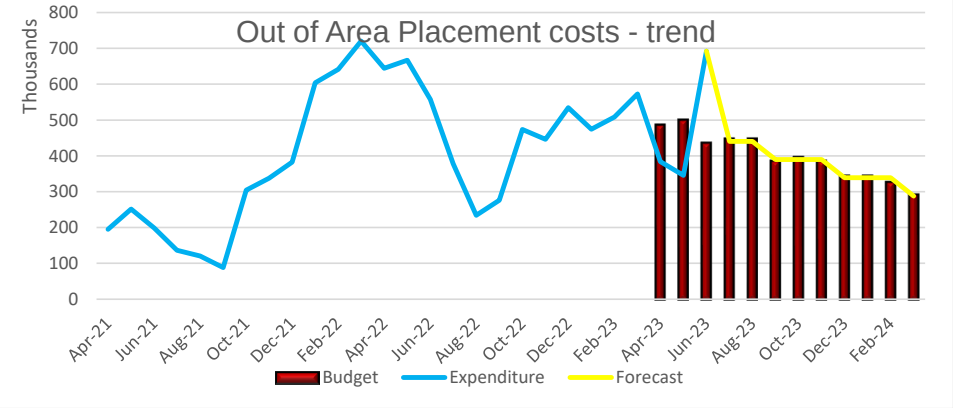
On such occassions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where possible service users are placed within the Trust geographical footprint.

Breakdown - Purchase of Healthcare

Heading	Budget Year to date £k	Actual Year to date £k	Variance £k
Out of Area			
Acute	395	595	200
PICU	997	808	(189)
Locked Rehab	571	661	91
Services - NHS	176	215	40
IAPT	44	164	120
Yorkshire Smokefree	21	9	(12)
Other	147	294	147
Total	**2,351**	**2,747**	**396**







Out of area bed placements continues to be a Trust priority programme to address the operational and financial pressures that this causes.

The graph to the left highlights the volatility of expenditure as the demand, and requirement for placements, changes.

Overall expenditure is broadly in line with plan although this has been shown as under in April and May and then over in June. This now includes all activity whilst discussions continue with a commissioner over which they are responsible for directly.

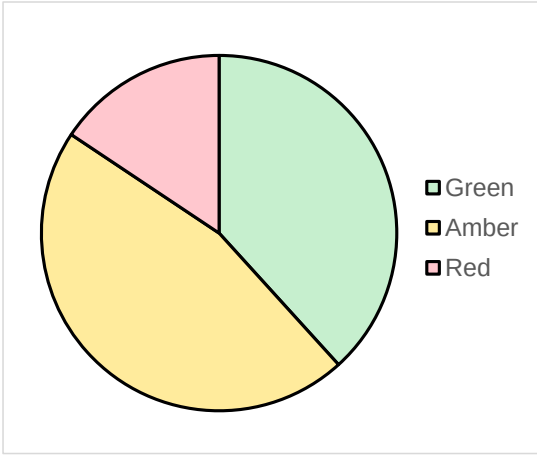
Acute activity is above plan, significantly in May and June, whilst PICU activity is under in June. Both assume that activity will be in line with the planned trajectory from July 2023 onwards. This assumption presents a

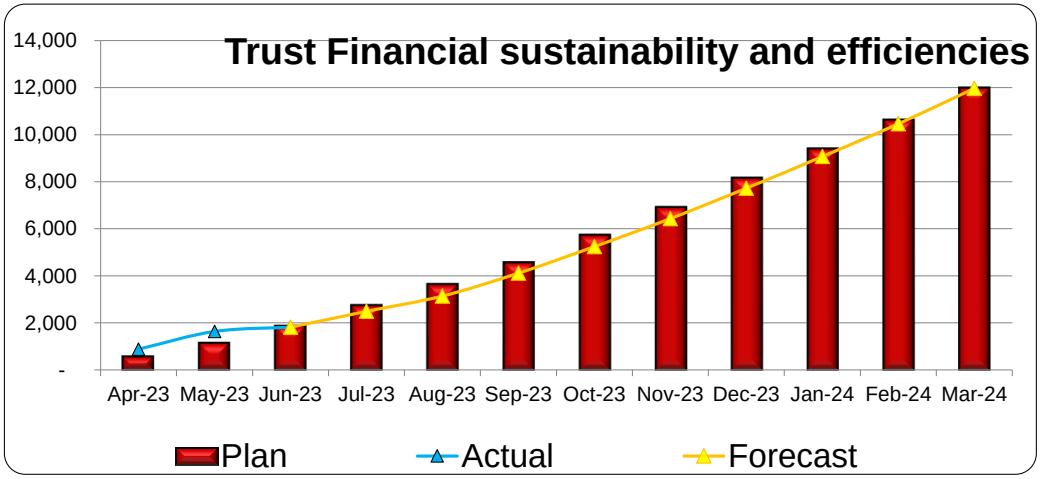
2.4 Value for Money, Financial sustainability and efficiency

The Trust financial plan includes a requirement to demonstrate financial sustainability and efficiency in order to achieve the financial target. This is both the current financial year and as part of the longer term financial plan where continual savings are required to safeguard long term financial sustainability. For 2023 / 24 a target of £11.96m has been identified and included within the plan.

This links closely with the Trust priority to improve the use of resources with a continual strive to ensure that services provide value for money and the best possible use of resources.

		Year to Date				Forecast			
Workstream Categorisation	**Breakdown**	**Target**	**Achieved Recurrent**	**Achieved Non Recurrent**	**Unachieved / Shortfall**	**Target**	**Green**	**Amber**	**Red**
Out of Area Placements	Pg. 10	436	436			3,197	436	2,761	
Agency & Workforce	Pg.	400	195	269		4,380	785	2,205	
Medicines optimisation		100	91			400	131		
Non Pay Review		188	0			1,048		550	1,872
Income contributions		126	47			500	227		
Interest Receivable	Pg. 4	350	513			1,400	1,957		
Provider Collaborative	Pg.	260	260			1,044	1,044		
Total		**1,859**	**1,543**	**269**	**0**	**11,969**	**4,580**	**5,517**	**1,872**
Recurrent		1,759	1,543			10,943	4,580	5,517	
Non Recurrent		100		269		1,026			1,872





Value for money performance for the year to date is £47k behind plan and further work, as highlighted by the pie chart showing the RAG rating of schemes, is required to ensure that the programme delivers in full and supports the delivery of the overall financial target.

Elements of this delivery, specifically those linked to workforce strategies, have been identified non recurrently and longer term recurrent mitigations will need to be secured.

Although workstreams are in place risks remain relating to reducing out of area placements, reduction of premium workforce payments and identification of new non pay cost reductions.

3.0 Statement of Financial Position (SOFP) 2023 / 24

Balance Sheet / Statement of Financial Position (SOFP)	2022 / 2023 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	165,175	170,168	1
Current Assets			
Inventories & Work in Progress	231	231	
NHS Trade Receivables (Debtors)	1,574	1,516	
Non NHS Trade Receivables (Debtors)	2,853	1,091	
Prepayments	3,482	3,554	
Accrued Income	9,372	2,959	2
Cash and Cash Equivalents	74,585	82,130	Pg 15
Total Current Assets	**92,097**	**91,481**	
Current Liabilities			
Trade Payables (Creditors)	(6,524)	(8,795)	3
Capital Payables (Creditors)	(739)	(487)	
Tax, NI, Pension Payables, PDC	(7,696)	(13,044)	4
Accruals	(32,952)	(26,633)	4
Deferred Income	(4,172)	(1,064)	
Other Liabilities (IFRS 16 / leases)	(51,979)	(57,545)	1
Total Current Liabilities	**(104,062)**	**(107,567)**	
Net Current Assets/Liabilities	**(11,965)**	**(16,085)**	
Total Assets less Current Liabilities	**153,210**	**154,082**	
Provisions for Liabilities	(4,319)	(4,255)	
Total Net Assets/(Liabilities)	**148,891**	**149,827**	
Taxpayers' Equity			
Public Dividend Capital	45,657	45,657	
Revaluation Reserve	14,026	14,026	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	83,988	84,892	
Total Taxpayers' Equity	**148,891**	**149,795**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2023.

1. Increase in lease / rental costs with effect from 1st April 2023 were higher than expected (and significant increases had already been included in the plan). This results in increases in both assets and liabilities.

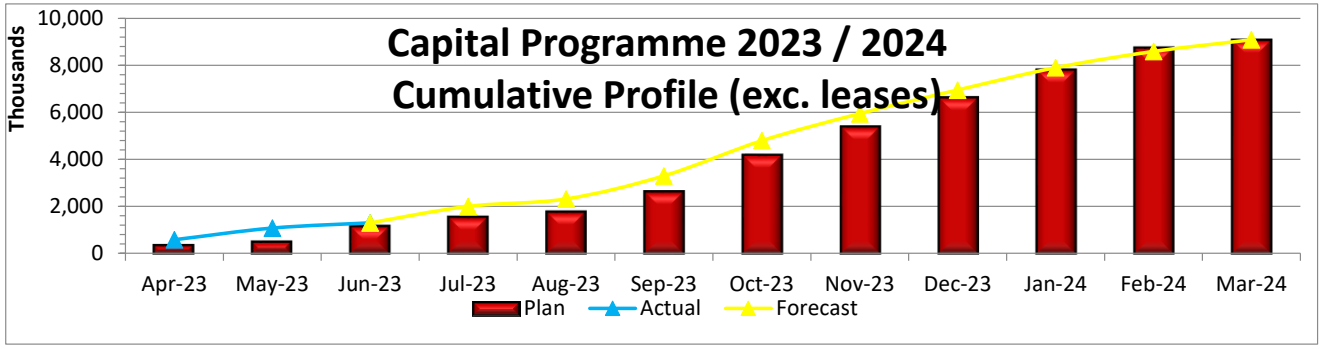
2. Accrued income reduced in month as the £9m from NHS England was paid. The remaining balance will be reviewed in month as the Trust aims to maximise cash.

3. Trade payables remain high, £4.4m relates to purchase orders receipted but not invoiced, this is expected to reduce in July.

4. Accruals have reduced in month as the pay award was paid in month. The only element outstanding of this is the Tax, NI and Pension which will be paid in July and is reflected in the cashflow forecast.

3.1 Capital Programme 2023 / 2024

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						
Site Infrastructure	1,475	0	0	0	1,475	0
Seclusion rooms	750	0	2	2	750	0
Maintenance (Minor) Capital						
Clinical Improvement	285	25	0	(25)	713	428
Safety inc. ligature & IPC	990	155	295	140	1,445	455
Compliance	430	300	0	(300)	200	(230)
Backlog maintenance	510	0	0	0	75	(435)
Sustainability	300	0	2	2	225	(75)
Plant & Equipment	40	0	0	0	45	5
Other	1,223	23	694	671	1,075	(148)
IM & T						
Digital Infrastructure	1,100	350	0	(350)	1,200	100
Digital Care Records	180	0	0	0	70	(110)
Digitally Enabled Workforce	815	35	0	(35)	815	1
Digitally Enabling Service Users & Carers	400	0	0	0	400	0
IM&T Other	270	0	0	0	280	10
TOTALS	**8,768**	**888**	**993**	**105**	**8,768**	**0**
Lease Impact (IFRS 16)	5,203	5,203	7,358	2,155	7,366	2,163
New lease	303	283	300	17	324	21
TOTALS	**14,274**	**6,374**	**8,651**	**2,277**	**16,457**	**2,183**



Capital Expenditure 2023 / 24

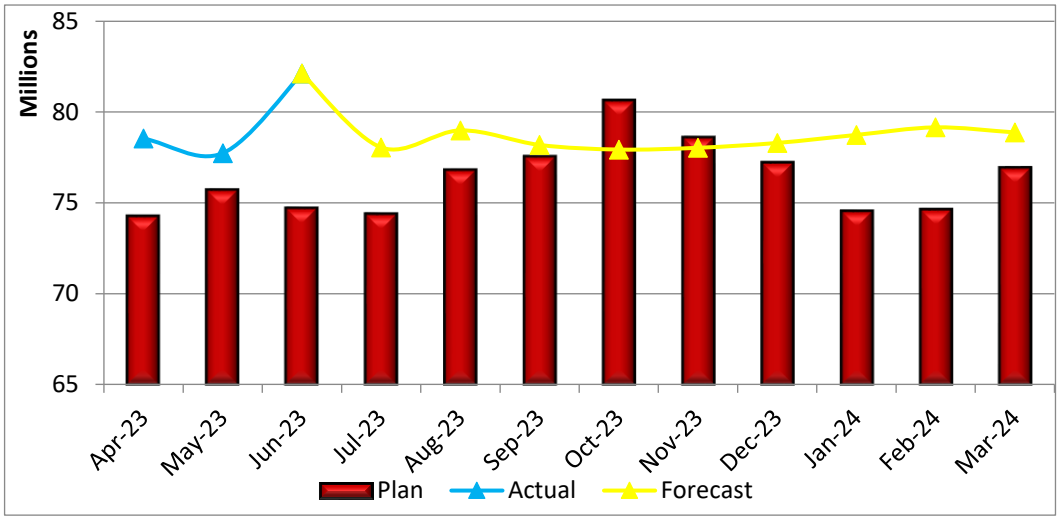
The Trust has continued to work within the West Yorkshire Integrated Care Board capital allocation in establishing it's capital programme for 2023 / 24. This totals £8,768k.

Changes, implemented under IFRS 16 (leases), mean that these costs are now included within the NHS England Capital Departmental Expenditure Limits (CDEL) but is separate from the ICB capital allocation so is presented below the line here.

Spend to date is ahead of plan. This relates to significant progress made on the door replacement programme and continued costs on 2022 / 23 schemes.

Major scheme and IM & T spend is profiled to commence later in the year.

3.2 Cash Flow & Cash Flow Forecast 2022 / 2023

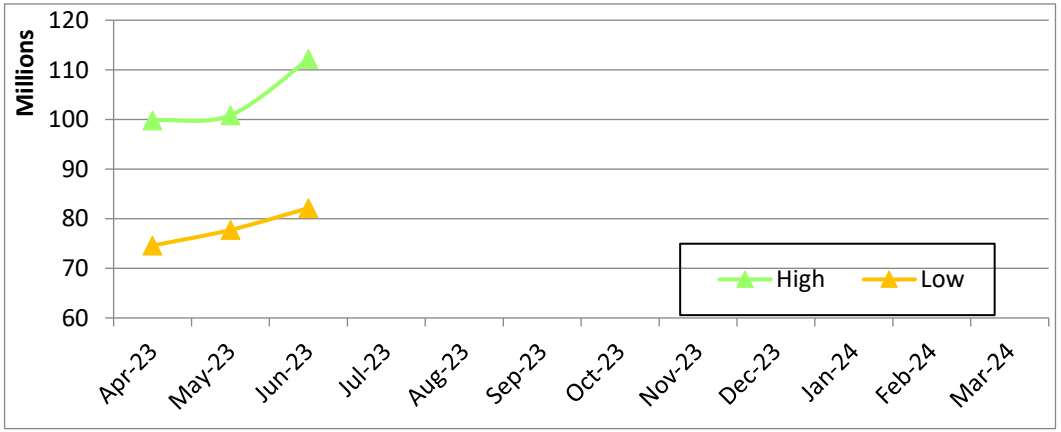


Cash remains healthy

Cash increased in month due to receiving the funding for the central pay award. The Tax / NI and pension elements of this are unpaid at the end of the month so represents the increase in cash in month.

The Trust is monitoring interest rates to assess the optium time to invest.

	Plan £k	Actual £k	Variance £k
Opening Balance	74,585	74,585	
Closing Balance	74,711	82,130	7,419



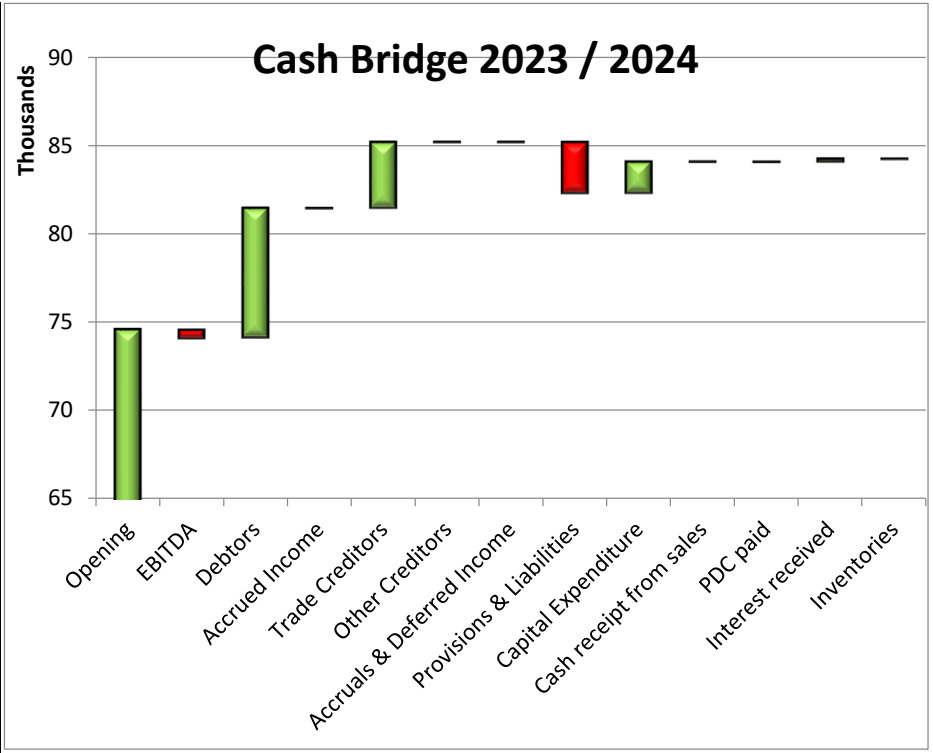
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £112.2m
The lowest balance is: £82.1m

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	**74,585**	**74,585**	0	
Surplus / Deficit (Exc. non-cash items & revaluation)	4,798	4,315	(483)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	455	7,805	7,350	
Trade Payables (Creditors)	(2,838)	892	3,730	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	(277)	(3,172)	(2,895)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(2,776)	(993)	1,783	
Cash receipts from asset sales	0	0	0	
Leases	0	(2,229)	(2,229)	
PDC Dividends paid	0		0	
PDC Dividends received	0		0	
Interest (paid)/ received	764	927	163	
Closing Balances	**74,711**	**82,130**	**7,419**	



The table above summarises the reasons for the movement in the Trust cash position during 2023 / 2024. This is also presented graphically within the cash bridge.

Cash is £7.4m higher than plan, the main drivers are creditors (where NHS invoices have been delayed at the start of the year) offset by a movement in deferred income linked to the adult secure collaborative.

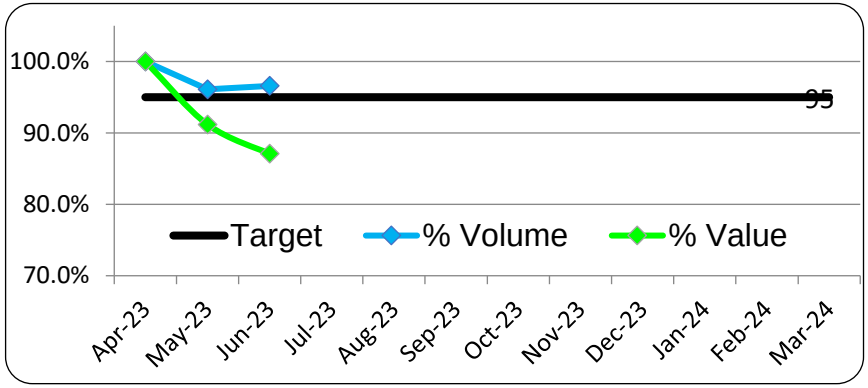
4.0 Better Payment Practice Code

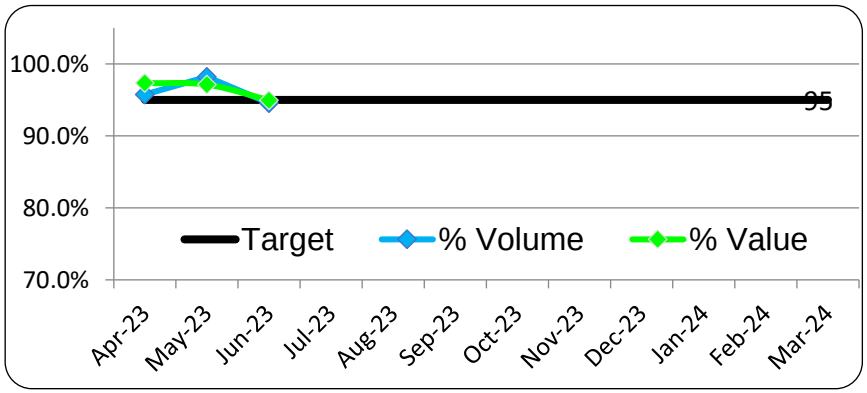
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently. NHS performance by value is on a downward trend, due to the low number of invoices received one large invoice failing can significantly affect this metric. The team will target this area to improve over the next quarter.

NHS	Number %	Value %
In Month	97%	87%
Cumulative Year to Date	97%	93%

Non NHS	Number %	Value %
In Month	95%	95%
Cumulative Year to Date	96%	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 (£)
15-Jun-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4979	834,073
26-Jun-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS35	544,330
01-Jun-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008018	315,157
02-Jun-23	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 273	233,393
01-Jun-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS11	185,000
26-Jun-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS12	185,000
29-Jun-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5048	165,147
01-Jun-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4975	159,820
15-Jun-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	4989	143,098
26-Jun-23	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72485397	141,940
01-Jun-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008013	112,442
08-Jun-23	IT Services	Trustwide	Daisy Corporate Services	3I510052	90,250
12-Jun-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC013INV	90,180
22-Jun-23	Consultancy	Altogether Better	Fischer Associates Ltd	FISCH202306	84,480
19-Jun-23	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trus	324052	81,922
26-Jun-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	999660	63,962
22-Jun-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	128 11208	56,000
26-Jun-23	Drugs	Trustwide	NHS Business Services Authority	1000077185	49,994
16-Jun-23	Utilities	Trustwide	Edf Energy Customers Ltd	000015590509	46,068
28-Jun-23	Purchase of Healthcare	Barnsley	Family Lives	2461	39,709
30-Jun-23	Data Lines	Trustwide	Virgin Media Ltd	60051098	34,914
22-Jun-23	Drugs	Trustwide	Lloyds Pharmacy Ltd	HCSLP003	32,737
22-Jun-23	Drugs	Trustwide	Lloyds Pharmacy Ltd	115762	29,927
08-Jun-23	Purchase of Healthcare	Calderdale	Cygnet Health Care Ltd	WKE0290742	28,693
01-Jun-23	Purchase of Healthcare	Kirklees	Ieso Digital Health Ltd	UK001317	28,672
14-Jun-23	Purchase of Healthcare	Kirklees	Cygnet Health Care Ltd	STE0288735	27,637
16-Jun-23	Utilities	Trustwide	Edf Energy Customers Ltd	000015583600	26,826
01-Jun-23	Purchase of Healthcare	Wakefield	St Andrews Healthcare	90121927	25,281
08-Jun-23	Purchase of Healthcare	Wakefield	St Andrews Healthcare	90123004	25,088

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 post / new investment were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year.

* 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). 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. As such they 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, reduce expenditure or increase income.

* 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. ICB - Integrated Care Board.

* 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

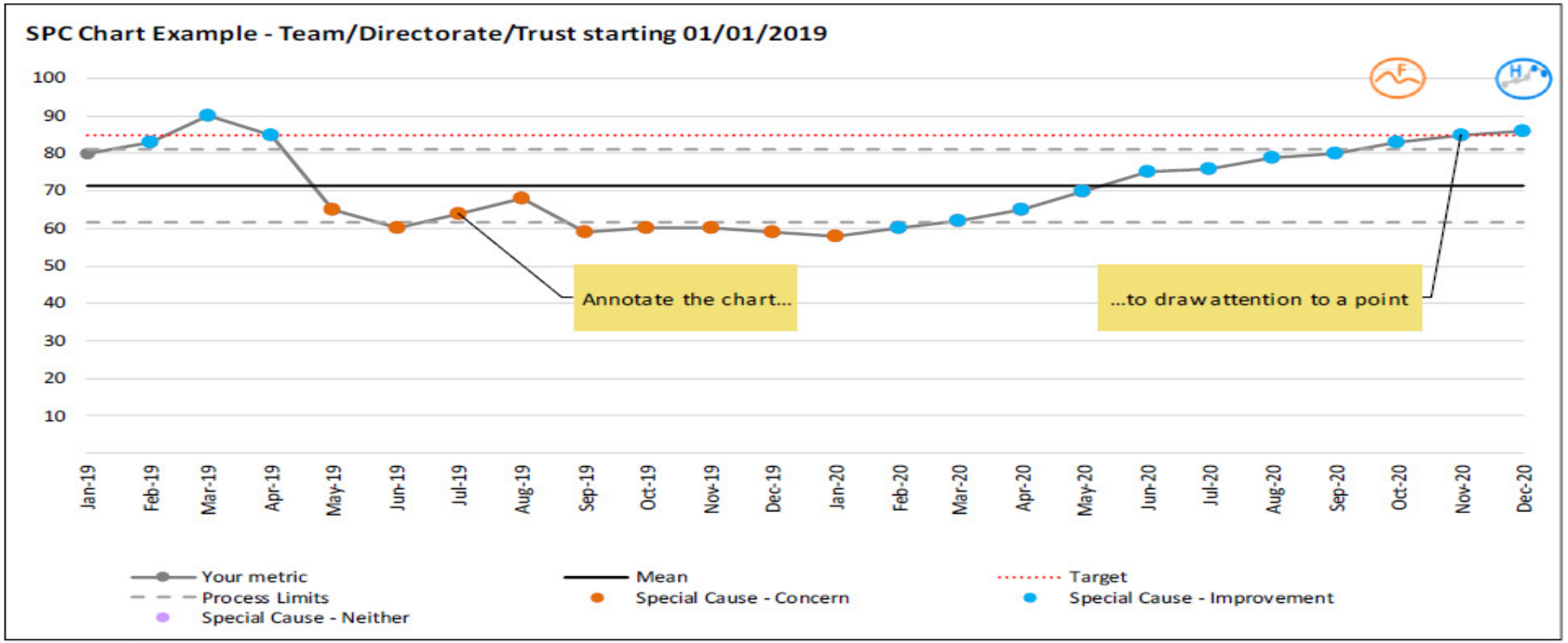
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data 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.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 July 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 Sue Barton – Interim Director of Strategy & Change		
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. • 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):	Risk 1.1 - 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 Risk 1.2 - Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. 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. Risk 3.2 - 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 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.		

Care Board/Place based partnerships	
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 leads 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 Health and Care Alliance. **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 and Barnsley Place updates**.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 July 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	Update from meeting of 5th July 2023
	
	Key items discussed included:
	
	• Patient story- this focused on the benefits of virtual wards in Doncaster to a 90-year-old patient.
	• Chair's report.
	• Chief Executive report
	  ○ The NHS South Yorkshire Joint Forward Plan was submitted to NHS England on 1st July 2023.
	  ○ The second conference for the South Yorkshire Children and Young People's Alliance took place in early June.
	  ○ A report on the contribution of voluntary, community and social enterprise sector in Yorkshire and Humber has been published.
	  ○ There was an update on plans to mark 75 years of the NHS.
	  ○ Key achievements since the launch of the NHS South Yorkshire Integrated Care Board on 1 July 2022 were highlighted.
	  ○ The Quality, Service Improvement and Redesign (QSIR) Programme continues to be rolled out across South Yorkshire.
	  ○ Further industrial action is planned in July.
	  ○ All four South Yorkshire local authorities have been recognised at the Local Government Chronicle Awards 2023.
	• Questions from the public included how effectively equality impact assessments are being used.

	• Place reports.
	  o Sheffield –the Place Plan was shared, and key priorities highlighted.
	  o Barnsley – the use of Kooth to support children and young people was highlighted, as was a successful recent carers event.
	  o Doncaster- it was advised that one approach is being taken across the system to develop cost efficiencies. A 5 pillar approach is being taken for system priorities.
	  o Rotherham- the Health and Care Plan has been agreed. A 'wear it green' for mental health day recently took place.
	• 2022/23 ICB Annual Accounts and Annual Report- South Yorkshire ICB's Annual Report and Accounts were presented to the Integrated Care Board for final adoption.
	• 2022-23 Q1 South Yorkshire Clinical Commissioning Groups Annual Accounts and Report.
	• 2023/24 NHS South Yorkshire Operating Plan- an update was provided on the plan. A full review of financial performance will take place at the end of Q1.
	• NHS South Yorkshire ICB 5-year Joint Forward Plan and Engagement Report.
	• ICB Running Costs: Organisational Change Programme- the next phase of the programme will be completed by the end of July/early August.
	• Integrated Performance Report (IPR)- an update was provided on key performance risks and mitigation plans.
	• Corporate Assurance Report.
	• Consolidation of place commissioning policies for three services was agreed.

Date of next meeting	Next meeting in public is scheduled for 6th September 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 12th July 2023
	• Managing Director report- key points highlighted in the report included:
	  o Rapid review into data on mental health inpatient settings: final report and recommendations.
	  o Publication of the NHS Long Term Workforce Plan.
	  o Yorkshire and Humber Perinatal Mental Health Services Coordinating Provider- it was updated that partners across Humber and North Yorkshire, South Yorkshire, and West Yorkshire, worked together to support an expression of interest for Leeds & York Partnerships NHS Foundation Trust (LYPFT) to be the

	coordinating provider ('lead provider') of perinatal inpatient mental health services across Yorkshire and Humber. LYPFT has now received official confirmation from NHSE that the expression of interest was successful. o Governor event. o Development day for the Board is planned for August. o South Yorkshire ICB – Joint Forward Plan Draft. • South Yorkshire Integrated Care Board Feedback. • Commissioning roles of the collaborative and the role of the commissioning hub were discussed. • Update on progress against the agreed priorities. • Chair of South Yorkshire MHLDA Provider Collaborative- the proposal for Sharon Mays to be the next Chair of the SY MHLDA Provider Collaborative was approved. • Draft workplan.
Date of next meeting	Next meeting scheduled for 13th September 2023.

4. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

Member	Chief Executive and Chair
Items discussed	Update from meeting on 29th June 2023 • The June meeting was a development session. • There was an excellent presentation from the hospice outlining the services they provide and the key role they play. • The process to develop a short and medium-term financial sustainability plan was outlined.
Date of next meeting	Next meeting scheduled for 27th July 2023.
Minutes	Papers and draft minutes when available Barnsley place public board meetings :: South Yorkshire ICB

Barnsley Place Partnership Delivery Group

Member	Interim Director of Strategy and Change
Items discussed	Update from meeting on 11th July 2023 Key items discussed included: • Migrant health deep dive- proposals for action to improve health among migrants living in Barnsley were shared. Recommendations included: o Working in partnership with migrant communities and other organisations across Barnsley. o Making it easier for migrants to register for primary care o Improving communication between healthcare staff and migrants. o Equipping and upskilling healthcare staff. o Increasing awareness of rights and entitlements.

	It was agreed that this work would be taken forward in the Barnsley Health Equity Group. • Index of deprivation- an update on the development and application of the Barnsley Index of Deprivation was provided. • Neighbourhoods- a proposal for how the Barnsley Place Partnership can develop health and social care at the neighbourhood level was shared. It was agreed that the working group will take discussions forward with each of Barnsley's six neighbourhoods. • Place plan, efficiencies, and priorities update- a stocktake will be taken at the end of Month 4. • Mental Health, Learning Disability and Autism (MHLDA) Highlight Report- an overview of the governance arrangements in relation to the Barnsley Place MHLDA was shared. • Escalations from other sub groups. • Escalations for Partnership Board.
Date of next meeting	Next meeting scheduled for 8th August 2023.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair and Interim Director of Strategy and Change
Items discussed	<u>Update from meeting on 28th June 2023</u> Agenda items included: • South Yorkshire Integrated Care Partnership Strategy- the South Yorkshire Joint Forward Plan is under development, soon to be submitted. Once this has been finalised and shared the Alliance will consider links and connections to the work of the Alliance at a future meeting. • Health Checks for individuals with a Learning Disability- the final 2022/23-year end position was a health check completion rate for eligible (non-declining) patients aged 14+ of 86.9%. The health check completion rate for patients aged 14-17 was 77.6%. There are plans to employ a further 11 physician associates and to focus on uptake by 14-17 year olds. • Health Checks for individuals with severe mental illness- a pilot project where a joint team deliver a full physical health check for patients in 3 practices has proved successful. This is being rolled out. • Frailty & Dementia. • Carers Roadshow. • Alliance Organisational Development.
Date of next meeting	Next meeting scheduled for 27th July 2023.

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change/ Deputy Chief Executive

Items discussed	Update from meeting on 1st June 2023 Agenda items included: • Barnsley Culture Strategy engagement- a report was presented to outline the rationale for a Cultural Strategy to ensure work around participation and engagement with culture and heritage and that contribution to the visitor economy is strategically aligned to the Barnsley 2030 priorities of the borough. • Creativity and wellbeing. • Barnsley Premier Leisure presentation. • Health inequalities update.
Date of next meeting	The next meeting is scheduled for 9th November 2023.
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 July 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:	Sue Barton – Interim Director of Strategy and Change		
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):	Risk 1.1- 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. Risk 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. 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. Risk 3.2- 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 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 the former clinical commissioning groups and leads the integration of health and care services across West Yorkshire. The partnership continues to develop the governance arrangements, which will be reviewed and adapted as they bed in. Formal reviews 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.
Recommendation:	**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.** **And RECEIVE the minutes of relevant partnership boards/committees.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 July 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 the former clinical commissioning groups and leads the integration of health and care services across West Yorkshire.

The partnership continues to develop the governance arrangements, which will be reviewed and adapted as they bed in. Formal reviews 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 recent 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 27th June 2023 Agenda items included: • CCG Q1 Annual Report and Accounts 2022-23. • ICB Annual Report and Accounts 2022-23.
Date of next meeting	Next meeting scheduled for 18th July 2023.
Further information:	https://www.westyorkshire.icb.nhs.uk/meetings/integrated-care-board/integrated-care-board-meeting-27-june-2023

West Yorkshire Health & Care Partnership Board

Member	Chief Executive

Items discussed	Update from meeting of 6th July 2023
	
	Agenda items included:
	
	• Update from the Partnership Chief Executive Lead. Key updates included:
	  ○ The Government announced on 25 May 2023 that it would rebuild five major hospitals by 2030, as part of the New Hospital Programme. This will include Airedale General Hospital.
	  ○ Calderdale Cares Partnership has appointed Jo Bibby to the role of Independent Chair.
	  ○ The requirement for all ICBs to reduce running costs by 30% is progressing, with a substantial amount of work being undertaken in the NHS West Yorkshire ICB.
	• Patient and public voice: dentistry – what's happening for people in West Yorkshire.
	• Dentistry and oral health in West Yorkshire.
	• 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 population planning and reducing inequalities in mental health outcomes by ethnicity.
	• Developing a Partnership Agreement between the West Yorkshire Combined Authority and the NHS West Yorkshire Integrated Care Board- a draft Partnership Agreement that sets out shared commitment to working together on the factors that affect population health: fair economic growth, climate and tackling inequality was shared.

	• Social determinants of health and inclusion for West Yorkshire – a partnership approach. • Developing the West Yorkshire Partnership Board.
Date of next meeting	Next meeting scheduled for 5th September 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: https://www.wypartnership.co.uk/meetings/partnershipboard/papers/west-yorkshire-health-and-care-partnership-board-meeting-6-june-2023

West Yorkshire Mental Health, Learning Disability and Autism Partnership Board

Member	Director of Provider Development, Chief Operating Officer and Medical Director
Items discussed	Update from meeting of 11th July 2023 Agenda items included: • Chair's update. • Workforce update – Inclusive recruitment campaign; Collaborative bank; International recruitment of mental health nurses. • Adult mental health- NHS 111 for mental health crisis, implementation update. • Neurodiversity. • Dementia and older people's mental health. • Planning and performance. • Escalations from other workstreams. WY MHLDA Bulletin (13/7/23) available here: West Yorkshire Health and Care Partnership Mental Health, Learning Disabilities and Autism Programme update (office.com)
Date of next meeting	Next meeting scheduled for 8th August 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 6th July 2023 Key items discussed included: • Report of the Place Lead. This included reference to an appointment to the independent committee chair role not being progressed following recent interviews. Dr Ann Carroll (current chair) has agreed to extend her term as chair until the end of the financial year (March 2024) or until an appointment can be made. • Report from the Chair of the Transformation and Delivery Collaborative (formerly Provider Collaborative) & Wakefield Professional Leadership Group- Adult ADHD waiting times for assessment was highlighted as an escalation point. This will be the subject of a paper at a future Committee meeting. • Public Health Profiles Local Mortality Trends. • Wakefield Strategic Delivery Plan 2023 – 2026 - the plan was approved. • Summary of Quality Exception Report. • Performance Exception Report. • Finance update, position at month 2 and year end forecast. • Wakefield District Health and Care Partnership Terms of Reference update- amendments to the Committee Terms of Reference were approved. • Wakefield Place Risk Register- this was received.
Date of next meeting	Next meeting scheduled for 7th September 2023.
Further information	Meeting papers are available here: Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk) https://www.wakefielddistricthcp.co.uk/wp-content/uploads/2023/06/Combined-Meeting-Pack-Wakefield-District-Health-and-Care-Partnership-Committee-Meeting-6-July-2023.pdf

Transformation and Delivery Collaborative (formerly Wakefield Provider Collaborative)

Member	General Manager, Wakefield Community Services
Items discussed	Update from meeting on 27th June 2023 Key items discussed included: • Escalations from alliances/programmes. • Place Delivery Plan. • Terms of Reference. • Draft Maturity Matrix. • Harnessing the Power of Communities Programme- VCSE • Workforce planning tool.

	• Items for escalation to Wakefield District Health & Care Partnership Committee.
Date of next meeting	Next meeting scheduled for 25 July 2023.

Wakefield Mental Health Alliance

Member	Director of Provider Development (Chair), with Trust representative as a member.

Items discussed	The last meeting of the Wakefield Mental Health Alliance was 14th June 2023.
	
	The planned agenda for the meeting on 19th July 2023 is as follows:
	• Mental Health Alliance Dashboard.
	• Standing item updates.
	  ○ Mental Health Emergency Dept Strategy Group.
	  ○ Older People and Dementia Group.
	  ○ Community Mental Health Transformation.
	  ○ NHS 111 roll out.
	• Mental Health Alliance stakeholder meeting update.
	• Deep dive- perinatal mental health.
	• Wakefield Mental Health Alliance next phase.
	• Children and Young People Mental Health Programme.
	• Partner updates.
	• Wakefield Transformation and Delivery Collaborative feedback.
	• Wakefield District Health and Care Partnership Committee feedback.
	• West Yorkshire MHLDA Partnership Board feedback.
	• Alliance Forward Plan.

Date of next meeting	Next meeting scheduled for 16th August 2023.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Provider Development)

Items discussed	The last meeting of the Health and Wellbeing Board was on 9th March 2023.
	
	The planned agenda for the meeting on 20th July 2023 is as follows:
	• Chair's announcements.
	• Public questions.
	• Annual report 2022/23.
	• Looking forward 2023/24.
	  ○ JSNA.
	  ○ Adult Health.
	  ○ Big Conversation themes.

	• Green spaces. • Better Care Fund. • Development of Integrated Care Strategy. • Health Protection Annual Report. • Overview and Scrutiny Committee minutes. • Connect Care minutes.
Date of next meeting	Next meeting scheduled for 12th September 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 Development Session on 29th June 2023 Agenda items included: • Finance- a presentation was shared summarising the 2023/24 financial plan, month 2 forecast, risk and issues. • Operating Model- an overview of the background, objectives, strategic options, timeline and initial functional design proposal was shared. • An introduction into Community Health, Care and Wellbeing Services in Calderdale and Development of Neighbourhood Teams. • Health and Economy- a presentation was shared focusing on how the economy impacts on people's health and wellbeing.
Date of next meeting	Next meeting scheduled for 20th July 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	Interim Director Strategy and Change
Items discussed	Update from meeting on 13th July 2023 Items discussed included: • Home First Model and Feedback from Calderdale Cares Partnership Board. • Long Covid. • VSI Alliance procurement.

	• Voluntary Action Calderdale procurement of the crisis cafe safe space/ peer support. • Workshops update. • Funding pressures and opportunities.
Date of next meeting	Next meeting is scheduled for 10th August 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	Update from meeting of 28th June 2023
	
	Items discussed included:
	• West Yorkshire Health Care Partnership Climate Change Strategy.
	• The financial sustainability of Voluntary, Community and Social Enterprise organisations in Calderdale.
	• Increased cost of living, poverty and health.
	• Health and Wellbeing Strategy - progress Update for 2023/24.
	• Items for information:
	  ○ Calderdale Safeguarding Adults Board 2021-22 Annual Report.
	  ○ Better Care Fund 2022-23 Year-end report.
	  ○ Calderdale Commissioning Strategy 2022-2025.
	  ○ Health and Wellbeing Board Forward Plan for August.

Date of next meeting	Next meeting is scheduled for 24th August 2023.
Further information	Papers and minutes are available at: https://calderdale.moderngov.co.uk/ieListMeetings.aspx?CId=148&Year=0

Kirklees

The Kirklees Delivery Collaborative meets on a regular basis, and has finalised a Collaborative Agreement for partners' signature.

The Kirklees Mental Health Alliance continues to meet and progress workstreams. Governance arrangements for the Alliance are aligned to the Kirklees place governance arrangements.

Kirklees ICB Committee

Member	Chief Executive (deputy – Director of Provider Development)

Items discussed	Update from meeting on 12th July 2023.
	
	Items discussed included:
	• People story.
	• Primary Care update.- this covered some of the key areas of focus in Primary Care, primarily focussing on access and the expansion of the primary care workforce, and requirement of Primary Care Networks to produce draft Capacity and Access Improvement Plans.
	• Kirklees Urgent Community Response Service Review update.
	• Sub-Committee Work Plans.
	• Questions from Members of the Public.
	• Accountable Officer's Report- this focused on a number of areas including:
	  ○ Update on Home First/Discharge to Assess Work.
	  ○ North Kirklees Urgent Care Redesign Workshop.
	  ○ Poverty Matters: Director of Public Health Annual Report 22/23.
	  ○ Report from Kirklees and Calderdale Health Partnership Domestic Abuse Summit.
	  ○ Mid Yorkshire Hospitals NHS Teaching Trust.
	  ○ Maternity – Early Booking Campaign.
	• Kirklees Place Quality Report.
	• Finance and Contracting Report.
	• Performance Report against Key Performance Indicators for 2022/23.
	• High Level Risk Report.
	• Items for the Attention of the ICB Board.
	• Committee Work Plan.
	• Receipt of Minutes.

Date of next meeting	Next meeting scheduled for 13th September 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 July 2023 Items discussed included: • Kirklees Environment Strategy- a presentation was given outlining the Environment Strategy. This is one of the 4 Top Tier Strategies in Kirklees and has been co-designed with partners, businesses and residents. An Environment Strategy Partnership Group will take the work of the strategy forward. • Kirklees Drug and Alcohol Strategy- a presentation was given outlining the Kirklees Drug and Alcohol Strategy. • Kirklees Health and Care Communications Network Update- the network is now well-established, with Terms of Reference

	and reporting into the Kirklees Health and Care Partnership Forum • Work plan.
Date of next meeting	Next meeting scheduled for 3rd August 2023.

Kirklees Health and Wellbeing Board

Invited Observer	Director of Provider Development

Items discussed	Update from meeting of 29th June 2023
	
	Key agenda items included:
	• Director of Public Health Report- this was presented. The report captures lived experience and insights gathered in winter 22/23. Key themes include challenges with household bills, food costs, travel costs, mental health, housing, social isolation, support from other and work opportunities, protecting family, but also a key theme of hope things would get better. Examples of recommendations were shared e.g. promoting uptake of support/financial assistance, considering how to embed support with rising costs into clinical pathways, and Poverty Aware Practice training.
	• Kirklees Health and Wellbeing Strategy update- an update on progress was shared.
	• Connected Care update- a system- wide event has been held focusing on discharge planning. Ongoing work has been taking place around the community services contract.
	• Healthy places priority- progress updates were shared. These included:
	  ○ Examples of groups in the community.
	  ○ Local partner updates to develop range of spaces and activities to promote physical activity and emotional wellbeing.
	  ○ An example of an affordable food initiative.
	  ○ Safe and active travel.
	• Health and Care Plan Update- the approach to the plan development was outlined via a system planning group. Starting well, living well, aging well are the three strategic themes to the Plan, with mental wellbeing and dying well crosscutting all.
	• West Yorkshire ICB Forward Plan update- the Forward Plan will be launched in July 2023.
	• West Yorkshire Climate Change Strategy.
	• Local Declaration on Tobacco Control- Kirklees Council have signed up to the Local Declaration on Tobacco Control.

Date of next meeting	Next meeting scheduled for 27th July 2023.
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 3rd July 2023 Key agenda items included: • June ICB Committee Development Session reflections- future role of Kirklees Delivery Collaborative. • Kirklees Collaborative Agreement- this was approved. • Kirklees Delivery Collaborative Oversight of Place Strategy Design – Proposal. It was agreed to stand down the group who have worked together to develop the Health and Care Plan now this has been approved, and to utilise the Delivery Collaborative to undertake the on-going monitoring and assurance functions. The group will be reinstated to undertake specific pieces of work for example the refresh of the Health and Care Plan for 2024/25 as required.
Date of next meeting	Next meeting scheduled for 7th August 2023.

Kirklees Mental Health Alliance

Member	Director of Provider Development (Co-Chair), with Trust representative as a member.
Items discussed	Update from meeting on 26th June 2023 • Mental health response vehicle update for Yorkshire and Humber from YAS. • Patient story. • Programme highlight reports (by exception only). • Strategic developments- WY MHLDA Partnership Board. • Forward Plan. • System financial recovery. • Loneliness Strategy.
Date of next meeting	Next meeting scheduled for 7th August 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 July 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		
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):	Risk 1.1- 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 Risk 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. 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. Risk 3.2- 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 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), and this issue continues to be a focus, with support from West Yorkshire integrated care system (ICS) recruitment and retention workstreams. 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 and the Women's Pathway work has commenced. • Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow. • Work with the West Yorkshire Complex Rehabilitation Programme to explore opportunities for joint working. • Work to understand variance between PICU (psychiatric intensive care) and adult secure pathways. • Involvement in national work to revise the secure service specifications. • Attendance at school careers events. • A project to consider how patient reported outcome measures are captured across the collaborative, working with the Yorkshire and Humber Involvement Network. For the 3 months to June 2023 the collaborative operated with a financial surplus. The Adult Eating Disorders Provider Collaborative reported a deficit at month 3. This and can be attributed to deficits against the out of area budget and the cross flows income target. A year end deficit position is forecast. Due to current staffing challenges, the Children and Young People's collaborative continues to operate at reduced occupancy. A restoration and re-occupancy plan has been developed, the trajectories of which are being met. Nevertheless, this has resulted in increased use of out of area beds. A deficit position was reported at month 3, largely due to 2 extraordinary, high cost and complex packages of care. A year end deficit position is forecast. **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 Co-ordinating Provider contract has been shared with the Trust by NHS England. This has been reviewed by the Commissioning Hub and discussions with NHSE/I remain ongoing. The Partnership Agreement for the collaborative is in the process of being updated, and Hosting Agreement for the South Yorkshire and Bassetlaw Commissioning Hub has been updated and signed by the Trust. Risk share discussions continue between providers. A year-to-date deficit is reported. **Phase 2 Provider Collaboratives** The Trust underwent a process of 'due diligence' and 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. The West Yorkshire Specialised Mental Health, Learning Disabilities and Autism Programme Board also supported this recommendation at its meeting on 24th March 2023. A project group has been established with representation from SWYPFT FCAMHS colleagues and the Commissioning Hub to manage the transition to a Provider Collaborative, in line with the MOU. 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. In November 2022, NHSE/I published the Perinatal Provider Collaborative selection process. Lead Provider (coordinating provider) applications were invited. An expression of interest was developed by LYPFT, with input from partners via the Perinatal Partnership Board. This was shared with all partner Boards, and submitted in March 2023. Following a panel process in April 2023, NHS England has now confirmed that LYPFT will be the lead provider for the Yorkshire and Humber Perinatal Mental Health Collaborative.

	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 July 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:

- Gaining further understanding of agreed 2023/24 uplifts for the larger independent sector providers, and impact on financial plans for the collaboratives.

- Annual review and update of the West Yorkshire Provider Collaboratives Quality Surveillance Process. Updates reflect the learning from the last 12 months and are in line with the National Quality Board's 'Quality Risk Response and Escalation Guidance'. The revised process has been shared with providers for comment.

- Further development of Standard Operating Procedures (SOPs) for all West Yorkshire Provider Collaboratives, for example a SOP for temporary reduced activity/closure to admissions.

- Understanding the new Patient Safety Incident Response Framework (PSIRF). The Commissioning Hub 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 continues to be a focus, with support from West Yorkshire integrated care system (ICS) recruitment and retention workstreams.

3.1 West Yorkshire Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Board has continued to meet, and the collaborative have 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 and the Women's Pathway work has commenced.
- Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow.
- Work with the West Yorkshire Complex Rehabilitation Programme to explore opportunities for joint working.
- Work to understand variance between PICU (psychiatric intensive care) and adult secure pathways.
- Involvement in national work to revise the secure service specifications.
- Attendance at school careers events.
- A project to consider how patient reported outcome measures are captured across the collaborative, working with the Yorkshire and Humber Involvement Network.
- A training and development project focussing on how West Yorkshire adult secure providers can collaborate to develop a secure care training programme – developing clinical skills, shared cultures and approaches to care.

SWYPFT, in its role as Lead Provider, completed 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.

For the 3 months to June 2023 the collaborative operated with a financial surplus of £698k. A surplus position of £2,822k is forecast and this will be subject to the collaborative risk/reward

share arrangement. However, there are risks to this position associated with independent sector price increases.

There has been a focus on reviewing the 2023/24 Lead Provider Contract Variation. 2022/23 contract variations with in-area partners are being progressed to signature as a priority.

The most recent meeting of the Collaborative Committee of the Trust Board took place on 5th June 2023, with a further meeting planned for 8th August 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 were developed. Primary care partners will host the physical health monitoring. A task and finish group continue to meet to progress implementation and funding opportunities.

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 3, a deficit position of £105k 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. An Inpatient and Referral Oversight Group has been established to manage patient and referral flow.

The forecast position for the 2023/24 financial year is a £422k deficit. The collaborative will investigate ways to increase crossflows income and reduce OOA placements.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

Due to current staffing challenges, the Children and Young People's collaborative continues to operate at reduced occupancy. A restoration and re-occupancy plan has been developed, the trajectories of which are being met. Nevertheless, this has resulted in increased use of out of area beds.

A year-to-date deficit of £760k is reported for the 2023/24 financial year to June 2023 against a balanced plan. Two high-cost exceptional packages of EPC's are primarily driving the position.

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. This has been reviewed by the Commissioning Hub and discussions with NHSE/I remain ongoing.
- The Partnership Agreement is being updated, and Hosting Agreement for the SYB Commissioning Hub. The Hosting Agreement has been signed by the Trust.
- 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. However, a way forward has been agreed and a final version of the Lead Provider contract from NHSE is awaited.

A year to date deficit of £93k is reported, with forecast deficit of £255k.

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/I undertook consultation for phase 2 Adult Secure and CYPMH services. Following consultation, Adult Low and Medium Secure Acquired Brain Injury and Deaf Service and Women's Enhanced Medium Secure Services will continue to be commissioned directly by NHS England and Improvement (NHSE/I) with a national ring-fenced budget. NHSE/I 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 U13s 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 PC approach at this time.

In West Yorkshire (WY), the Trusts who comprise the WY MHLDA collaborative have agreed a set of principles to determine which Trust is the preferred option to be the coordinating 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

NHSE has developed a standard operating procedure (SOP) to support with operationalising the FCAMHS recommendations, coproduced with experts by profession and experience.

The Trust underwent a process of 'due diligence' and 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. The West Yorkshire Specialised Mental Health, Learning Disabilities and Autism Programme Board also supported this recommendation at its meeting on 24th March 2023.

A project group has been established with representation from SWYPFT FCAMHS colleagues and the Commissioning Hub to manage the transition to a Provider Collaborative, in line with the MOU.

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.

Progress against the MOU is as follows:

- SWYPFT FCAMHS colleagues and the Commissioning Hub met to discuss current processes for quality monitoring in May 2023, and any current issues. An options paper as to how quality oversight will be managed going forward has been developed and will be discussed at the FCAMHS Partnership Board, Provider Collaborative Patient Safety and Quality Group, and August Collaborative Committee.
- The Commissioning Hub continue to shadow existing quality review processes.
- The Commissioning Hub have met with NHSE to understand data available via the national FCAMHS dashboard.
- Quarterly highlight reports have been shared by SWYPFT FCAMHS colleagues with the Commissioning Hub.
- SWYPFT FCAMHS colleagues share any new quality concerns with the Commissioning Hub.
- Serious incidents (SIs) continue to be reported by providers in line with the National SI framework, with SWYPFT as Lead Provider notified. SWYPFT FCAMHS colleagues will notify the Commissioning Hub of any SIs during the transition period.
- The Commissioning Hub have shadowed Q4 contract meetings between SWYPFT and the subcontracted providers.
- All providers have been notified of invoice arrangements for 2023/24.

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 was developed by LYPFT, with input from partners via the Perinatal Partnership Board. This was shared with all partner Boards, and submitted in March 2023. Following a panel process in April 2023, NHS England has now confirmed that LYPFT will be the lead provider for the Yorkshire and Humber Perinatal Mental Health Collaborative.

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 July 2023
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**Assessment against NHS Constitution**		
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:	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 provide assurance to Trust Board that the Trust meets the rights and pledges set out in the NHS Constitution in relation to patients and staff, and that it is mindful of the commitments in the NHS Constitution in delivering, planning and developing its services.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 1.3 - 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 Risk 1.4 - 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 Risk 2.2 - Failure to create a learning environment leading to lack of innovation and to repeat incidents. Risk 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 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		

	Risk 4.1 - 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 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 Risk 4.3 - Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	This assessment by the Board of Directors measures the Trust against the NHS Constitution and provides evidence of the Trusts effectiveness, efficiency and economy, as well as the quality of its healthcare delivery which supports its contribution to the objectives of the integrated care partnership (ICP) and integrated care board (ICB), and place-based partnerships.
Any background papers / previously considered by:	Previous assessments submitted annually to the Trust Board. A full copy of the NHS Constitution can be found on the Department of Health website at: NHS Constitution for England - GOV.UK (www.gov.uk) This assurance document has been assessed against the Trust Constitution, Trust Board and Committee workplans agenda's, papers and minutes, by the Deputy Director of Corporate Governance, Performance and Risk.
Executive summary:	The NHS Constitution was published in January 2009, following an extensive public consultation. It established the principles and values for the NHS in England and set out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieving, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required, by law, to take account of the NHS Constitution in their decisions and actions. The NHS Constitution also applies to public health services, which are now the responsibility of local authorities. The Government has committed to renewing the NHS Constitution every ten years with the full involvement of patients who use the NHS, the public who fund it and the staff who work in it. In July 2015, the Constitution was updated to reflect a limited package of changes. In January 2021 the NHS Constitution was updated to reflect the rules had changed regarding UK residents' access to healthcare in the EU, Norway, Iceland, Liechtenstein and Switzerland following the UK's exit from the EU. The Trust meets the rights and pledges of the NHS Constitution with the rationale as to why this conclusion has been reached outlined in the detailed paper attached which includes a summary of evidence against each of the rights and pledges.

	Risk appetite The delivery of the NHS Constitution rights and pledges supports the Trust's endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to APPROVE the paper, which demonstrates how the Trust is meeting the requirements of the Constitution.**

South West Yorkshire Partnership NHS Foundation Trust

The NHS Constitution – patients and the public
How the Trust meets its obligations
Trust Board 25 July 2023

Heading	Compliance	Evidence	Lead
• R1 You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.	Yes	Core services are commissioned by integrated care boards covering the places where the Trust delivers services namely, Barnsley, Calderdale, Kirklees and Wakefield. In October 2021, the West Yorkshire Adult Secure Provider Collaborative went live, and SWYPFT entered into a Lead Provider Contract with NHS England. In May 2022, the South Yorkshire Adult Secure Provider Collaborative went live, and SWYPFT entered into a Lead Provider Contract with NHS England. The Trust is in the process of agreeing a contractual hand over from NHSE to SWYPFT for all relevant contracts. The Trust, as Lead Provider (LP), has now established sub-contract arrangements with providers within the region, known as “in-area” subcontracts and with providers, where service users are placed in adult secure services, outside West Yorkshire, known as “out of area” subcontracts. The Trust has in place a tripartite Direct Agreement that is signed by the provider, SWYPFT and NHSE/I. This confirms that the commissioning responsibility will transfer to NHSE/I, in the exceptional circumstance that the Lead Provider should cease to be the Lead Provider.	Director of Finance, Estates & Resources
• R2 You have the right to access NHS services. You will not be refused access on unreasonable grounds.	Yes	The Trust has contracts in place for its services with commissioners and endeavours to provide access to services within its available resources. The Trust’s complaints and contracting processes would identify any instances where the Trust has not met or is perceived not to have met this right.	Director of Finance, Estates & Resources

Heading	Compliance	Evidence	Lead
• R3 You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.	Yes	The Trust has contracts in place for its services with commissioners and endeavours to provide access to services within its available resources. The Trust's complaints and contracting processes would identify any instances where the Trust has not met or is perceived not to have met this right.	Director of Finance, Estates & Resources
• R4 You have the right to expect your local NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary and, in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.	Yes	The Trust does assess the health needs of the local community in the development of its operational and strategic plans and, as part of the development of its transformation programmes. The Trust is working with commissioners, stakeholders, service users and carers, and local people to transform its services and develop new models and pathways of care that meet people's needs. As part of two integrated care systems the Trust works with partners in each place it provides services to understand the needs of local populations and design service provision accordingly. The Trust is a member of the local Health & Wellbeing Boards who have a statutory duty to do this. The Trust uses Joint Strategic Needs Assessment data available in each place to inform and shape strategic and service change priorities.	Director of Strategy & Change
• R5 You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.	N/A	N/A to the Trust. This is determined by commissioners. This section of the NHS Constitution has now been amended to state: You have the right to authorisation for planned treatment in the EU under the UK EU Trade and Cooperation Agreement where you meet the relevant requirements. You also have the right to authorisation for planned treatment in the EU, Norway, Iceland, Lichtenstein or Switzerland if you are covered by the Withdrawal Agreement and you meet the relevant requirements.	N/A
• R6 You have the right not to be unlawfully discriminated against in the provision of NHS services including on the grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.	Yes	The Trust complies with appropriate legislation relating to discrimination and has an Equality, Involvement, Communication and Membership Strategy in place (approved by Trust Board September 2020) with the prime aims of respecting and valuing difference and promoting a fairer organisation. The Trust has committed to implementing the NHS Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) in accordance with the NHS Standard Contract. The Trust Board has an Equality Involvement and Inclusion	Chief Nurse, Director of Quality and Professions / Chief People Officer

Heading	Compliance	Evidence	Lead
		Committee. The Trust has a Race Equality and Cultural Heritage (REACH) staff network group, a disability staff network, LGBT+ staff network and staff carers network. The REACH network has supported the Trust in a number of equality and inclusion initiatives including supporting the development of Equity Guardians. The Trust has also established a clinical network, called Race Forward, to reduce bullying and harassment from service users and carers on staff from BAME backgrounds. The Trust uses Equality Impact Assessments (EIA) to evaluate the effect of its strategies and policies on its service users and the communities it serves. The Trust implemented the Equality Delivery System 2 (EDS2), and Trust Board agrees for each of the four EDS2 goals to focus on one key outcome area assessed by service users and staff. The Trust has been graded as achieving EDS2. The Trust utilises all available equality data to ensure equity of access to services for the communities the Trust serves, including video consultations and treatment sessions, improved communication through use of social communication tools e.g., SystmOne messaging tool.	
• R7 You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.	Yes	The Trust does provide some services subject to waiting times as outlined in the Handbook to the NHS Constitution which are reported monthly to the Trust Board under the national metrics in the Integrated Performance Report: • Patients waiting (99%) for a diagnostic test should have been waiting less than 6 weeks from referral. • A maximum 72 hour wait for follow-up after discharge from psychiatric in-patient care for people under adult mental illness specialties on Care Programme Approach. • There is a right for patients to start consultant-led non-emergency treatment within a maximum of 18 weeks of a GP referral and for the NHS to take all reasonable steps to offer a range of alternatives if this is not possible. (Only applicable to Musculoskeletal (MSK) services in Barnsley)	Chief Nurse, and Director of Quality and Professions

Heading	Compliance	Evidence	Lead
		There are further waiting times which are not currently subject to the NHS Constitution that are monitored by the Board, Committees and Operating Management Group (led by the Chief Operating Officer). Neuro development waiting lists for children with Attention Deficit and Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD) are still a concern. Waiting list initiatives are in place to work towards stabilising this position from March 2023. 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. The percentage of children treated in 18 weeks in core CAMHS remains a challenge. Mental health support teams have been developed in all areas, working with families and the co-determinants of health.	
• P1 The NHS commits to provide convenient, easy access to services within the waiting times set out in the Handbook to the Constitution.	Yes	As part of its contractual requirement through the service specification with commissioners, the Trust is required to report on local waiting times in relation to improving access to psychological therapies (NHS Talking therapies) and psychological therapies, referral and treatment times in relation to the Barnsley Care Group musculoskeletal service (MSK). The Trust meets the required timescale. The Trust has a history of regularly meeting national targets for access to NHS Talking therapies, and when there is an issue in terms of meeting any local targets action plans are put in place to address. Access is one of the Trust's quality priorities set out in its Quality Accounts and performance is monitored and reported on a quarterly basis. The Trust continues to provide services in a flexional and dynamic way following learning from the Covid-19 pandemic, including the use of digital media where appropriate. The Trust maintains face to face services dependant on patient need.	Director of Finance, Estates & Resources / Chief Nurse and Director of Quality and Professions

Heading	Compliance	Evidence	Lead
• P2 The NHS commits to make decisions in a clear and transparent way so that patients and the public can understand how services are planned and delivered.	Yes	The Board meets in public and papers and minutes for public Trust Board meetings are published on the Trust's website. Minutes from Board Committee meetings are included in the public Board papers. The Trust holds an Annual Members' Meeting and usually holds regular public events throughout the year. The Trust has a Members' Council in place comprising of elected public and staff governors, and appointed stakeholder representatives. Meetings are held in public, and papers and minutes are published on the Trust's website. The Trust's Equality, Involvement, Communication and Membership Strategy outlines its approach to involvement and engagement. Service users and carers are involved in planning and designing Trust services, including the transformational service change programme. The Trust's services have individual service user groups. A description of the Trust's service offer is available on the Trust's website and in hard copy. The Trust utilises all available equality data to ensure equity of access to services for the communities the Trust serves, including video consultations and treatment sessions, improved communication through use of social communication tools e.g., SystmOne messaging tool.	Chief Executive
• P3 The NHS commits to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them.	Yes	The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be occasions when the nature of an individual's illness may make this inappropriate. The Formulation Informed Risk Management (FIRM) system has been implemented within the Trust as a framework for recording risk, and to ensure access to up-to-date risk information and management plans across all services supporting smooth transitions of care. Care planning continues to be a priority area for the Trust Quality Improvement programme. The Trust has improved systems and processes to ensure that all service users have a care plan in place and that they know	Chief Operating Officer / Chief Nurse and Director of Quality and Professions

Heading	Compliance	Evidence	Lead
		who is responsible for their care. The Care Programme Approach (CPA) and standard care standards demonstrate the Trust's commitment to put service users at the centre of care planning. Service user and their carers' perceptions of the Trust are regularly reviewed through national and local surveys. The Trust is committed to system wide improvement of services and interagency protocols through the Integrated Care Systems (ICSs) and local partnership arrangements. The Trust has transition arrangements in place between services to ensure that handovers are as smooth as possible.	
• R8 You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.	Yes	The Trust has in place strong and robust processes for the employment, appraisal and re-validation of medical staff. The Trust ensures all appropriate staff are registered with the Health and Care Professions Council (HCPC). There can often be a need to utilise temporary staffing. When this is required the Trust endeavours to use bank staff where appropriate. In circumstances, where it has to use agency staff, these are from approved suppliers to ensure the quality, skills and experience of staffing is maintained. The Trust has an e-rostering system for all inpatient areas with agreed establishment levels for registered and non-registered staff. The Trust is registered with no conditions with the Care Quality Commission (CQC). The Trust is licensed by NHS England with no conditions and continues to comply with licencing requirements. The Trust is compliant with relevant National Institute for Health and Care Excellence (NICE) guidelines. The Trust has a robust system in place to undertake appropriate employment checks for its entire staff. The Trust has an ongoing Continuous Professional Development (CPD) approach. A Workforce Development Strategy, including mandatory training plan, is in place. The Trust's Patient Safety Strategy brings all aspects of patient	Chief Nurse and Director of Quality and Professions / Chief People Officer / Chief Medical Officer

Heading	Compliance	Evidence	Lead
		safety together in one document. The Trust has an unannounced visits programme in place. Safer staffing reports are included within the monthly Integrated Performance Report and the Board requires a safer staffing and workforce report every six months. The Trust undertakes a robust workforce planning process each year linked to service and financial plans.	
• R9 You have the right to be cared for in a clean, safe, secure and suitable environment.	Yes	The Trust has an Estates Strategy to support and meet the needs of services. Development of the Estates Strategy included a detailed six-facet survey of Trust estate. The Trusts new ten-year estates strategy is being presented to Trust Board in July 2023. The Trust is compliant with Fire and Occupational Health & Safety (OHS) legislation. Patient-led assessments of the care environment (PLACE). assessments have been conducted during 2023/24 with outcomes presented to Trust Board in July 2023. The assessments have and continue to produce good results. Infection prevention and control advisers and specialist advisers in place with regular programme of audits in place. The Trust undertakes an annual Health and Safety Monitoring Audit. The Trust Board approves an annual Health and Safety action plan.	Director of Finance, Estates and Resources / Chief Operating Officer
• R10 You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.	Yes	The Trust's approach is based on the key areas included in the Department of Health Food Standards in relation to nutritional care, healthier eating for the whole hospital community and sustainable procurement of food and catering services. In all areas, the Trust works with its dieticians to create a balanced nutritional and healthy menu to cover the Trust's diverse patient base and also cooks to request for special diets. Work is continuing with procurement to raise awareness of the standards and the role the Trust plays with suppliers. Nursing and medical	Director of Finance, Estates and Resources

Heading	Compliance	Evidence	Lead
		staff are also aware of their role within the process. These processes are capture within the Trust's Food Policy which was updated to include the latest guidelines including the latest guidance on allergens.	
• R11 You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of the healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.	Yes	The Trust publishes an annual Quality Account describing performance against key quality priorities and plan for improvement. The Trust's performance management processes include summary statistics on service activity data to enable comparisons of Trust outcomes with the 'what good looks like' and health needs assessment intelligence to support local decision-making to ensure continuous improvement. The Trust Board and its Committees receive performance and other reports. Trust Board reports are publicly available on the Trust's website. The Trust maintained the vast majority of reporting metrics throughout the pandemic and the clinical governance and clinical safety committee delivered on its workplan. The Trust has an ongoing change programme in place including engagement and involvement. Programmes of improvement are reviewed and prioritised on a regular basis. Dedicated website pages supported by and strategic plans. Trust's own programme of visits to all in-patient locations and a range of community teams registered with the Care Quality Commission (CQC) where compliance with essential standards is reviewed. The Trust continues to work towards the delivery of the action plan agreed with the CQC following unannounced visits and has processes in place to learn from the outcome of previous visits to the Trust. 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.	Director of Estates, Finance & Resources / Chief Nurse and Director of Quality and Professions

Heading	Compliance	Evidence	Lead
		The Trust has a programme of PLACE visits undertaken annually, which have achieved positive results in July 2023.	
• P4 The NHS commits to identify and share best practice in quality of care and treatments.	Yes	The Trust has a leadership and clinical management structure, including Care Group matrons whose role is to ensure best practice is being followed and effective clinical governance is maintained and developed. The Trust has quality improvement and patient safety strategies with implementation plans in place and formal systems in place to share good practice through the Quality Improvement Group. Accreditation for Trust services, such as electroconvulsive therapy (ECT), memory services in Barnsley, Calderdale, Kirklees and Wakefield, and secure services peer review undertaken annually. Living our values continues to be a consistent message throughout the Trust. Trust quality monitoring visits programme in place. Clinical network for forensic services with providers as part of Allied Health Services Network members and the West Yorkshire Health & Care Partnership (WYHCP). Annual staff Excellence Awards which celebrate the difference that our staff and teams make to the lives of local people took place face to face in May 2023. (also see R11) The Trust has processes in place to learn from incidents and cross-Trust learning has been strengthened over the course of 2022/23. The leadership structure for operational leadership includes clinical networks which ensures the spread of best practice across pathways trust-wide, and the matron role (implemented in 2019) in acute inpatient areas. The matron role leads on quality, best practice and standards of care. The Trust has an established Clinical Ethics Advisory Group (CEAG) (2020). The Trust is engaged with and has representation on South Yorkshire / West Yorkshire integrated care systems mental	Executive Management Team

Heading	Compliance	Evidence	Lead
		health work streams and partnership groups. CQC regulation leads monitor performance against CQC regulations, and the Trust undertakes quality monitoring visits across its services which are supported by non-executive Directors and governors.	
• R12 You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if you doctor says they are clinically appropriate for you.	Yes	The Trust is compliant with relevant NICE guidelines. The Trust has a policy and procedures in place with timelines to implement NICE guidance. The Trust has a robust procedure in place for the approval and oversight of medical treatments within the Drug and Therapeutic sub-committee.	Chief Nurse and Director of Quality and Professions / Chief Medical Officer
• R13 You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain the decision to you.	N/A	N/A	
• R14 You have the right to receive vaccinations that the Joint Committee on Vaccinations and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.	Yes	The Trust is commissioned by NHS England to provide school age children (5-19) vaccination and immunisation programme including flu in Barnsley.	Chief Operating Officer
• P5 The NHS commits to provide screening programmes as recommended by the UK National Screening Committee.	N/A	Where appropriate, all national screening programmes are in place and managed through the Screening Advisory Committee for South Yorkshire in respect of screening services provided by Barnsley Care Group.	Chief Operating Officer
• R15 You have the right to be treated with dignity and respect,	Yes	Staff work to professional codes of conduct, Trust policies and Care Programme Approach (CPA) standards.	Chief Operating Officer /

Heading	Compliance	Evidence	Lead
in accordance with your human rights.		The Trust's Equality, Involvement, Communication and Membership Strategy sets out how the Trust accords to an individual's human rights. Living our values continues to be a consistent message throughout the Trust. The Trust has values-based recruitment and induction programme. The Trust has a strong pastoral care function to support service users and their carers, and staff. The Trust has a contractual duty of candour and has arrangements in place to ensure it meets the extended legal duties of candour introduced by the CQC. Regular reporting has been established at Care Group, Executive Management Team (EMT) and Board level.	Chief Medical Officer / Chief Nurse and Director of Quality and Professions
• R16 You have the right to be protected from abuse and neglect, and care and treatment that is degrading.	Yes	The Trust has a robust policy and arrangements in place through its approaches to safeguarding vulnerable adults and children and is an active member of local safeguarding boards.	Chief Nurse and Director of Quality and Professions / Chief Operating Officer
• R17 You have the right to accept or refuse treatment that is offered to you, and not be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests. (NB different rules apply for patients detained in hospital or on supervised community treatment under the Mental Health Act 1983.)	Yes	The Trust has a Consent Policy in place. The Trust has clear policies, procedures and guidance in place for the administration of the Mental Health Act (MHA), Mental Capacity Act (MCA) and for Deprivation of Liberty Standards. The Trust works in partnership with advocacy services provided by local authorities to provide support for service users and carers. The Trust's complaints processes would identify any instances where the Trust has not met or is perceived not to have met this right. The Trust introduced an updated training plan for Mental Health Act / Mental Capacity Act compliance and is meeting revised targets.	Chief Medical Officer / Chief Nurse and Director of Quality and Professions
• R18 You have the right to be given information about the test	Yes	The Trust has medicine information leaflets including translation into other languages if required and utilises information available	Chief Medical Officer /

Heading	Compliance	Evidence	Lead
and treatment options available to you, what they involve and their risks and benefits.		from NHS Choices. Service user information leaflets, which set out service user rights. Service users are given copies of their care plans. Service users and carers are part of developing Trust approach to care planning. Ongoing engagement with service users and carers, particularly around CPA. The Trust continues to meet the Accessible Information Standard and compliance is detailed on the Trust website.	Chief Nurse and Director of Quality and Professions
• R19 You have the right of access to your own health records and to have any factual inaccuracies corrected.	Yes	The Trust has a Patient Identifiable Information Policy – service user access and a Freedom of Information Policy. The Trust complies with requirements of Data Protection & Security Toolkit (DPST), CQC registration and NHSE's Licence conditions.	Director of Finance, Estates and Resources/ Chief Nurse and Director of Quality and Professions
• R20 You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure	Yes	Trust meets Department of Health privacy and dignity guidance and has made an annual declaration of compliance to its regulator and to service users regarding elimination of mixed sex accommodation. The Trust has a Service User Confidentiality and Data Protection Policy, incorporating information sharing and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area. When breaches do occur, they are thoroughly investigated with learning identified and notification to our commissioners or the Information Commissioner where appropriate.	Chief Nurse and Director of Quality and Professions/ Director of Finance, Estates and Resources
• R21 You have the right to be informed about how your information is used.	Yes	The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area.	Director of Finance, Estates and Resources/ Chief Nurse and Director of

Heading	Compliance	Evidence	Lead
			Quality and Professions
• R22 You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered and, where you wishes cannot be followed, to be told the reasons, including the legal basis.	Yes	Patient Identifiable Information Policy – service user access. Freedom of Information Policy. The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area.	Director of Finance, Estates and Resources/ Chief Nurse and Director of Quality and Professions
• P6 The NHS commits to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively.	Yes	The Trust has one main clinical information system (SystmOne) across its Care Groups. The Trust is also working with partners to ensure interoperability between systems, such as those used by local authorities, to make accessing information on care easier for staff working in integrated teams. Information sharing protocols in place with partners as appropriate.	Director of Finance, Estates & Resources
• P7 The NHS commits that, if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution.	Yes	The Trust is able to make a declaration that it complies with the national standard in relation to Eliminating Mixed Sex Accommodation.	Chief Nurse and Director of Quality and Professions
• P8 The NHS commits to anonymise the information collected during the course of your treatment and use it to support research and improve care for others.	Yes	The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area. When breaches do occur, they are thoroughly investigated with learning identified and notification to the Information Commissioners Office where appropriate. The Trust has robust governance arrangements in place to cover its research and development work.	Director of Finance, Estates and Resources Chief Medical Officer
• P9 The NHS commits, where identifiable information is used, to	Yes	The Trust has a confidentiality and data protection policy and has systems and processes in place that give patients and service	Director of Finance,

Heading	Compliance	Evidence	Lead
give you the chance to object wherever possible.		users the right to object to the holding and sharing of their information.	Estates and Resources
• P10 The NHS commits to inform you of research studies in which you may be eligible to participate.	Yes	The Trust has an in-house research and development department that manages, facilitates, and governs all research to ensure it reflects services and the geographical area the Trust serves. Support is available to staff, patients / service users and carers who would like to become more involved in research as well as those who are established researchers. Advice and information is available on NHS research approval, ethics, the research passport, letters of access, training and funding opportunities, patient / service user and carer involvement in research and dissemination.	Chief Medical Officer
• P11 The NHS commits to share with you any letters sent between clinicians about your care.	Yes	All service users have access to their clinical records (Patient Identifiable Information Policy – service user access). Service users are offered a copy of their care plan and are able to receive a copy of any correspondence between clinicians about them unless there is a specific risk identified to their physical and/or mental wellbeing.	Chief Nurse and Director of Quality and Professions / Director of Finance, Estates and Resources/ Chief Operating Officer
• R23 You have the right to choose your GP practice and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.	N/A	N/A	N/A
• R24 You have the right to express a preference for using a particular doctor within your GP practice and for the practice to try to comply.	N/A	N/A	N/A
• R25 You have the right to transparent, accessible and comparable data on the quality of	N/A	N/A	N/A

Heading	Compliance	Evidence	Lead
local healthcare providers, and on outcomes, as compared to others nationally.			
• R26 You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs.	N/A	N/A	N/A
• P12 The NHS commits to inform you about the healthcare services available to you, locally and nationally.	Yes	Information is available on the Trust's website and in information leaflets. The Trust's service offer by district is available on its website, which provides individual service information on services offered and teams. The Trust is compliant with Accessible Information Standards and has implemented Easy Read options for commonly accessed documents.	Chief Nurse and Director of Quality and Professions / Chief Operating Officer
• P13 The NHS commits to offer you easily accessible, reliable and relevant information in a form you can understand and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available.	Yes	Information available on the Trust's website, in information leaflets and the Trust's Quality Accounts. The Trust's service offer by Care Group is available on its website, which provides individual service information on services offered and teams. Information on mental health conditions is included on the Trust's website. Service user survey findings are displayed on wards and units. Feedback mechanisms are in place for service users and their carers, including 'real time' collection of customer experience feedback. Advocacy information is available on wards and in patient information. The Trust is compliant with Accessible Information Standards and has implemented Easy Read options for commonly accessed documents.	Chief Operating Officer / Chief Nurse and Director of Quality and Professions
• R27 You have the right to be	Yes	As above (see R18, P12, P13).	Chief Operating

Heading	Compliance	Evidence	Lead
involved in planning and making decisions about your health and care with your care provider or providers, including your end-of-life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.		The Trust offers and has available interpreter / translation services either face-to-face or by telephone. An agreed end-of-life care pathway involving all agencies involved in end-of-life care is in place. Care plans are co-produced wherever possible, allowing service users to be fully involved in planning their care and treatment. Compliance is monitored via the monthly Integrated Performance Report and the Clinical Governance Clinical Safety Committee and remedial steps taken wherever necessary.	Officer / Chief Nurse and Director of Quality and Professions
• R28 You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.	Yes	The Trust has a Duty of Candour policy in place supported by robust processes for complaints and redress. The Trust monitors compliance with the policy which is reviewed by the Clinical Governance & Clinical Safety Committee and Board.	Chief Nurse and Director of Quality and Professions
• R29 You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in the decisions to be made affecting the operation of those services.	Yes	Patients, services users and their carers can be involved in the Trust through the Members' Council, Trust membership and volunteering. Equality, Involvement, Communication and Membership Strategy in place. The Trust has in place an insight report which includes feedback from stakeholders, governors, patient's carers and services to help improve services. The Trust is continuing to engage with service users and carer groups to ensure all teams and wards will have the ability to involve, listen and respond to feedback from people who use Trust services at all levels of the organisation. Trust service users / carers on local partnership boards.	Chief Nurse and Director of Quality and Professions / Director of Strategy

Heading	Compliance	Evidence	Lead
		Information provided to local HealthWatch.	
• P14 The NHS commits to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services.	Yes	As above (see P2, P3, R29).	Chief Nurse and Director of Quality and Professions
• P15 The NHS commits to work in partnership with you, your family, carers and representatives.	Yes	As above (see P2, P3).	Chief Operating Officer / Chief Nurse and Director of Quality and Professions
• P16 The NHS commits to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one.	Yes	Service users are offered a copy of their care plan. Care plans are co-produced with service users wherever possible. The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be occasions when the nature of an individual's illness makes this inappropriate.	Chief Operating Officer / Chief Nurse and Director of Quality and Professions / Chief Medical Officer
• P17 The NHS commits to encourage and welcome feedback on your health and care experiences and use this to improve services.	Yes	The Trust welcomes feedback from service users and carers and actively encourages people to comment on its services. The Trust uses this information to inform service development and improvement. The Trust is working towards real time service user feedback through the Friends and Family service user test. Service user surveys are undertaken as part of our commitment to learn and improve across all of our Care Groups. Feedback facility on the Trust's website. Feedback is provided through the Customer Services Team, which is reported to Trust Board quarterly and annually.	Chief Nurse and Director of Quality and Professions
• R30 You have the right to have any complaint you make about NHS services acknowledged within three working days and to	Yes	Customer Services Policy and Customer Service Team structure with annual reports to Trust Board. Performance measures in place. Complaints acknowledged within three working days and investigated appropriately.	Chief Nurse and Director of Quality and Professions

Heading	Compliance	Evidence	Lead
have it properly investigated.			
• R31 You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.	Yes	As above. The Trust encourages face to face meetings to discuss complaints as the first act of resolution. Formal complaints always involve the offer of a further face to face meeting.	Chief Nurse and Director of Quality and Professions
• R32 You have the right to be kept informed of the progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.	Yes	Customer Services Policy and Customer Service Team structure. All responses are shared with complainants and personally signed by the Chief Executive including actions to be taken as a result. Identified learning is monitored by the Clinical Governance Clinical Safety Committee.	Chief Nurse and Director of Quality and Professions
• R33 You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman if you are not satisfied with the way your complaint has been dealt with by the NHS.	Yes	This is referenced in all correspondence around complaints. Everything possible is done to prevent this. During the previous reporting year, 2022/23 the Trust received 9 requests for information from the parliamentary health service ombudsman (PHSO). Six of these were from two complainants. All requests were responded to, and information shared with the ombudsman to enable them to review and decide whether to investigate complaints at the second and final stage of the NHS complaints process. The Trust received an outcome for 7 complaints where no further action was required by the Trust. The two remaining complaints are still being assessed by the PHSO. The Trust received 10 requests for information from the PHSO in 2021/22. The Trust received notification that 2 cases had closed with no further action or recommendations. The Trust is still waiting for the outcome of the ombudsman's scrutiny on 6 cases at the point of writing this report. 1 request from the joint Ombudsmen, the Local Government and Social Care Ombudsman (LGSCO) regarding the historic care provided to a service user with a primary diagnosis of autism and his discharge	Chief Nurse and Director of Quality and Professions

Heading	Compliance	Evidence	Lead
		from Trust services. The LGSCO has awarded in the complainant's favour. The final request has been recently reviewed and the request has subsequently been withdrawn.	
• R34 You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.	Yes	Customer Services Policy and information on the Trust's website.	Chief Nurse and Director of Quality and Professions
• R35 You have the right to compensation where you have been harmed by negligent treatment.	Yes	Claims Management Policy.	Chief Medical Officer
• P18 The NHS commits to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint and the fact that you have complained will not adversely affect your future treatment.	Yes	Customer Services Policy and Customer Service Team structure.	Chief Nurse and Director of Quality and Professions
• P19 The NHS commits to ensure that, when mistakes happen or if you are harmed while receiving health care, you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again.	Yes	The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts. This is done via Blue light alerts, individual care group governance meetings and monitored by the Clinical Governance Clinical Safety Committee. Arrangements in place to ensure the Trust and its staff meet the Trust's Duty of Candour responsibilities.	Chief Nurse and Director of Quality and Professions
• P20 The NHS commits to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services.	Yes	The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts. Quality Improvement Group established to share learning between and across Care Groups.	Chief Nurse and Director of Quality and Professions / Chief Medical

Heading	Compliance	Evidence	Lead
		Learning lessons reports are reviewed by the Clinical Governance and Clinical Safety Committee. Post investigation meetings are held at a local level.	Officer

The NHS Constitution also sets out nine responsibilities of patients and the public.

- Please recognise that you can make a significant contribution to your own, and your family's, good health and well-being, and take some personal responsibility for it.
- Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.
- Please treat NHS staff and other patients with respect and recognise that violence or the causing nuisance or disturbance on NHS premises could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.
- Please provide accurate information about your health, condition and status.
- Please keep appointments or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.
- Please follow the course of treatment which you have agreed and talk to your clinician if you find this difficult.
- Please participate in important public health programmes such as vaccination.
- Please ensure that those closest to you are aware of your wishes about organ donation.
- You should give feedback – both positive and negative – about your experience and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

The NHS Constitution – staff
How the Trust meets its obligations
Trust Board 26 July 2022

Heading	Compliance	Evidence	Lead
The rights are there to help ensure staff:			
• have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives	Yes	Workforce Strategy agreed which includes workforce development, and staff engagement and wellbeing as key priority areas. People (formerly human resources) policies and procedures on annual leave, sickness absence, flexible working, carer leave, adoption rights and benefits, age retirement, equal opportunities in employment, job share, paternity leave, maternity leave, special leave, stress, etc. Harassment and	Chief People Officer

Heading	Compliance	Evidence	Lead
		Bullying Policy and Grievance Policy and Procedures in place. Friends and Family Test for staff. Wellbeing survey / national staff survey. Occupational health policy and service in place including Musculoskeletal and staff counselling services. Values-based recruitment, induction and appraisal policies in place. Regular meetings with Staff side representatives, and inclusion of Staff side in key appointments to the Trust e.g., Chief Executive and Chair.	
• have a fair pay and contract framework	Yes	Workforce strategy agreed by the Trust Board. Trust pay structure based on Agenda for Change and Trust follows guidance issued by National Pay Bodies as appropriate. HR Policies and Procedures as above. Workforce Strategy sets out Trust approach to pay. Support to the concept of Living Wage. Annual internal audit of compliance with national and local policies in place	Chief People Officer
• can be involved and represented in the workplace	Yes	Workforce strategy agreed by the Trust Board includes staff engagement as key priority area. Disciplinary Policy and Procedures. Grievance Policy and Procedures. Set out in the Social Partnership Agreement between the Trust and staff side organisations. Staff engagement strategy. Staff engagement events. Annual staff survey. REACH, Staff Carers, Staff Side, Disability and LGBT+ staff Networks established. Elected staff governors on the Members' Council. Substantive lead Freedom to Speak up Guardian in place. Regular staff network meetings with Trust Board.	Chief People Officer
• have healthy and safe working conditions and an environment free from harassment, bullying or violence	Yes	HR policies and procedures. Staff survey. Health and Safety Policy. Health and Safety Steering Group. Health and Safety annual audit and work programme. Occupational health service. Risk assessments of workplace. Managing Aggression and Violence lead in place with supporting	Chief People Officer

Heading	Compliance	Evidence	Lead
		Management of Violence and Aggression Trust Action Group (MAV TAG).	
• are treated fairly, equally and free from discrimination	Yes	HR policies and procedures. Equality, Inclusion and Involvement Committee, of the Trust Board in place, both the Chair of the Trust and Chief Executive are members. Trust staff are required to undertake mandatory equality training. Equality networks, annual workforce equality impact assessment. Equality impact assessment of all policies and procedures REACH, Staff Carers, Staff Side, Disability and LGBT+ staff Networks established. WRES, WDES and EDS2 action plans agreed. Substantive lead Freedom to Speak up Guardian in place. The Trust has also established a clinical network, called Race Forward, to reduce bullying and harassment from service users and carers on staff from BAME backgrounds.	Chief People Officer
• can, in certain circumstances, take a complaint about their employer to an Employment Tribunal	Yes	Disciplinary and Grievance Policies and Procedures. Trust staff advised of their rights following disciplinary action. Substantive lead Freedom to Speak up Guardian in place.	Chief People Officer
• can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.	Yes	HR Policies and Procedures. Information given to staff and Trust welcome events include information for staff. New Raising Concerns / Freedom to Speak Up (Whistleblowing) Policy agreed with Staff Side in Consultation and the Freedom to Speak Up Guardian Whistleblowing report taken to Clinical Governance & Clinical Safety Committee every six months. Freedom to speak up steering group established in 2022-23 Raising concerns leaflet widely available. Posters on Freedom to Speak Up widely distributed. Intranet site for staff on raising concerns in place. Freedom to Speak Up Guardian have regular meetings with the Chief People Officer, Chief Nurse, Director of Quality and Professions and Senior Independent Director. Substantive lead Freedom to Speak up Guardian in place. Responsibility for Freedom to Speak up now sits with Corporate Governance	Chief People Officer

The NHS Constitution also sets out seven staff pledges, which, although not legally binding, represent a commitment by the NHS to provide high-quality working environments for staff.

- The NHS commits to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.
- The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to enable them to fulfil their potential.
- The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.
- The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- The NHS commits to have a process for staff to raise an internal grievance.
- The NHS commits to support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice, or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998.

The NHS Constitution also sets out six existing legal duties that staff must observe. (This list is not meant to be exhaustive.)

- To accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.
- To take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.
- To act in accordance with the express and implied terms of your contract of employment.
- Not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.
- To protect the confidentiality of personal information that you hold unless to do so would put anyone at risk of significant harm.
- To be honest and truthful in applying for a job and in carrying out that job.

The Constitution also sets out how staff should play their part in ensuring the success of the NHS.

- You should aim to provide all patients with safe care, and to do all you can to protect patients from avoidable harm.
- You should follow all guidance, standards and codes relevant to your role, subject to any more specific requirements of your employers.
- You should aim to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole.

- You should aim to find alternative sources of care or assistance for patients, when you are unable to provide this (including for those patients who are not receiving basic care to meet their needs).
- You should aim to take up training and development opportunities provided over and above those legally required of your post.
- You should aim to play your part in sustainably improving services by working in partnership with patients, the public and communities.
- You should aim to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work, (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff, or the organisation itself at the earliest reasonable opportunity.
- You should aim to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis and their individual care and treatment.
- You should aim to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation.
- You should contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged, and colleagues are supported where errors are made.
- You should aim to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care.
- You should aim to take every appropriate opportunity to encourage and support patients and colleagues improve their health and wellbeing.
- You should aim to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access and outcomes between differing groups or sections of society requiring health care.
- You should aim to inform patients about the use of their confidential information and to record their objections, consent or dissent.
- You should aim to provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 25 July 2023
Agenda item 12.2

Private/Public paper:	Public		
Title:	Barnsley Health and Care Plan 2023-25		
Paper presented by:	Sue Barton, Interim Director of Strategy and Change Joe Minton, Associate Director – Strategy, Population Health Management and Partnerships, Barnsley Place, South Yorkshire Integrated Care Board		
Paper prepared by:	Front sheet: Sue Barton, Interim Director of Strategy and Change Health and Care Plan: Barnsley Place based partnership		
Mission/values:	The proposals are in line with the Trust mission and values		
Purpose:	To share the agreed Barnsley place based partnership health and care plan 2023-25 with the Trust Board		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 1.1 - 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 Risk 1.2 - Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision 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 Risk 3.2 - Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives Risk 3.3 -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 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		

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The health and care plan has been developed by the Barnsley Place based partnership and is aligned to the South Yorkshire Integrated Care System strategy and plans
Any background papers / previously considered by:	Plan presented into the Executive Management Team on 20th July 2023
Executive summary:	The plan sets out the vision, aims and objectives for Barnsley health and care system for the next 2 years. It includes an explanation of how the plan delivers on health inequalities and links to the Barnsley 2030 plan and board. Examples are given as to how this will impact on the experience of Barnsley people The document includes a look back at the achievements of 2022/23 Shared goals, enablers and priorities are set out with key actions described which will • Tackle inequalities in outcomes, experience and access • Improve outcomes in population health and healthcare • Enhance productivity and value for money • Help the NHS support broader social and economic development
Recommendation:	**To receive the plan and note the alignment to the work of the Trust**

Copy of Barnsley HC Plan 23/25 FINAL (moderngov.co.uk)

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Trust Board 25 July 2023
Agenda item 13.1

Private/Public paper:	**Public**		
Title:	**Trust Estate Strategy 2023 to 2033**		
Paper presented by:	Adrian Snarr – Director of Finance, Estates and Resources		
Paper prepared by:	Nick Phillips - Deputy Director of Estates and Facilities		
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:	The estate strategy is a key item in planning future estate needs and understanding how these match to • Clinical need • Future funding requests • Sustainability • Wider estate issues A clear estate strategy will help the Trust in these areas particularly in securing capital funds when set against the system approach to capital funding with a combined ICB capital budget which is generally oversubscribed. In addition the strategy will be a strict requirement in accessing potential national funding.		
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 inequality in health outcomes or life expectancy. Risk 4.3 - Failure to support the wellbeing of staff resulting in an increase in sickness/absence staff turnover and vacancies		
Contribution to the objectives of the Integrated Care System/Integrated	A Trust estate strategy is key in ensuring the Trust has the correct level and quality of estate to support its clinical and wider operational delivery. A Board approved estate strategy will support future applications for system capital for projects to be considered.		

Care Board/Place based partnerships	The Trust needs to be able to demonstrate that its estates supports the delivery of high quality, safe care to the communities its serves, and the wider system.
Any background papers / previously considered by:	This strategy supersedes the current strategy that has been in place since 2012 Executive management team 13 July 2023
Executive summary:	This estate strategy for the Trust sets out the proposals for the next 10 years, in line with the vision, mission and strategic objectives of the Trust. The strategy identifies how the Trust will ensure that its estate continues to support high quality care through the provision of high-quality estate which represents value for money and moves us towards a net zero carbon estate. It builds on the previous estates strategy which this now supersedes. The main components of the strategy are: • The estate enhances and facilitates high quality service models and be able to respond effectively to changing service user needs, new technologies and community developments. • The quality of the estate has a beneficial impact on service users and staff and meets current guidance for best practice. • All accommodation meets accreditation and statutory requirements and is in non-stigmatising locations which meet access and equality requirements. • Accommodation enhances opportunities within the integrated care system and supports delivery of the NHS long term plan and is in line with the principles of one public estate. • All accommodation provides value for money. • The Trust only owns estate where it is an essential aspect of the service delivery. • Investment is reviewed in relation to sustainability. The specific recommendations meet these overarching criteria. Costs are included for reference purposes but at present these are budget only and will change as projects are developed, the years in which spending is planned will change as the capital availability is refined. Whilst the strategy is for ten years it is anticipated that it will be a living document subject to periodic review.
Recommendation:	**Trust Board are asked to APPROVE the Estates Strategy for 2023 to 2033.**

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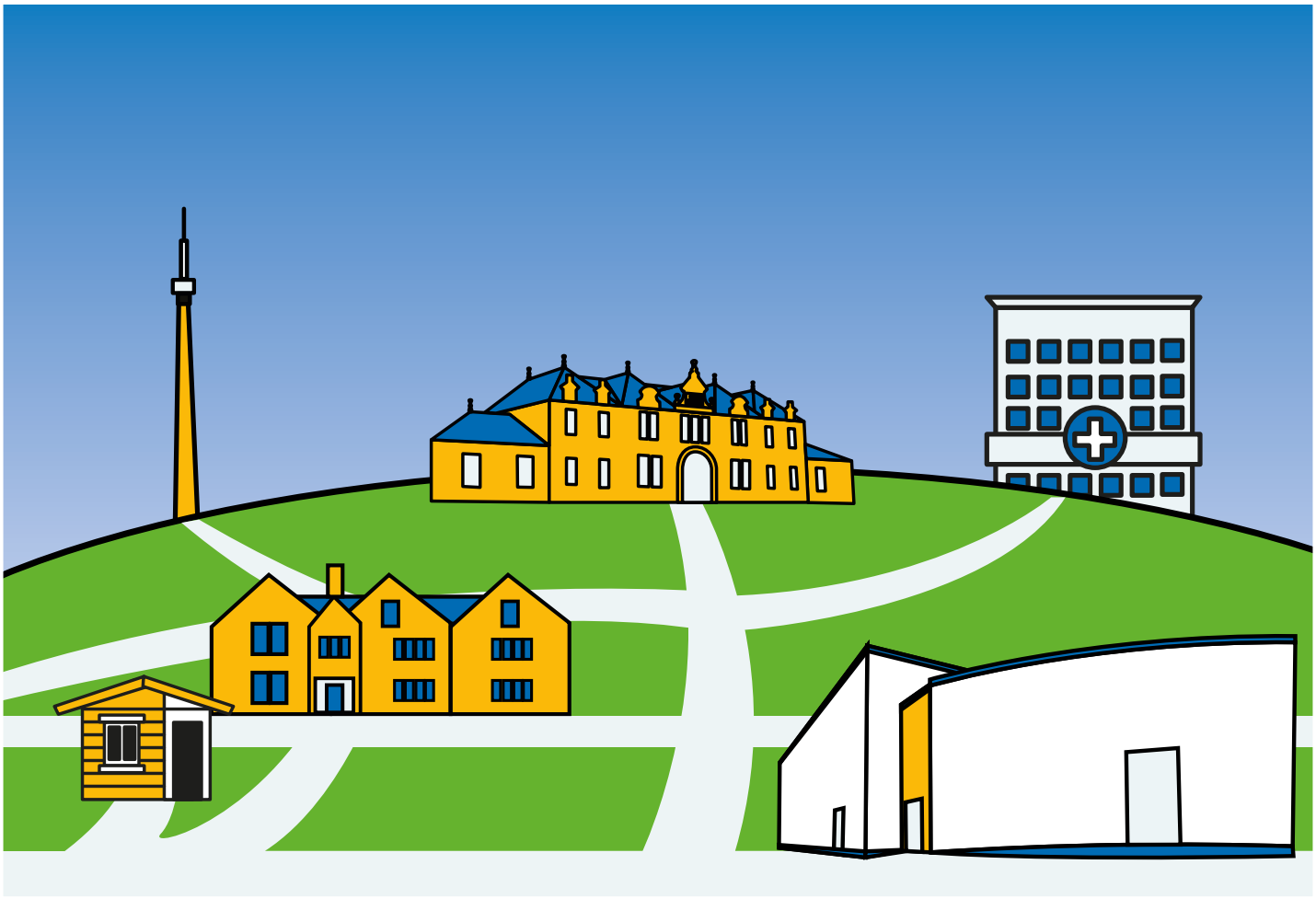


Estates strategy

2023 - 2033

With **all of us** in mind.

Contents

Executive Summary

This estate strategy for South West Yorkshire Partnership NHS Foundation Trust (the Trust) sets out our proposals for the next 10 years, in line with the vision, mission and strategic objectives of the Trust. It identifies how we will ensure that our estate continues to support high quality care through the provision of high quality estate which is value for money and moves us towards a net zero carbon estate. It builds on the previous estates strategy which this now supersedes.

Analysis of our estate suggests that

- Agile working is putting pressure on space, particularly for meetings
- Investment in Trust owned inpatient wards has resulted in a modern, fit for purpose bed base. Future work on ward sizes may impact on this
- There are pressures on space although much of the community estate is only used intensively for part of the week
- The non trust owned bed base is generally of a lower quality and more expensive to operate
- The forensic estate remains a key strategic aim

The aims of the strategy are to ensure that

- The estate enhances and facilitates high quality service models and be able to respond effectively to changing service user needs, new technologies and community developments
- The quality of the estate has a beneficial impact on service users and staff and meets current guidance for best practice
- All accommodation meets accreditation and statutory requirements and is in non-stigmatising locations which meet access and equality requirements
- Accommodation enhances opportunities within the integrated care system and supports delivery of the NHS long term plan and is in line with the principles of one public estate
- All accommodation provides value for money
- The Trust only owns estate where it is an essential aspect of the service delivery
- Investment is reviewed in relation to sustainability
- Digital innovations will shape estate use, the strategy will be in line with the Trust digital strategy.

The proposals described in the strategy cover each care group and support services and includes which place the proposal covers across the Trust geography. The proposals are summarised in the table below.

Locality	Proposal
Trustwide	Commit to the formulation of a net zero carbon roadmap which clearly defines actions in order to meet the 2040 deadline Support delivery of the outcomes of the Older People's Inpatient Transformation Consultation
Wakefield	Upgrade of Airedale Health Centre Upgrade of Flemming Court Review of clinical room usage (Trustwide impact) Review of clinic designs (Trustwide impact)
Kirklees	Hub for North Kirklees Appraisal of the future options for inpatients Consideration of the renewal of the lease renewal for Folly Hall with a clear date of 2025
Calderdale	Appraisal of ward-based services in the west and the future role of Hebden Bridge Health Centre Appraisal of the future options for inpatients
Barnsley	Programme of intensified use of high-quality premises in order to reduce the quantity of poor-quality estate including models yet to emerge from the neighbourhood approach. This to include recognition that the Trust will not always be the owner of the space Consideration of replacement for Lundwood, Wombwell and Penistone sites Consideration of New Street as a central hub, with a view to a multidisciplinary alternative for appropriate services Development of Kendray Hospital site in order to reduce the reliance on older estate on the site
Forensics	Formation of a forensic "campus" to incorporate standards in accommodation found at the Unity Centre and to facilitate working at medium and low secure to be coordinated better. The refurbishment of Gaskell initially as a decant ward will be part of this process
Specialist services	Refurbishment of the Horizon centre to maximise its potential
Trustwide support	Seek further consolidation following implementation of agile working

It is understood that the Trust estates strategy will need to be responsive to changes in the environment and therefore this strategy should be considered a live document

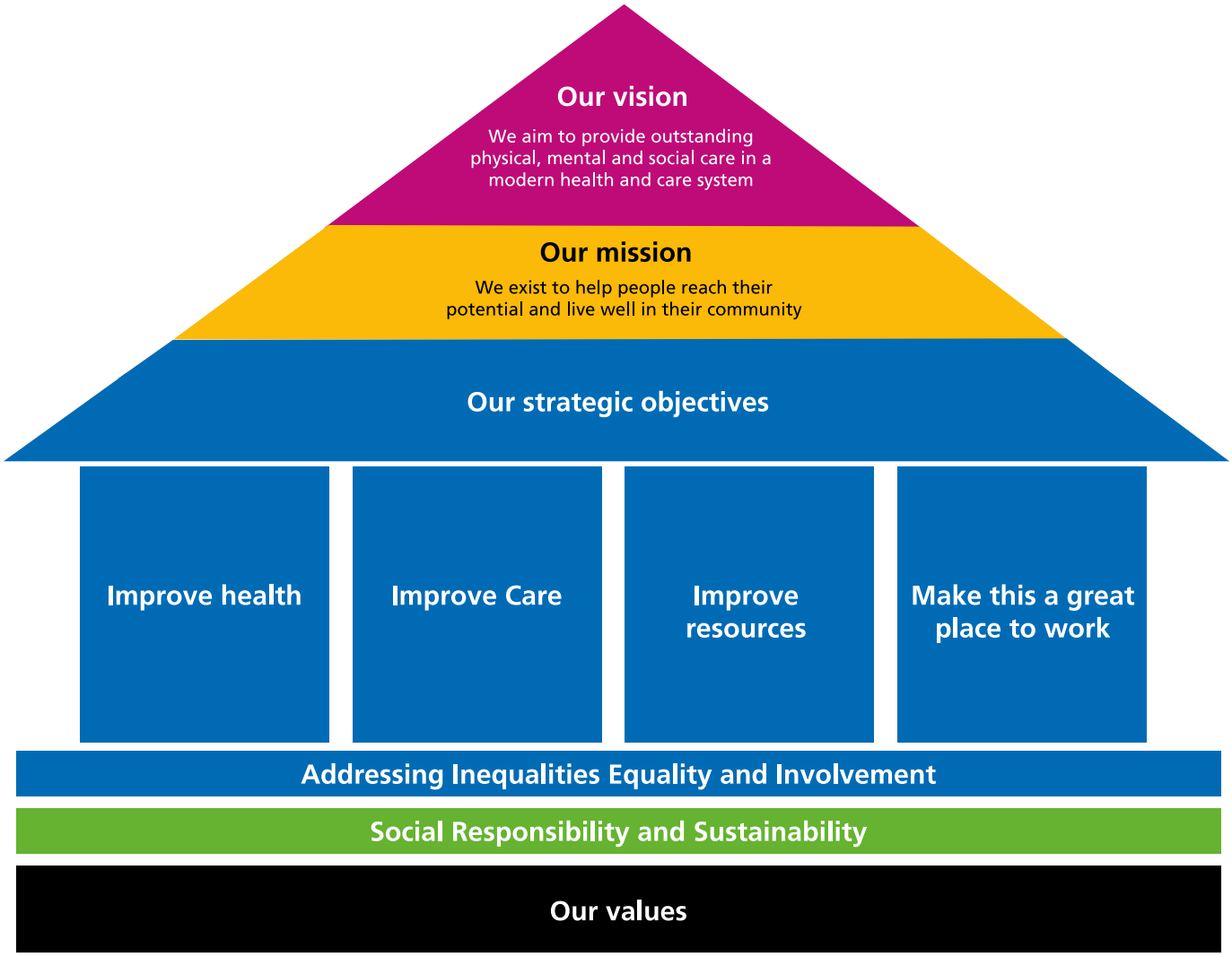
1. Introduction

This estate strategy for South West Yorkshire Partnership NHS Foundation Trust (the Trust) sets out our proposals for the next 10 years, in line with the vision, mission and strategic objectives of the Trust. It identifies how we will ensure that our estate continues to support high quality care through the provision of high quality estate which is value for money and moves us towards a net zero carbon estate. It builds on the previous estates strategy which this now supersedes.

1.1 Strategic alignment and context

Our Trust mission and values were developed in co-production with our service users, carers, staff, partner organisations (e.g. local authorities, other NHS Trusts and commissioners) to understand from all these stakeholders what they expected from SWYPFT. Our mission states why we exist, and our values set out what should underpin our approach to achieving this.

Trust mission, vision and strategic objectives is set out below.



Our vision

To provide outstanding physical, mental and social care in a modern health and care system

Our mission

We help people reach their potential and live well in their community

Our 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

This strategy and the way in which it will be implemented reflects and supports the realisation of our Trust values, as well the Trust's five strategic ambitions, which are to be:

- 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**
- A **compassionate and innovative organisation** with **equality, co-production, recovery** and **creativity** at its heart

The diagram below demonstrates the strategic alignment of this strategy with others internally, locally, regionally and nationally.

1.2 Purpose of the estate strategy

The overall purpose of this document is to:

- Provide a plan to address current issues
- Highlight changes needed to the estate based on service delivery developments across the Trust's different care groups and support functions
- Provide an estate development programme of works for the next 10 years
- Recognise the need for the Trust to move towards a net zero carbon estate
- Understand the cost of implementation
- Consider how we will fund the developments
- Understand barriers to implementation
- Consider environmental sustainability issues in line with the Trust's sustainability strategy
- Highlight areas where the Trust will impact on the wider integrated care system estate strategy

2. Where are we now

This estate strategy both succeeds and complements previous documents, notably the estate strategy for 2012-22 which this replaces.

The previous strategy delivered on the following key developments:

- The hub programme which delivered new hubs in Wakefield, Halifax and Pontefract whilst enhancing the Barnsley town centre hub
- The delivery of the Unity Centre
- The improved wellbeing and learning centre

The Trust operates in several localities and has property in two integrated care system (ICS) areas. Funding particularly around estate is covered by the West Yorkshire ICS but this strategy will need to be referenced into South Yorkshire planning assumptions for Barnsley based buildings and services.

2.1 Characteristics of the estate

The table below provides a high-level summary of the estates cost against income for each locality. Further detail can be found in Appendices 5,6 and 7.

Table: Summary of estate

	Barnsley	Calderdale	Kirklees	Wakefield	Forensics	Total
Population	243,000	207,000	433,000	352,000	2,090,000	
Total number of inpatient beds	77	69	52	98	138	434
Total community beds	0	14	31	15	0	60
Total income (£m)	74.6	28.1	60.2	50.0	28.3	241.3
Total annual spend on estate (excluding cost of capital) (£m)	4.77	4.88	1.02	1.12	0.70	12.50
Spend against income (%)	6.4	17.3	1.7	2.3	2.5	5.2
Total net book value (£m)	7.48	7.36	0.34	83.5 (includes forensic and Kendray)	N/A	98.7
Total floor area (m2)	23,372	7,704	11,928	22,105	9,696	74,865
Spend per sq. m (£)	204	633	85	51	73	167
Number of owned properties	9	2	1	4	1	17
Number of leasedproperties	20	2	7	9	0	38

Total cost excludes catering and domestic costs as well as management costs as at April 2023

The key aspects of the estate that emerge from the analysis are:

- The adoption of agile working, whilst beneficial in terms of an affordable and correctly configured estate, is putting pressure on space particularly for meetings but also for larger team gatherings
- Investment in Trust owned inpatient wards has resulted in a modern fit for purpose bed base, albeit with backlog issues remaining as alterations and adaptions to wards have been undertaken as well as new builds. However, work on future ward sizes may impact on this as the move towards smaller ward sizes is implemented
- There are pressures on space, although much of the community-based estate is only intensively used for part of a week
- The non-Trust owned bed base is generally of a much lower quality than the owned estate leading to issues around parity of esteem, safety and the ability to make plans
- Reference to the cost data also shows it is much more expensive to operate notably in the PFI (Private Finance Initiative) and LIFT (Local Improvement Finance Trust). The forensic campus of care should be considered as a key strategic aim in order to complete the rationalisation of forensic estate which started under previous strategies

2.2 Common themes

A number of common themes occur across the estate including:

- A lack of inpatient accommodation in Calderdale and Kirklees that fully meets current standards for measures such as access to outdoor space, privacy and dignity, and good observation, or is fully robust in relation to the acuity of the patients
- The lack of meeting space for team meetings
- The ratio of buildings relative to the level of activity that takes place is not consistent across the Trust. Barnsley enjoys a consistently higher level of accommodation across both owned and leased property compared to any other area. Kirklees has very little accommodation to work from. Whether the space is well used should be a constant theme across the life of the strategy
- The lack of equity for patients and staff across different locations
- The impact of agile working on some aspects of team cohesion
- The need for more flexible workspaces
- Lack of quality external exercise and relaxation space
- Space standards adopted from national guidance should be reviewed internally and some new Trust standards considered for clinic rooms. This is based on engagement with staff and relates mainly to consultation space

2.3 History of the estate

The current estate has developed over an extended period and is a result of a combination of the adoption of existing estate followed by a more structured approach arising from previous estate strategy work. Examples of the structured approach to estate development are the hubs, the LIFT buildings in Barnsley, Folly Hall in Kirklees, the forensic and acute inpatients units at Fieldhead and to some extent The Dales even though design challenges mean it is not truly fit for purpose.

Within the community estate notable examples of buildings which have been made to fit and require further consideration before investments are made are Airedale, Wombwell, and Silkstone health centres and the Lundwood centre. The majority of these buildings are in Barnsley which has the largest footprint of any area.

2.4 Current estate analysis

The estate returns information collection (ERIC) return is a form that each NHS Trust has to submit to the Department of Health each year. It requires Trusts to provide information on the type of estate the Trust has in its portfolio and costs associated with running the estate and the services. This analysis has been used as a basis for our current position. A summary of this is included in Appendix 8.

2.5 Service user feedback

Some engagement took place across the acute wards in Wakefield, forensic services and Barnsley. This was through either direct service user interaction or as part of a structured group dependent on the advice of the care group. Questions were open and the language used was kept neutral so that a proper representation of the service user experience was received.

Comments were as follows:

- The rooms are nice
- Bedrooms are warm and comfortable
- Exercise space is limited
- We want to be able to walk outside more (forensics)
- Can we have televisions in bedrooms?
- The decoration is boring
- Shared spaces are sometimes too big
- Can we have some smaller rooms?
- I want better space to see visitors in (particular reference to children)
- I feel safe
- I feel looked after
- Activities do not interest me
- The food is good
- I want healthier options
- I want help to choose what's best for me (food)
- Can we grow our own food?

Not all of these relate to a wider strategy but do give clear pointers on design and what is important to service users. We are investigating how we can deliver an improved inpatient estate for Calderdale and Kirklees. Service user views form part of that exercise.

3. The future

3.1 Purpose of estates strategy

South West Yorkshire Partnership NHS Foundation Trust (the Trust) is setting in place a robust estate strategy that provides a framework for aligning estates requirements with service requirements. The estate involves major investment of both capital and revenue and must demonstrate value for money within the healthcare economy.

This estates strategy has been developed in the context of the service delivery strategy. The initial sections of the document provide analysis of the Trust's current estate position and the Trust's service delivery intentions for the future. The final section of this document builds on this analysis and sets out the way forward for the Trust in terms of the actions required to align the estate with best practice and service needs.

This estate strategy has been written in accordance with NHS Estates guidance 'Developing an Estate Strategy' and addresses 3 questions:

- Where are we now?
- Where do we want to be?
- How do we get there?

The overall purpose of this document is:

- To inform the Trust board of any major issues with the current estate
- To provide a strategy addressing the current issues from the executive summary
- To address the estates place in a wider integrated care system strategy
- To highlight changes in estate need based on service delivery developments across the Trust's different care groups and associated support services
- To provide an estate development programme of works for the next 10 years

3.2 Aims of the Estates Strategy

The criteria for measuring the adequacy of the estate are:

- The **estate must enhance and facilitate service models** and be able to respond effectively and speedily to changes in those models. For example, this requires buildings that are flexible and can easily respond to changing patient needs, including higher acuity patients; it also means that key requirements such as direct access to outside space for inpatients and provision of spaces that are appropriate for multiple functions must not be compromised through design. Any new or refurbished facilities must be driven by operational imperatives and avoid situations where operational policies represent a compromise arrangement based on constraints imposed by buildings.
- The **quality of the estate must have a beneficial impact on staff and service users** and meet current guidance for best practice. This means, for example, that rooms must not simply be the size required but that the outlook, location, and design must all enhance, and certainly not detract from, the clinical service that is being provided.

- All **accommodation must meet accreditation and statutory requirements** and maintain safety standards. However, all short-term expenditure should be assessed within the long-term service strategy so that money is not expended on "quick fixes" on properties that do not have an appropriately long life.

- All **accommodation for patients must be in appropriate, non-stigmatising locations** which meet access and equality requirements. The criteria for these locations should be explored with patients and carers as they might be different for different services.

- All **accommodation should be constantly reviewed in relation to the most effective service models.** These should include new technologies and wider community developments. In addition accommodation provision should align with other Trust strategic aims in particular clinical and sustainability strategies.

- Wherever possible **accommodation should enhance opportunities for the Trust** within the integrated care system and the wider NHS long term plan. This means that the Trust should engage fully in wider place-based initiatives as long as they benefit staff and service users. This may mean that the Trust will operate from premises not owned by the Trust as long as the core standards are met.

- Taking account of all of the quality related imperatives, **accommodation must provide value for money.**

- The Trust should **only own estate where this is an essential aspect of the service.** Examples might be inpatient, secure care and clinical space where specialism is required. All leased estate should be considered against the IFRS 16 – Leases. (International Financial Reporting Standards) for ensuring financial viability. This standard has a capital impact on all operating leases and its impact will increase over the life of this strategy.

- All **investment must be reviewed in relation to sustainability** in the widest sense of the word. This should include energy efficiency, accessibility and quality.

- The Strategy should recognise that solutions will need to include consideration for estate not in SWYPFT ownership using the principles of **"one public estate".**

3.3 Long term strategies for delivering services in area

The Trust operates mainly in the West Yorkshire system with Barnsley being located in South Yorkshire. Each of these systems has an estates strategy which is newly developed and is still forming. At present it is not at a detailed stage but will in future increasingly impact on the Trust's own strategies.

Key principles across each are:

- Place based approach to major developments

- Sustainable development

The range and coverage of services provided by the Trust has altered significantly in recent years, notably in the Barnsley area which is developing a neighbourhood approach as part of integrated care. This will particularly impact on operational estate.

The Trust continues to work towards its goal of enabling people to reach their maximum potential with initiatives that include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation.

The Trust understands that it needs to be clear about what it provides and how much it costs. To do this the Trust has been working on supporting patient level costing to clarify and cost mental health services in a way that helps understand the whole cost of delivering services. This new approach to describing the service offer will help the Trust:

- Explain to commissioners what services are provided and how much they cost
- To plan and ensure that it has the most effective and efficient workforce, estate and information technology to meet people's needs
- Deliver service improvement and innovation
- Increase the involvement of service users in commissioning and service improvement
- Engage with staff
- To develop a framework for wellbeing with better service integration

3.4 Environmental strategy and net zero carbon

At South West Yorkshire Partnership NHS Foundation Trust, we are committed to delivering high-quality services that promote health and wellbeing while also minimising the impact of our operations on the environment. As part of this commitment, we have developed a social responsibility and sustainability strategy that outlines our vision for a more sustainable future.

Our strategy focuses on three key areas:

1. Reducing our environmental impact – We will strive to reduce our carbon footprint, energy consumption and waste generation across our estate. We will also work towards sustainable procurement and travel and promote biodiversity and green spaces.
2. Promoting social responsibility – We will work towards enhancing the health and wellbeing of our staff, patients, and local communities. We will also strive to promote diversity, inclusion, and equality, and support local economic development.
3. Embedding sustainability in our operations – We will integrate sustainability principles into our decision-making processes and ensure that sustainability is a key consideration in all our operations.

As part of our commitment to this strategy, we are developing a new estates strategy that reflects our sustainability goals.

Our estates strategy will focus on reducing our environmental impact by:

- Improving the energy efficiency of our buildings and equipment
- Reducing waste generation through better waste management practices
- Encouraging sustainable travel and transport options

- Promoting biodiversity and green spaces across our estate
- Ensuring that all new buildings and refurbishments meet sustainability standards

By embedding sustainability principles into our estates strategy, we hope to create a more sustainable and resilient organisation that is better equipped to meet the needs of our patients and staff while also minimising our impact on the environment. We believe that this approach will help us to achieve our vision of delivering high-quality services that promote health and wellbeing for all. The Trust social responsibility and sustainability strategy is available on the intranet.

The wider NHS and government are signed up to the goal of being carbon neutral by 2040 in terms of directly controlled emissions which does cover the estate. There is an interim target for a reduction in emissions by 80% by 2028-32. The Trust has performed well in terms of this target to date. This has been achieved through both investment in estate and reduction in overall estate footprint.

The next stage of the reduction will require a much more targeted approach to reducing carbon through reduction in use and elimination of heating from fossil fuels and continuing to use electricity exclusively supplied from renewable sources. NHS England have issued guidance that all capital developments should be net zero carbon in support of these targets. Whilst the date for net zero carbon is outside the timeline of this strategy the 80% reduction is within the timeline of the strategy. The Trust is currently considering the implementation of a net zero carbon roadmap which will provide a costed, prioritised plan to achieving the standard. At present an overarching requirement for capital investment in this field is allowed in the planning appendices.

3.5 Proposals

The strategy makes several proposals for each care group and the whole of forensics as well as for support services. The strategy also references the place in which the need is recommended. It is recognised that management responsibility under the overall operational umbrella has changed but it is felt that the geographical nature of the estate is referenced in this strategy as the Trust operates in a number of places and two integrated care systems.

These proposals require consideration and prioritisation by the Trust. However, it is also important that minor works continue to be evaluated against the Trust priorities and work programme for major change; this will ensure that there are no inconsistencies or short-term investments that run counter to the longer-term strategy.

The supporting documentation to the strategy gives context to these recommendations.

Locality	Proposal
Trustwide	Commit to the formulation of a net zero carbon roadmap which clearly defines actions in order to meet the 2040 deadline Support delivery of the outcomes of the Older People's Inpatient Transformation Consultation
Wakefield	Upgrade of Airedale Health Centre Upgrade of Flemming Court Review of clinical room usage (Trustwide impact) Review of clinic designs (Trustwide impact)

Locality	Proposal
Kirklees	Hub for North Kirklees Appraisal of the future options for inpatients Consideration of the renewal of the lease renewal for Folly Hall with a clear date of 2025
Calderdale	Appraisal of ward-based services in the west and the future role of Hebden Bridge Health Centre Appraisal of the future options for inpatients
Barnsley	Programme of intensified use of high-quality premises in order to reduce the quantity of poor-quality estate including models yet to emerge from the neighbourhood approach. This to include recognition that the Trust will not always be the owner of the space Consideration of replacement for Lundwood, Wombwell and Penistone sites Consideration of New Street as a central hub, with a view to a multidisciplinary alternative for appropriate services Development of Kendray Hospital site in order to reduce the reliance on older estate on the site
Forensics	Formation of a forensic "campus" to incorporate standards in accommodation found at the Unity Centre and to facilitate working at medium and low secure to be coordinated better. The refurbishment of Gaskell initially as a decant ward will be part of this process
Specialist services	Refurbishment of the Horizon centre to maximise its potential
Trustwide support	Seek further consolidation following implementation of agile working

The above aims are designed to take account of the future Trust strategic goals as prioritised by the Trusts operational plans. In addition the increasing influence of the wider systems both within the NHS and the wider public sector are referenced as the Trust continues to operate as a key partner in these areas.

The strategy is designed to be able to adapt as the systems change and will operate within a wider Integrated care estate strategy.

3.6 Summary of proposed expenditure

Year	23/24	24/25	25/26	26/27	27/28	28/33*	Total
Projected income (£m)	1.7		0.45		0.5		2.65
Projected Expenditure (£m)	2.5	7.5	17.5	23.5	20.5	80	151.5

* Estimates at July 2023

4. Delivering the strategy and measuring our success

4.1 Gap analysis

The quality of the accommodation occupied by the Trust spans a wide range in terms of space standards, accessibility, quality of fit out and general environment, and fitness for the services it delivers. This means that there can be a lack of equity for staff, patients and carers who access services. There is an equally wide range of costs for each property and care group/locality partly because the cost base for different areas is different. For example, Barnsley in general attracts lower market rental and property costs.

The Trust has a variety of different arrangements for the properties that it does not own, including arrangements with GPs and other third party providers (for example, LIFT arrangements). Some of these arrangements include a lease payment whereas others do not attract costs.

In general, the investment in the hubs and clinical estate has proven beneficial to both staff and service users and much of the poor estate has been replaced. However, pockets of substandard accommodation do remain, and the Trust needs to consider their future.

It is important to note that generally these properties are cheap to run and benefit the financial viability of the service. This should not stop consideration to reprovide space but will impact on how that redevelopment will occur. For example, the two inpatient services at Lyndhurst and Enfield Down are delivered at very little cost to the Trust in terms of estate but they do not meet the same standards as for other inpatient areas. A solution should be sought which resolves these issues but will require agreement from commissioners and a review of funding arrangements to suit any proposed changes for a new clinical model.

In order to arrive at a property portfolio that addresses quality, equity, access, occupancy levels, value for money and flexibility, it is important to assess any shortfalls in the current portfolio, property by property.

The detailed gap analysis, by locality, is included at Appendix 9.

4.2 Delivering the strategy

The delivery of the strategy will be achieved through detailed plans and governance and overseen by the Estates Trustwide Action Group.

4.3 Measuring delivery of the strategy

The following set of core principles have been developed to monitor the estate's efficiency and suitability to deliver the services provided by the Trust and will be used as part of the measures for delivery of the strategy:

- The **estate must enhance and facilitate service models** and be able to respond effectively and speedily to changes in those models. For example, this requires buildings that are flexible and can easily respond to changing patient needs, including higher acuity patients; it also means that key requirements such as direct access to outside space for inpatients and provision of spaces that are appropriate for multiple functions must not be compromised through design. Any new or refurbished facilities must be driven by operational imperatives and avoid situations where operational policies represent a compromise arrangement based on constraints imposed by buildings.

- The **quality of the estate must have a beneficial impact on staff and service users** and meet current guidance for best practice. This means, for example, that rooms must not simply be the size required but that the outlook, location, and design must all enhance, and certainly not detract from, the clinical service that is being provided.
- All **accommodation must meet accreditation and statutory requirements** and maintain safety standards. However, all short-term expenditure should be assessed within the long-term service strategy so that money is not expended on "quick fixes" on properties that do not have an appropriately long life.
- All **accommodation for patients must be in appropriate, non-stigmatising locations** which meet access and equality requirements. The criteria for these locations should be explored with patients and carers as they might be different for different services.
- All **accommodation should be constantly reviewed in relation to the most effective service models.** These should include new technologies and wider community developments. In addition accommodation provision should align with other Trust strategic aims in particular clinical and sustainability strategies.
- Wherever possible **accommodation should enhance opportunities for the Trust** within the integrated care system and the wider NHS long term plan. This means that the Trust should engage fully in wider place-based initiatives as long as they benefit staff and service users. This may mean that the Trust will operate from premises not owned by the Trust as long as the core standards are met.
- Taking account of all of the quality related imperatives, **accommodation must provide value for money.**
- The Trust should **only own estate where this is an essential aspect of the service.** Examples might be inpatient, secure care and clinical space where specialism is required. All leased estate should be considered against the IFRS 16 – Leases. (International Financial Reporting Standards) for ensuring financial viability. This standard has a capital impact on all operating leases and its impact will increase over the life of this strategy.
- All **investment must be reviewed in relation to sustainability** in the widest sense of the word. This should include energy efficiency, accessibility and quality.
- The Strategy should recognise that solutions will need to include consideration for estate not in SWYPFT ownership using the principles of **"one public estate".**

4.4 Criteria for investment

All investment must meet the Trust's overarching business objectives. It must therefore:

- Be affordable and reduce or maintain revenue costs
- Address quality deficiencies
- Have long term benefits
- Increase equity
- Facilitate best practice in terms of service delivery
- Ensure sustainability
- Ensure flexibility for the service model

In addition, there are criteria that must be applied specifically to minor works, including:

- Expenditure must fit with the overall strategy for the service, and if not, it must only be committed if there are detrimental consequences to patient services or health and safety of staff if these works are not undertaken
- Capital expenditure should not increase revenue costs to a point that impacts on service delivery
- There must be measurable quality gains associated with the expenditure

These criteria are important as it is easy to spend small amounts in increments and yet remain at some distance from the standards that are required, when one major scheme might have achieved more.

It is recognised that short term operational pressures will mean that there is an ongoing programme of small works. However, the proposals in this report would mean a radical transformation of the premises across the Trust and must be subject to a validation and prioritisation and programming exercise within the Trust in accordance with the criteria set out above.

Overall, the recommendations contained in this strategy amount to a considerable capital investment. The Trust has seen that investment in the estate has paid dividend with a modern, fit for purpose, owned, bedded estate and high-class community hubs. However, this programme of investment has been self-financed. While the Trust is in a relatively healthy financial position, investment in the estate to the levels indicated in this strategy will not be possible in this way.

The Trust has a number of options which should be considered outside this strategy for how funding can be managed going forward. Options include:

- Self-funding of capital schemes using savings and or depreciation. To date, this is the only model the Trust has used. This means that the Trust has used the funds it has in the bank to spend above the depreciation level. While the Trust does have healthy reserves, this should be only part of a finance structure going forward, especially on larger projects which will not be affordable using this methodology. The move to the ICS system has introduced a new layer of capital control. At the present time this seems to be limiting capital opportunities across the ICS. However, an improved ICS estate strategy may help to release funds.
- Access to central funding. Recently central funding has been available for schemes and is accessed through the ICS route. The Trust has engaged in this process but to date no schemes have been taken forward for further consideration. It is clear that all future funding will follow this route and will be dependent on the ICS and its constituent organisations having a coherent and centrally approved estate strategy. At present the estate strategies are forming and will be developed. It is vital that the Trust continues to engage with this process.
- Borrowing is another option for the Trust, and this has been explored in order to understand costs. Borrowing does negatively impact on the Trust's financial rating. It also is accounted against the Trust's capital allowance putting additional strain on the resource and removing funds for building improvement.

It should be noted that all capital developments have a revenue implication which can negatively impact on a service.

5. Recommendations

The Trust has invested heavily in estate and has a well-balanced and effective portfolio of owned properties.

The needs over the next ten years as identified in this strategy will change as the NHS environment changes, and as such this strategy should be considered a live document and be constantly updated as clinical, commissioning and other factors change. The need to work as part of a wider ICS estate strategy may mean that the Trust strategy has to reflect developments that are proven to benefit others as part of the wider ICS. This coupled with the fact that one of the main recommendations will impact on other Trusts will mean that the developments will receive much external interest.

As stated, this should not disadvantage the Trust's service users as their needs are our prime goal.

Table: Summary of estates strategy recommendations

Locality	Proposal
Trustwide	Commit to the formulation of a net zero carbon roadmap which clearly defines actions in order to meet the 2040 deadline Support delivery of the outcomes of the Older People's Inpatient Transformation Consultation
Wakefield	Upgrade of Airedale Health Centre Upgrade of Flemming Court Review of clinical room usage (Trustwide impact) Review of clinic designs (Trustwide impact)
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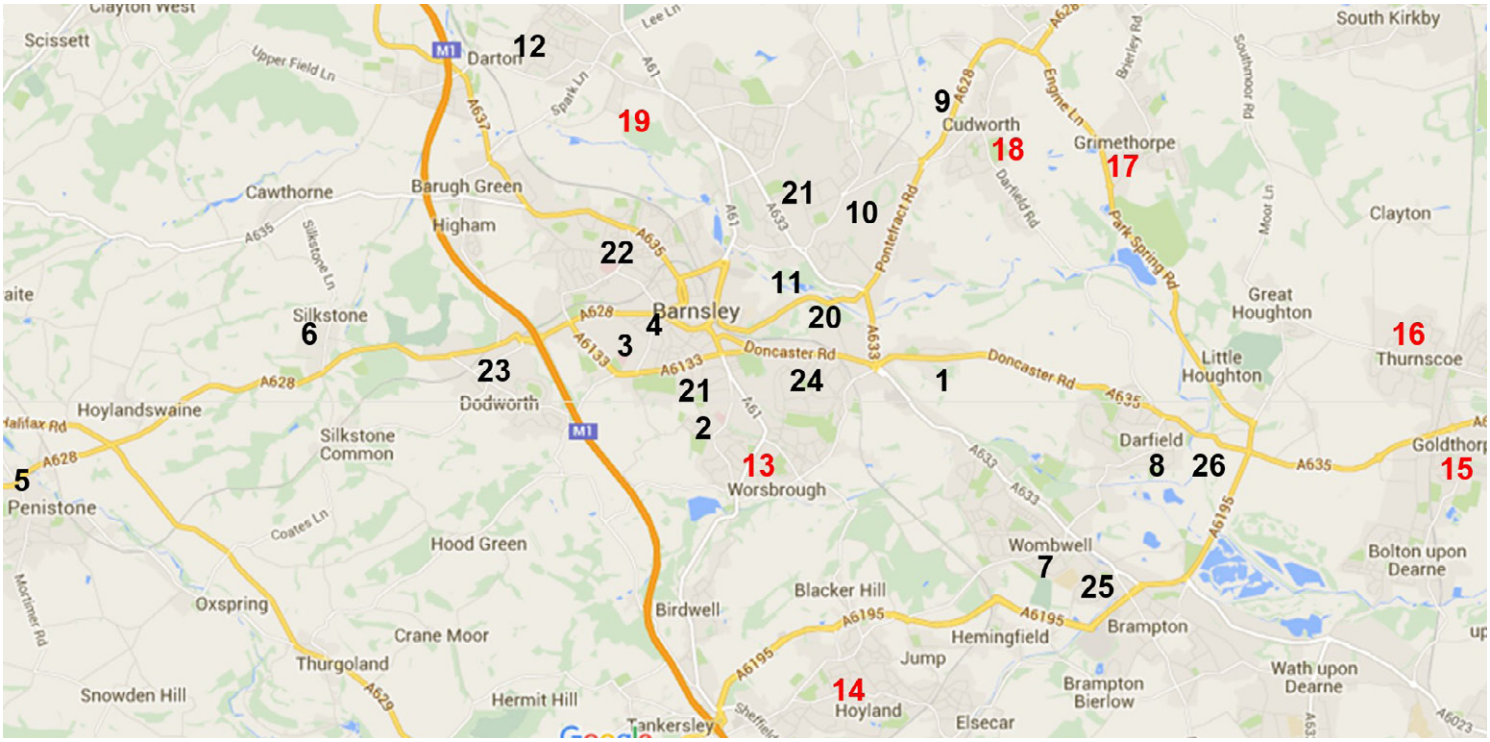
Calderdale	Appraisal of ward-based services in the west and the future role of Hebden Bridge Health Centre Appraisal of the future options for inpatients
Barnsley	Programme of intensified use of high-quality premises in order to reduce the quantity of poor-quality estate including models yet to emerge from the neighbourhood approach. This to include recognition that the Trust will not always be the owner of the space Consideration of replacement for Lundwood, Wombwell and Penistone sites Consideration of New Street as a central hub, with a view to a multidisciplinary alternative for appropriate services Development of Kendray Hospital site in order to reduce the reliance on older estate on the site
Forensics	Formation of a forensic "campus" to incorporate standards in accommodation found at the Unity Centre and to facilitate working at medium and low secure to be coordinated better. The refurbishment of Gaskell initially as a decant ward will be part of this process
Specialist services	Refurbishment of the Horizon centre to maximise its potential
Trustwide support	Seek further consolidation following implementation of agile working

6. Appendices

Appendix 1: Trust maps

Estate summary and map – Barnsley locality

LIFT in red



© Google Maps

No.	Property	Location	Tenure	Lease expiry / break date	Use	Service occupancy	Description / comments
1	Kendray Hospital	Outskirts of town centre	Trust owned (via TCS)	N/A	Community, inpatient, administrative base	Health and wellbeing services Mental health services General community services Support services	Main site for Barnsley services.
2	Mount Vernon Hospital	Outskirts of town centre	2	N/A	Community, Inpatient	Health and wellbeing services Mental health services General community services	Disposal in 2020, current redevelopment to housing.
3	Keresforth Centre	Outskirts of town centre	Trust owned (via TCS)	N/A	Community	Specialist services	Scheduled for disposal 2022.

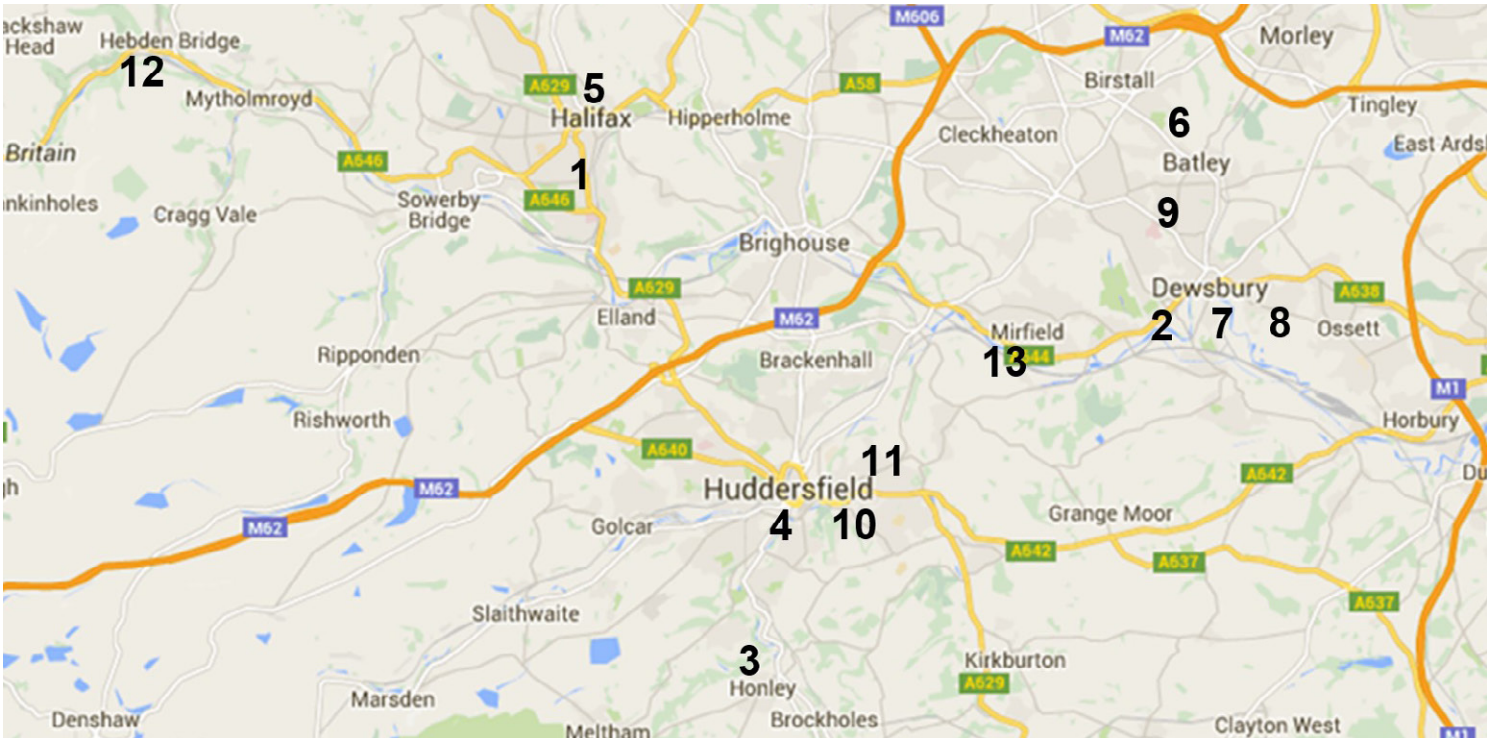
No.	Property	Location	Tenure	Lease expiry / break date	Use	Service occupancy	Description / comments
4	New Street Health Centre	Outskirts of town centre	Trust owned (via TCS)	N/A	Community	Specialist services General community services Barnsley Hospital FT	Community hub.
5	Penistone Clinic	Village centre	Trust owned (via TCS)	N/A	Community	General community services	Converted period building.
6	Silkstone Health Centre	Village centre	Trust owned (via TCS)	N/A	Community	General community services Mental health services	Underutilised facility providing branch surgery for GP practice.
7	Wombwell Health Centre	Outlying village	Trust owned (via TCS)	N/A	Community	Mental health services	Property to be reviewed in light of mental health transformation.
8	Darfield Clinic	Outlying village	Trust owned (via TCS)	N/A	Community	Mental health services	Review utilisation.
9	Cudworth Clinic	Outlying village	Trust owned (via TCS)	N/A	Community	Mental health services	Main community mental health team base. Review utilisation alongside Lundwood and Monk Bretton HCs.
10	Lundwood Health Centre	Outskirts of town centre	Trust owned (via TCS)	N/A	Community	Mental health services General community services	See above but also has potential as mental health single point of access team location as part of mental health community transformation.
11	Priory Day Unit	Outskirts of town centre	Trust owned (via TCS)	N/A	Community	Support services	Under review.
12	Mapplewell Health Centre	Outlying village	Trust owned (via TCS)	N/A	Community	General community services	Minor capital works recently completed to support relocation of services from Darton. Good location for clinical delivery.
13	Worsborough LIFT	Residential area (outskirts of town)	Leasehold (LIFT)		Community	0-19 General community services Mental health services	Purpose-built community health development. Limited utilisation by care group. Could be targeted for increased occupancy.
14	Hoyland LIFT	Outlying village	Leasehold (LIFT)		Community	0-19 General community services Mental health services	Clinical/office accommodation within a purpose-built community health development. Limited utilisation by care group. Could be targeted for increased occupancy.

No.	Property	Location	Tenure	Lease expiry / break date	Use	Service occupancy	Description / comments
15	Goldthorpe LIFT	Outlying village	Leasehold (LIFT)		Community	0-19 Mental health services General community services	Clinical/office accommodation within a purpose-built community health development. Limited utilisation by care group. Could be targeted for increased occupancy.
16	Thurnscoe LIFT	Outlying village	Leasehold (LIFT)		Community	0-19 General community services Mental health services	Clinical/office accommodation within a purpose-built community health development. Limited utilisation by care group. Could be targeted for increased occupancy.
17	Grimethorpe LIFT	Outlying village	Leasehold (LIFT)			0-19 General community services Mental health services	Clinical/office accommodation within a purpose-built community health development. Limited utilisation by care group. Could be targeted for increased occupancy.
18	Cudworth LIFT	Outlying village	Leasehold (LIFT)			0-19 General community services Mental health services	Clinical/office accommodation within a purpose-built community health development. Limited utilisation by care group. Could be targeted for increased occupancy.
19	Roundhouse LIFT (Athersley)	Barnsley neighbour-hood	Leasehold (LIFT)			0-19 General community services Mental health services	Clinical/office accommodation within a purpose-built community health development. Limited utilisation by care group. Could be targeted for increased occupancy.
20	Grange Lane Industrial Estate	Outskirts of town centre	Leasehold	Rolling		General community services	Review utilisation and lease.
21	Monk Bretton Clinic	Outskirts of town centre	Leasehold	Expiry 2021		General community services	Clinical/office accommodation within a purpose-built GP development. Close proximity to Lundwood and Cudworth. Review utilisation and lease.
22	Victoria Medical Centre	Outskirts of town centre	Leasehold	Expiry 2024		General community services	Clinical/office accommodation within a purpose-built GP development. In close proximity to New Street. Review utilisation.
23	Apollo Court, Dodworth	Village centre	Leasehold	Expiry 2027	Community	General community services	Clinical and office accommodation within a GP practice. Review utilisation and lease.

No.	Property	Location	Tenure	Lease expiry / break date	Use	Service occupancy	Description / comments
24	Oaks Park Medical Centre	Outskirts of town centre	Leasehold	Expiry 2027		0-19 General community services Mental health services	Clinical/office accommodation within a purpose-built GP facility within a residential area. Review utilisation and lease.
25	Chapelfield Medical Centre	Outlying vllage	Leasehold	Expiry 2027		0-19 General community services	Clinical/office accommodation within a purpose built GP development. Review utilisation and lease alongside Wombwell HC.
26	Garland House Surgery	Outlying village	Leasehold	Expiry 2029		0-19 General community services	Clinical/office accommodation within a purpose-built GP development. Review utilisation and lease.

Excludes all sessional use activity

Estate summary and map – Calderdale and Kirklees localities



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No.	Property	Location	Tenure	Lease expiry / break date	Use	Service occupancy	Description / comments
1	The Dales Unit	Outskirts of town centre	Leasehold	Break 2019 Ends 2061 (co-terminus with PFI arrangement)	Inpatient	Mental health services Specialist services	Oakdale Ward potential to utilise further.
2	The Priestley Unit	Dewsbury and District Hospital	Leasehold	*	Inpatient & Community	Mental health services	
3	Enfield Down	Honley, Huddersfield	Informal lease arrangement with Kirklees Council	N/A	Rehabilitation	Mental health services (R&R)	
4	Folly Hall Mill	Central Huddersfield	Leasehold	Break at 2020 Expiry 31/10/25	Community	Mental health services Specialist services Health and wellbeing services	Hub for Greater Huddersfield.
5	Laura Mitchell Health and Wellbeing Centre	Central Halifax	Trust owned	N/A	Community	Mental health services Specialist services Health and wellbeing services	Hub for Halifax.
6	Beckside Court	Batley town centre	Leasehold	Break at 2020 Expiry at 27/04/25	Staff Base	Mental health services	Staff base for North Kirklees.
7	Fox View Hub	Dewsbury and District Hospital	Leasehold	*	Staff Base	Specialist services	Learning disability staff base for North Kirklees.
8	Cullingworth Street	Dewsbury and District Hospital	Leasehold	*	Community	Specialist services	Learning disability consulting adjacent to Fox View Hub.
9	Ravensleigh Resource Centre (inc cottage and annexe)	Dewsbury	Trust owned	N/A	Community	Mental health services	
10	Brian Jackson House	Central Huddersfield	Licence	3 months notice	Community	Specialist services	
11	Chestnut Centre	Deighton, Huddersfield	Licence	3 months notice	Community	Specialist services	
12	Hebden Bridge Health Centre	Hebden Bridge	Trust owned	N/A	Community	Mental health services Specialist services	
13	Pathways	Mirfield, Huddersfield	Informal arrangement with Kirklees Council		Community	Mental health services (R&R inc. Recovery College)	

Excludes all sessional use activity

*** Landlord option to determine from 2015 with 2 years notice.**

Estate summary and map – Wakefield locality

© Google Maps

No.	Property	Location	Tenure	Lease expiry / break date	Use	Service occupancy	Description / comments
1	Manygates Clinic	Outskirts of town centre	Leasehold	Expiry 2022	Community	Specialist services (ADHD/ASD)	
2	Unit 11, Eagle Point	Wakefield, J41	Leasehold	2021	Receipt and distribution	Support services	Warehouse building.
3	Fieldhead Hospital	Outskirts of Wakefield town centre	Trust owned	N/A	Community, inpatient, forensics, Trust HQ, administrative base	Mental health services Forensic services Specialist services Support services	
4	Drury Lane Health and Wellbeing Centre	Wakefield town centre	Leasehold	Rental		Mental health services Specialist services	Main Wakefield hub.
5	Airedale Health Centre	Castleford suburb	Trust owned	N/A	Community	Specialist services	Utilised by CAMHS – refurbishment completed February 2017.
6	Unit 2 Flem-ming Court, Glasshought-on	Glass-houghton Business Park	Leasehold	Unit 2 – 2018 Unit 11 – 2017	Community	Specialist services	

No.	Property	Location	Tenure	Lease expiry / break date	Use	Service occupancy	Description / comments
7	Pontefract Health Centre	Town centre	Leasehold (NHS PS)	Undocu-mented	Community	Specialist services Health and wellbeing services	
8	Pontefract Hub (Baghill House)	Edge of town centre	Trust owned	N/A	Community	Mental health services	
9	Thorneycroft House	Outskirts of Pontefract	Leasehold	Licence	Community	Specialist services	Former house utilised by CAMHS.
10	Poplars Community Unit	Hemsworth	Trust owned	N/A	Inpatient (OPS)	Mental health services	Poplars under review as part of the OPS inpatient transformation project.

Excludes all sessional use activity

Appendix 2: Summary of engagement

Group	Issues
Community mental health teams in Wakefield – cross section of community staff operating from hubs and health centres	• Meeting space at a premium • Airedale HC vital to future working but its fitness for purpose was brought into question • Car parking at hubs
Forensic services – "One voice" group representing secure services	• More external exercise space needed especially for walking • Better control of their own space would be nice, especially showers and heating • Courtyards aren't stimulating • Better visitor rooms needed • CCTV would make people feel safe • Some smaller individual space besides bedrooms would help, the large day spaces can be intimidating • Better, healthier food
Matrons – representing all ward area management excluding forensics	• Priestley is not a good layout for mental health, outside space requires improvement • CCTV to corridors is needed along with bodycams, all with better staff access to view • Changing acuity needs to be reflected in standards, even in OPS wards such as Willow • Seclusion room redesign needed • Increased use of anti-barricade doors is needed • Wards are too big (especially Unity when swing space is in use to maximum) • The "swing space" in Unity once in use is too much (linked to ward size) • As well as en suite rooms need better furniture • Staff space must not be compromised to provide service user space
Barnsley – governance meeting representing the care group	• Increased operating hours at community buildings • Multi-disciplinary team accommodation needs to be reviewed • Less large meeting space needed
Operational management group	• Improved control of buildings needed to improve utilisation • Eliminating mixed-sex accommodation is a concern especially on OPS wards • Anti-ligature becoming increasingly important • Concern re new financial restrictions around leases • Priestley/Dales replacement is vital • North Kirklees hub is needed • Replacement for Folly Hall will be an ongoing need

Group	Issues
Oakwell Ward staff and service users	• Do not compromise on staff space (related to ward offices – these are crowded) • Smarter buildings required, use of CCTV touch screens and interactive building management systems (doors, showers, heating etc) • Dignity issue in en suites with curtains • Better outdoor space needed for exercise • Better activity space needed • Big day spaces can be too noisy causing people to go to their rooms • TVs wanted in bedrooms • Decoration is a bit boring, more stimulating types would be good • Better visitor facilities required • Feels safe
Forensic management	• Campus identified in previous strategy is still needed • Better flow between low and medium secure services to be a campus outcome • Remove clinically isolated wards (Newhaven) • To achieve campus a decant will be needed
Unity Centre staff and service users	• Showers could be improved (water flow and duration) • En suites a bit too functional, bathroom furniture needed • Lots of transmitted noise from doors and hard surfaces • The windows whilst anti-ligature are not good for ventilation • “Swing space” too big • Visitor room could be better • The co-located activity space isn’t used. It would be better to keep separate as it is too big
Medical staff group	• Hard to comment on designs when at plan stage • Clinic rooms need review of standards • Doctors’ space in hubs presents a challenge to training • Consultation process for new designs could be longer to give more input • Use of e-consultations needed to be considered • How clinic rooms are booked gives operational challenges. Process needs to be “smarter” • Agile working is not suitable for the consultant role • Parity across the Trust needed on office space, parking etc

Appendix 3: Estate strategy key themes

Inpatient

2023/24

Infrastructure
Net zero carbon investment.

Forensics
Forensic services review of accommodation - "campus approach".

Calderdale and Kirklees
C&K bed base – propose a business case.

Trustwide
OPS transformation and formal consultation will ensure we can confirm a preferred estates model.
Out of area (OOA) bed provision – review estate options for supporting OOA cost reductions.

2024/25

Infrastructure
Net zero carbon investment.

Forensics
Gaskell Ward – consider as part of forensic campus. Possible completion of business case for development/modernisation.

Wakefield
Horizon Centre - complete business case for environmental improvements.

Trustwide
OPS transformation - submit business case to ensure implementation of preferred option following public consultation.

2025/26

Infrastructure
Net zero carbon investment.

Calderdale and Kirklees
C&K development work.

Forensics
Forensic campus – review business case for new development with a view to outline design

Trustwide
OPS transformation – Implementation phase of approved option.

2026/28

Infrastructure
Net zero carbon investment.

Calderdale and Kirklees
Commence C&K bed base development.

2028/29

Infrastructure
Net zero carbon investment.

Calderdale and Kirklees
C&K bed base development.

2029/33

Infrastructure
Net zero carbon investment.

Calderdale and Kirklees
Complete C&K bed base development.

Forensics
Commence detailed design on forensic campus.

Community

2023/24

Barnsley
Barnsley services transition to new service models.

Calderdale and Kirklees
North Kirklees hub – submit business case for new development, allowing for disposals and lease terminations if successful.

Forensics
CAMHS (forensics) – review accommodation and examine "forensic campus model".

Wakefield
Airedale HC – review future provision.

Trustwide
NHS PS accommodation – review occupation to support reduction of cost pressures (formal lease arrangements).

Perinatal mental health services – consider any estates requirements.

Rehabilitation and recover/OPS transformation and out of area bed provision – consider impact upon community services (estates related, e.g., Oakdale Ward, OPD, Priestley Unit).

2024/25

All community accommodation

Review/rationalise to ensure closer alignment between ICB partners.

LIFT buildings – increase utilisation. Reduce schedule of accommodation in LIFT (consider LIFT as wider healthcare provision).

Support services – review impact of hybrid on estate, consider more hot desking.

One public estate - continue discussions to understand public estate synergies (prime contact: Barnsley Council), especially in support services

Calderdale and Kirklees

North Kirklees Hub – complete development (subject to approval).

Folly Hall Mill – review occupation (in relation to Locala Princess Royal development).

Hebden Bridge HC - review future utilisation (aligned to Todmorden HC/Calderdale vanguard board).

One public estate - continue discussions to understand public estate synergies.

Wakefield

One public estate - develop discussions to understand public estate synergies.

Trustwide

Stop smoking – review utilisation and terminate leases where possible.

2025/26

Barnsley

LIFT buildings – terminate leases on of identified LIFT accommodation if approved.

Calderdale and Kirklees

Hebden Bridge HC – consider in light of Todmorden HC/Calderdale vanguard estate proposals.

Wakefield

ASD/ADHD Services – review Manygates for future suitability as standalone lease.

2026/28

Support services

Review use of estate for support services.

2029/30

Barnsley

Review community mental health accommodation.

Integrated care system (ICS)

2023/24

Share Trust approved estate strategy with ICS.

Agree how this is integrated into wider ICS estate strategy.

Other Trusts to share strategies.

2024/25

ICS estate strategy to be developed to reflect Trust ambitions.

Trusts revise estate strategies where appropriate.

Funding applications if available.

2025/26

Funding applications if available.

2026/28

Funding applications if available.

2029/30

Funding applications if available.

Review utilisation and lease

2023/24

Barnsley
Keresforth

2024/25

Barnsley
Silkstone HC

Wombwell HC

Cudworth HC

2025/26

Calderdale & Kirklees
Hebden Bridge

Wakefield
Fieldhead surplus land to market

Current lease end dates

2024/25

Barnsley
170 Sheffield Road

Victoria Medical Centre

Calderdale & Kirklees
Lyndhurst

Trustwide
NHS PS arrangements where possible

2025/26

Barnsley
LIFT properties as part of neighbourhood model changes

Calderdale & Kirklees
Enfield Down

Priestley Unit

The Dales Unit

Folly Hall Mill

Wakefield
Manygates

2026/28

Apollo Court

Oaks Park Centre

Chapelfield Medical Centre

2029/30

Garland House Surgery

Capital programme considerations (receipts and major capital expenditure)

2023/24

Receipts

Keresforth
£1.7m

Total
£1.7m

Expenditure

OPS transformation
£0.5m

Infrastructure
£1.5m

Seclusion
£1m

Total
£3m

2024/25

Expenditure

OPS transformation
£6m

Seclusion
£1m

Infrastructure
£0.5m

Total
£7.5m

2025/26

Expenditure

Fieldhead secure campus
£15m

OPS
£2.5m

Total
£17.5m

2026/27

Expenditure

C&K central bed base
£10m

Horizon remodel
£1.5m

Fieldhead secure campus
£12m

Total
£23.5m

2027/28

Receipts

Fieldhead land
£500,000 (not had a formal valuation)

Total
£500,000 (not had a formal valuation)

Expenditure

C&K Central Bed base
£20m

Horizon remodel
£0.5m

Total
£20.5m

2028/33

New five year plan to ICS

Expenditure

C&K central bed base
£80m

Total
£80m

Summary of proposed expenditure

Year	23/24	24/25	25/26	26/27	27/28	28/33*	Total
Projected income (£m)	1.7		0.45		0.5		**2.65**
Projected Expenditure (£m)	2.5	7.5	17.5	23.5	20.5	80	**151.5**

* Estimates at July 2023

Appendix 4: Equality Impact Assessment (EIA)

Date of EIA: 08/01/2021

Completed by: Head of Estates and Facilities

Equality Impact Assessment Questions:	Evidence based answers & actions:
1. Name of the document that you are Equality Impact Assessing	Estate Strategy 2022-2032
2. Describe the overall aim of your document and context? **Who will benefit from this policy/procedure/strategy?**	This strategy states our aspirations, intent, and commitment in continuing to make a positive difference to improve the health and wellbeing of the people we care for, enabled by a fit and proper Estate provision. This strategy outlines the importance of the built environment in supporting trust operational and clinical strategies, culture, organisational values, and guiding principles. The views and experiences of our staff together with those of our service users and carers are critical in driving forward the estate provision as their in-depth knowledge from their day-to-day experiences are paramount to designing fit for purpose and robust estate. This will also require close collaboration at all levels internally and externally with our partners to realise our aims and objectives as both nationally and locally there are increasing demands on finite resources, especially as the needs of the general population evolve. A successful NHS organisation recognises the need to make best use of its estate to enable delivery of its clinical services and support operational staff and management. This strategy seeks to achieve this by using the built environment to support the Trust in delivering quality service improvements and in transforming outcomes for service users, carers, and the communities we serve over the next ten years, recognising that there will be alterations required during this period. The strategy aims to articulate how our ambitions around the built environment and its guiding operational needs will lead to actual changes on the ground, and the benefits that these changes will bring to our service users, carers, their families, our staff and our wider communities. We are committed to working with our communities and partners to improve health outcomes for everyone, with high quality health care in the right place, at the right time, delivered by the right people.
3. Who is the overall lead for this assessment?	• Director of Finance • Associate Director of Estates and Facilities
4. Who else was involved in conducting this assessment?	• Staff and people who use our services • Stakeholders and partners • Equality and involvement managers

Equality Impact Assessment Questions:	Evidence based answers & actions:
5. Have you involved and consulted service users, carers, and staff in developing this policy/procedure/ strategy? **What did you find out and how have you used this information?**	The timeline and plan for involving people in the development of the strategy has been rigidly followed and delivered. The findings from engagement resulted in the Trust gathering views from staff and service users/carers, specifically: - • Service user digital feedback from their experiences of accessing Trust services and their specific needs will be obtained from questioning experiences and needs. • Learning and feedback from Covid-19 response in respect to Estate provision. Specifically around supporting new ways of working including increasing access to digital solutions. • Staff engagement in respect of both current and future estate requirements has been collated from various Trust meetings and forums as part of its general business operations. Much of this was undertaken pre covid and further work will be undertaken on this. • Service user/carer/member views - gathered in-directly through service change engagements and through equality processes. • Staff side – will be engaged and consulted as part of the strategy development • Executive Director leads and nominated Non-Executive Directors • Reference to the findings of the engagement process for the Digital Strategy 2021 to 24 which highlighted. **By staff** Key points: • Working from home / anywhere • More access to meetings with less travel • Saves time Key concerns: • Data security/confidentiality **By service users & carers** • Face to face will always be preferable to some individuals The feedback obtained to be used in the estate strategy and will help to derive the formulation of the action plans necessary to address key issues. The approach will ensure that there is equal opportunity to participate in decision making and service planning with access to services being equal for all and non-discriminatory. The feedback will also inform the preparations for milestone delivery plans which are based on Trust annual planning processes for prioritisation.

Equality Impact Assessment Questions:	Evidence based answers & actions:
6. What equality data have you used to inform this equality impact assessment?	**The communities we serve:** In all communities the 2011 census tells us there is on average across all areas there is a 1% difference in the population reported as male and female, with female reporting higher. Across all ages Calderdale has the highest 0-15 population at 19.6% and Barnsley has a higher working age population 30-44 at 26% and older population 60+ at 23.8%. Christianity and Islam respectively are both the highest reported religion and belief. We know that White British people make up 87% of our region's local authority population, more than the England average of 81%. The other main minority groups include Black or Black British people comprised 1%, less than the England average of 3%, while Asian or Asian British people comprised 8%, the same as the England average (2011 census). The local authorities with the largest proportions of Asian people are Kirklees (16%) and Calderdale (8%). This profile is likely to change significantly over the next 20 years with BME groups accounting for almost 80% of the UK's population growth (Policy Exchange, 2014). We know that those who report having a disability that impacts them a lot is higher than the census 2011 national average of just over 4% in our local areas range from 8% to over 13% in the communities the Trust cover. **Workforce data** As per workforce annual report 2020 The Trust currently employs 4,328 staff delivering a range of services including mental health, learning disability, forensic, some physical health and an extensive range of community services. • The Trust split of 77.9% female to 22.1% male is reflected approximately across most areas, except for Medical Staff (36%/64%). As in previous years, female staff make up over three quarters of Trust staff • As in previous years, the highest number of Trust staff fall in the age bands 40-49 and 50-59 with over 55% of the total staff being between 40 and 59. Just over 42% of medical staff are between 40 and 49. Support Services have the highest percentage of staff in the 60-69 age bands with 14% (102) being 60 or over • The data shows that 6.1% of our staff consider themselves to have a disability, the same figure as last year. The total number of staff is 266, this is an increase of 11 since last year.

Equality Impact Assessment Questions:	Evidence based answers & actions:
Question 6 continued	• The Trusts staff profile has a larger White British representation than the local demographic of the people that it serves collectively. Trust wide, 90% of the total staff in post are white British which is similar to previous years and equates to an over-representation of 1.3% (last year 1.1%). Mixed race staff are underrepresented by 0.2%, Chinese staff are over-represented by 0.2%, Black staff are over-represented by 1.6% and South Asian staff are under-represented by 3.2%. However, the Trust's local demographic has large variation in BAME representation and there is a significant under-representation of South Asian staff in Kirklees/Calderdale (exact figures not available due to mixed teams) • The number of staff who have not stated their religious belief (Unknown) has decreased slightly from 2018 (23%) to just below 21% currently. Staff reported as 48% Christianity, 3%Islam, 12% other and 17% Atheism. • There has been a significant increase in the number of staff reporting their religion and sexual orientation. Currently 83% of staff have provided data indicating their sexual orientation, which is a slight improvement on last year's figures.
7. What does this data say?	The local population we serve and the staff who work in our services represent a diverse population. Our public sector equality places a legal duty to ensure we do not discriminate and ensure fair and equal access to our services making sure they are cultural appropriate and that working conditions for staff offer equality of opportunity in employment and development. From the figures shown in the data there is more work to do to ensure that our services reach and support our diverse population and that workforce and volunteers continue to reflect and represent the population we serve.

Equality Impact Assessment Questions:	Evidence based answers & actions:
8. Taking into account the information gathered above, could this policy /procedure/ strategy affect any of the following equality group unfavourably: • **Race: No** • **Disability: No** • **Gender: No** • **Age: No** • **Sexual orientation: No** • **Religion or belief: No** • **Transgender: No** • **Maternity & Pregnancy: No** • **Marriage & civil partnerships: No** • **Carers (Our Trust requirement): No** See below for further information.	**Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.** The purpose of the strategy is to understand the high-level needs for the estate with specific regard to supporting clinical and operational strategies as they evolve. The strategy itself will not enter into detailed assumptions around individual needs but will give a framework for key estate developments. These projects will be subject to wider involvement and in some cases formal consultation as set out in the Trust Equality, involvement, communication and membership strategy. The high-level plan set out in the strategy will allow for the planning of the financial and physical resources which will be required over the extended period of the strategy. The EIA will support the overarching consideration of equality, diversity and inclusion in these schemes. As schemes are focused around a specific service or directorate the estates team will ensure that the EIA for that service or directorate is taken into account. Working with partners and stakeholders the strategy will demonstrate through a high level plan year on year improvements for people with protected characteristics and carers, families and friends to ensure we improve the lives of everyone. The strategy will use an inclusive approach to understand impact, listen to to the voice and views of those impacted and act on the feedback to drive service improvements. This means we will ensure the voice of these groups is gathered, recorded, reflected, and considered in the decisions we make as a Trust regarding our estate provision To formulate a clear estate strategy it is essential that the approach is totally inclusive and all that we do has the person at the centre. The introduction and wide-scale adoption of technology means that the dependency on having digitally enabled estate with the means to flex provision to respond to issues means that a different approach to the designation of space is increasingly desirable We need to understand how this flexible model will affect different parties who utilise the Trust estate and how they can access space in a manner which is effective and in line with other strategic goals We will proactively continue to explore all avenues to mitigate this as far as possible. Through effective service planning, design, equality, and quality impact assessment processes, we will listen to our service users and carers, to further understand both individual and collective potential barriers to effective estate utilisation and design. We will take this learning and will work collaboratively with all stakeholders to explore how we can provide a safe, effective and sustainable estate.

Equality Impact Assessment Questions:	Evidence based answers & actions:
8.1 Race	The Trust need to consider estate provision which meet the needs of our diverse population. Specific targeted work to ensure the diverse population in Kirklees are served well and the emerging growth of an Asian population in Wakefield will be a key focus in service improvement. The key considerations should be: • The design and equipment of catering and bathing facilities. Considering differing cultural approaches and cooking methods. • Storage of food and separating products, separate washing up facilities and draining. • The use of entry and access equipment such as reader screens, digital appointment platforms in buildings and building entry requiring verbal access or search requirements. • Psychological safety of buildings, including location of buildings and rooms. • Appropriate toilet facilities and consideration of bathing preferences. • Layout of rooms and ability to move furniture in line with faith practices. • Décor reflective of all cultures and positive images and artwork in public spaces. This list is not exhaustive and estates teams will be expected to work with communities to design public spaces in line with the above considerations. **Race equality** Taken from Census 2011 for each area England average White 85.5%, Asian 5.1%, Black 3.4%, Mixed 2.2%, Chinese & Other 1.7% Kirklees average White 79.1%, Asian 15.7%, Black 1.9%, Mixed 2.3%, Chinese & Other 0.7% Barnsley average White 97.9%, Asian 0.7%, Black 0.5%, Mixed 0.7%, Chinese & Other 0.2% Calderdale average White 89.6%, Asian 7%, Black 0.9%, Mixed 1.3%, Chinese & Other 0.6% Wakefield average White 95.4%, Asian 2.6%, Black 0.77%, Mixed 0.9%, Chinese & Other 0.29% When taking account of race the Trust must ensure that estates are reflective of the community we serve. These are key considerations for estates.

Equality Impact Assessment Questions:	Evidence based answers & actions:
8.2 Disability	Across all communities the Trust will ensure that our services remain fully accessible due to a higher than national average proportion of people whose day-to-day activities are limited 'a lot' by their disability. We will use the service EIA to ensure we fully understand the nature of the disability so we can adjust and adapt our estate at a service level, remaining person centred throughout. **Disability groups** **Day to day activities limited by disability** Taken from 2011 census for each area England average Not at all - 47.2% A little - 13.2% A lot - 4.2% Kirklees average Not at all - 45.5% A little - 12.5% A lot - 13.7% Barnsley average Not at all - 76.1% A little - 11.3% A lot - 12.6% Calderdale average Not at all - 56.5% A little - 12.2% A lot - 13.8% Wakefield average Not at all - 77.93% A little - 9.33% A lot - 8.31% Enhanced estate provision coupled with service innovation can have a positive impact, promoting services with a person-centric approach to the availability and ease of access to care. In addition several people with a disability can rely heavily on public transport – estates with access to local public transport networks is essential. Highlighted below are some key considerations: **For people who are blind or partial sighted:** • For people who are partially sighted good colour contrast between doors and walls, flooring and walkways, uncluttered walkways and fixed seating can support people who access our estates. • For people who are registered blind further considerations to access are required in crossings, walkways and paths leading up to our estates, tactile signs, tactile walkways and easy navigation routes to reception areas facilitated through building layout are important.

Equality Impact Assessment Questions:	Evidence based answers & actions:
Question 8.2 continued	For more information https://www.rnib.org.uk/nations/walescymru/how-we-can-help/visibly-better-designing-accessible-housing-and-buildings/ **For people who have a visual impairment and a learning disability:** • In general our estates should avoid highly patterned wallpaper, carpets, table coverings and furnishings. • Reflective surfaces should be minimal to minimise glare, this includes glossy tiles and shiny worktops. • Use vertical blinds to help control the potential adverse effects of natural lighting, such as glare and shadows. • Light levels should be consistent throughout the room, avoid pools of light or darkness. For more information https://www.rnib.org.uk/professionals/health-social-care-education-professionals/social-care-professionals/learning-disabilities/ People with a physical disability including people who use a wheelchair. Improving the accessibility of public spaces and building is raised by many disabled people, and a moderate number of carers and members of the general public. Disabled people and carers highlight many potential improvements to public spaces, including; • Improving the accessibility of footpaths, ensuring dropped kerbs are available, • Preventing cars from parking on pavements, • Removing unnecessary street furniture, • Ensuring pavements do not have a steep camber. People with a disability and carers also highlighted improvements to accessibility which could be made in public buildings, including: • Increased availability and improved cleanliness of disabled toilets • Adult changing toilets • Different types of seating/designated wheelchair seating areas • Wider doorways and fewer heavy doors/automatic doors • Use of ramps rather than stairs • Accessible lifts • Signs at visible heights • Reception areas at a visible height • Various level table seating and kitchen facilities • Range of disabled parking – bays with different loading options -side, rear and top

Equality Impact Assessment Questions:	Evidence based answers & actions:
Question 8.2 continued	Improved accessibility of public buildings and spaces, and the consideration of accessibility can only be achieved through co-design. All new and future designs (Trust buildings and infrastructure) should consider disabled people and make them naturally more accessible. https://www.gov.uk/government/publications/uk-disability-survey-research-report-june-2021/uk-disability-survey-research-report-june-2021 **Estates to support people who are deaf or hard of hearing:** • To improve the acoustics: use soft furnishings such as carpets, install acoustic panels, and fit rubber caps on chair and table legs. • Position an employee/individual with hearing loss in an area that has good acoustics and where they can see the rest of the room. • Adjust the layout of a meeting room and use good lighting to help everybody see each other clearly, which is important for lipreading. • If you play music in your workplace, either turn this off or down. • If your employee uses a communication professional such as a sign language interpreter, factor in the need to seat an additional professional, and ensure that they are in a well-lit area. https://rnid.org.uk/information-and-support/work-job-employment/supporting-deaf-employees-staff-hearing-loss/workplace-adjustments/
8.3 Gender	Gender equality is reported as part of our workforce approach and we will continue to ensure environments and workplaces remain gender sensitive and appropriate. This will consider those that identify as transgender or non-binary and require specific estates requirements such as gender-neutral toilets and ensuite bathrooms for example. Taken from 2011 Census data England average Male - 49.2% Female - 50.8% Kirklees average Male - 49.4% Female - 50.6% Barnsley average Male - 49.1% Female - 50.9% Calderdale average Male - 48.9% Female - 51.1%

Equality Impact Assessment Questions:	Evidence based answers & actions:
Question 8.3 continued	Wakefield average Male - 49% Female - 51% Estate signage should reflect the diversity of gender and consider gender neutral options where appropriate.
8.4 Age	The Trust provides services to children and young people through to older age adults. The table reflects the population age of the communities the Trust serve and there is increasing evidence that Barnsley represent a higher than average older population and Calderdale a higher than average age range of 0-15 age range. The Trust will ensure that environments support people of all ages. Taken from 2011 Census data England average 0-15 18.9%, 16-29 18.6%, 30-44 20.3%, 45-64 22.4%, 65+ 16.9% Kirklees average 0-15 15.8%, 16-29 18.5%, 30-44 20.3%, 45-64 22.2%, 65+ 15.8% Barnsley average 0-15 18.5%, 16-24 10.8%, 25-44 26%, 45-59 20.9%, 60+ 23.8% Calderdale average 0-15 19.6%, 16-29 16.4%, 30-44 20.1%, 45-64 24.2%, 65+ 16.6% Wakefield average 0-15 18.4%, 16-29 17.2%, 30-44 19.6%, 45-64 24.2%, 65+ 17.6% **Creating estates for young people:** The needs to give appropriate training and weight to Equalities Impact Assessments that include the specific needs of children as part of the 'age' protected characteristic. Any planning policies should explicitly acknowledge the differences amongst children and young people and adult spaces. In addition, early years children have differing levels of capability and independence than children in middle childhood (ages 6-12). Indeed, evidence shows that boys and girls can have differing play preferences and needs, with boys' preferences often better served. A study in Sweden found adolescent girls to be around ten times more scared in public space than their male counterparts (Akerman et al. 2017)
8.5 Sexual orientation:	The Trust will consider how the built environment can be used to support people of all orientations. This includes using estates to provide positive and supportive messages such as rainbow flags, inclusive crossings and artwork and creative spaces to display the Trust commitment.

Equality Impact Assessment Questions:	Evidence based answers & actions:
8.6 Religion or Belief:	Faith and spiritual care and support in an important component of person-centred care provided. The Trust have a spirit in mind service who play a central role in engaging faith and spiritual leaders in the communities we serve and involving them in the work of the Trust. Understanding religion and belief plays an important role in providing a relevant estate offer. Spaces to support religion and belief are essential if we are to facilitate and commitment to upholding religious and faith-based practices. • The lay-out and design of spaces should be reflective and meet the needs of all faith and religion. • How we use estates to celebrate festivals needs to be inclusive. Celebrating religious festivals through the use of estate decoration such as lights, banners and trees, requires a respectful balance of all faith groups. • How we use estates to support our staff can include things like changing areas, access to faith rooms/space and cultural representation in décor and design. The information below tells us that Calderdale and Kirklees require a focus on Muslim faith, with Christian faith representing a large proportion of people who use our services in all areas. Other faiths will be reflected in geographical areas and in line with service EIAs and person-centred care and planning. Taken from 2011 Census data England average Christian 71.8%, Buddhist 0.3%, Hindu 1%, Jewish 0.5%, Sikh 0.7%, Muslim 10.1%, Other 0.2%, No religion 15.1% Kirklees average Christian 67.2%, Buddhist 0.2%, Hindu 0.3%, Jewish 0.1%, Sikh 0.7%, Muslim 10.1%, Other 0.2%, No religion 14% Barnsley average Christian 59.4%, Buddhist 0.5%, Hindu 1.5%, Jewish 0.5%, Sikh 0.8%, Muslim 5%, Other 0.4%, No religion 24.7% Calderdale average Christian 60.6%, Buddhist 0.3%, Hindu 0.3%, Jewish 0.1%, Sikh 0.2%, Muslim 7.8%, Other 0.4%, No religion 30.2% Wakefield average Christian 66.4%, Buddhist 0.16%, Hindu 0.25%, Jewish 0.04%, Sikh 0.12%, Muslim 2.0%, Other 0.3%, No religion 24.4%

Equality Impact Assessment Questions:	Evidence based answers & actions:
8.7 Transgender	A trans equality policy aimed at workforce and people who use services will be co-designed and the approach endorsed by partner organisations. The policy and agenda for transgender people will be included as part of the review of estate provision across the Trust. The 2020/21 Census report may provide further baseline data. The implications for estates in the policy are: • Admission to single sex accommodation for those who live in their confirmed gender should always be offered according to their gender presentation. • Transgender and gender non-conforming people have equal rights to access appropriate services for their needs as any other person and therefore should also be admitted to a ward that is as close to their support networks as possible. Trans: A Practical Guide for the NHS: http://www.gires.org.uk/assets/DOH-Assets/pdf/doh-trans-practical-guide.pdf Reducing Health Inequalities for LGBT People – Briefings for Health & Social Care Staff: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_078347
8.8 Pregnancy & Maternity	Workforce policies and services aimed at maternity and pregnancy will be co-designed with people who represent this group. Peer support worker roles in areas of work that support people with maternity and pregnancy mental health issues are increasing, this ensures that lived experience is reflected in our service offer. The built environment can support people throughout pregnancy and ongoing maternity provision through sensitive design. The strategy will allow for this provision with the national standards in place to be regarded as a minimum standard.

Equality Impact Assessment Questions:	Evidence based answers & actions:
8.9 Marriage & civil partnerships	It is not anticipated that this strategy will directly impact people identified in this group. All estates facilities consider a range of partnerships and images used in estates to convey partnerships are few. If signage or estates space is required, it will remain gender neutral to encompass the range of recognised partnerships in our population. England average Married 46.6%, Single 34.6%, In a [registered] civil partnership 0.2%, Divorced 9.0%, Widowed 6.9%, Separated 2.7% Kirklees average Married 48.4%, Single 32.4%, In a [registered] civil partnership 0.2%, Divorced 9.3%, Widowed 6.8%, Separated 2.8% Barnsley average Married 46.6%, Single 34.6%, In a [registered] civil partnership 0.2%, Divorced 9.0%, Widowed 6.9%, Separated 2.7% Calderdale average Married 46.7%, Single 32.1%, In a [registered] civil partnership 0.3%, Divorced 10.5%, Widowed 7.3%, Separated 3.0% Wakefield average Married 48.2%, Single 30.9%, In a [registered] civil partnership 0.18%, Divorced 10.5%, Widowed 7.5%, Separated 2.6% Source unknown
8.10 Carers (Our Trust requirement)	It's likely that every one of us will have caring responsibilities at some time in our lives with the challenges faced by carers taking many forms. Many carers juggle their caring responsibilities with work, study and other family commitments. Some, younger carers, are not known to be carers and this means that the sort of roles and responsibilities that carers must provide varies widely. Within the local footprint of Southwest Yorkshire Partnership NHS Foundation Trust, there is an estimated 160,000 unpaid carers. The Trust approach to more flexible ways of working which will influence the Estate Strategy will help people manage caring needs and work. This may include: • Better access to estates to perform caring duties. This includes good access to public transport networks. And services close to home or near where people live. • That the needs of carers can be met through supported parking arrangements, designated parking if needed and free parking where possible. • That spaces are made available in our estates to meet the needs of carers, including visiting space, access to refreshments and food, and lounges designated for carers if needed. • That our estates positively support the value carers add to the care of an individual and this includes carers of all ages, especially young carers who may require young people friendly

Equality Impact Assessment Questions:	Evidence based answers & actions:
9. What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-	This strategy is subject to Trust Board approval with delivery through the Trust's Executive Management Team. The Director of Finance the lead directors accountable for delivery of this strategy. This will be supported by Head of Estates and Facilities and the wider capital and operational estates teams and day to day support from all executive directors, deputy directors, business delivery units (BDUs). The implementation of the strategy will require involvement from all clinical and operational services across the Trust, supported by corporate services. Progress and delivery will be monitored by the Trust Board and Executive Management Team robust governance, via annual update reports. The Executive Management Team will approve the priorities formulated via the annual planning process, following consultation with the Operational Management Group and all appropriate meetings and forums Via the annual planning cycle, this will also provide opportunities to review and ensure continued alignment between Trust priorities relating to estate provision and design at national, regional, integrated care system and place levels.
9a Promotes equality of opportunity for people who share the above protected characteristics;	Whilst the accessible design of buildings is regulated by the Building Regulations Part M: Access to and use of buildings, the Equality Act does require "reasonable adjustments" to be made when providing access to goods, facilities, services and premises. The duty to make reasonable adjustments is set out in paragraph 2 of both Schedule 2 (in relation to public authorities and service providers); Schedule 8 (in relation to employers) and Schedule 15 (in relation to associations). In addition, work to involve people as a central component of co-design will continue to help the Trust drive estates through the voice and views of people who use them including the local population for large scale developments or estate changes. From the workforce data in 2020 the Trust sees no adverse barriers to accessing its estate for any of its staff regardless of their ethnicity, disability or sexual orientation.
9b Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;	The built environment is governed by a set of standards to ensure that NHS buildings remain accessible for all. New buildings and improvements must work within a framework to ensure that there are no barriers to access resulting in discrimination. The Trust continue to work with local communities in the design and development of local services and this includes estates. Estate improvements should demonstrate involvement of all protected groups to ensure the design or décor considers equality and diversity. The Trust has also introduced a new model for preventing Harassment and Bullying and has 12 months communications plan.

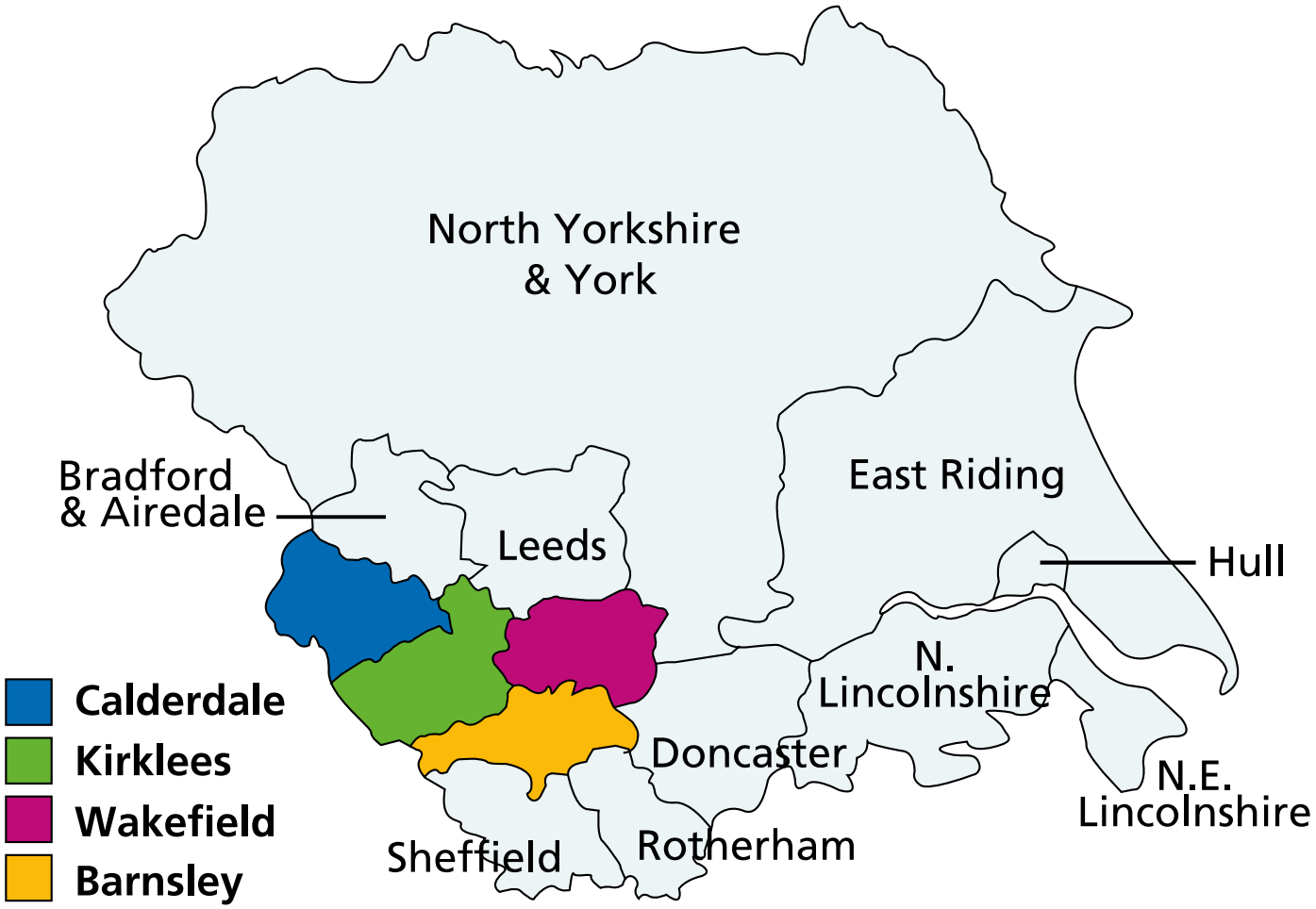
Equality Impact Assessment Questions:	Evidence based answers & actions:
Question 9b continued	The built environment is seen as a key enabler for supporting the Trust in making SWYPFT a great place to work and the strategy will focus on developing an inclusive digital culture that supports the prevention of harassment and bullying.
9c Promotes good relations between different equality groups;	The Trust values promote good relations and these form part of our approach to ensuring up to date EIAs are available, we involve people in decisions regarding estates, recruitment, training, and appraisal functions. This strategy applies equally to all staff and all breaches are monitored, would be investigated accordingly, and reported to the Director of HR, OD and Estates.
9d Public Sector Equality Duty – "Due Regard"	EIAs are completed at a service level and/or as part of the introduction of new/revised digital solutions or technologies as appropriate. These documents are used in the planning, implementation, and development of services. A short form EIA and process supports decisions a that are required urgently. Each assessment has an identified action plan to support service improvement. The voice of people who use our services is captured using feedback and involvement. Risk based best practice audit provides the opportunity to identify if there are any issues/trends related to protected characteristics, relationships between different groups and 'due regard'.
10 Have you developed an Action Plan arising from this assessment?	No but this EIA document will inform the development of the milestone delivery plans and associated Trust annual digital priorities.
11 Assessment/Action Plan approved by **(Director Lead)**	Sign: Date:08/01/2021 Title: Head of Estates and Facilities
12	Once approved, you must forward a copy of this Assessment/ Action Plan to the Equality and Engagement Development Managers: Aboobaker.bhana@swyt.nhs.uk Zahida.mallard@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 5: Locality background/demography

The Trust is a leading provider of mental health, learning disability and community services.

Services are provided to a population of approximately 2.6m across the South and West Yorkshire districts of Barnsley, Calderdale, Kirklees, and Wakefield.

Map showing Trust coverage:



This population is very diverse with:

- Both urban and rural communities
- High unemployment in some areas
- Pockets of deprivation and areas of relative wealth within all three districts
- Communities with a high proportion of people from black and minority ethnic (BME) backgrounds
- groups including first generation immigrants, refugees and asylum seekers

The Trust is also one of two NHS providers of medium secure forensic services to a population of two million across the Yorkshire and Humber region.

Appendix 6: Trust profile

The Trust was authorised to become an NHS Foundation Trust in 2009 and its name was changed to South West Yorkshire Partnership NHS Foundation Trust. The Trust was previously known as the Southwest Yorkshire Mental Health Trust and was formed following the merger of various NHS bodies in 2002.

In May 2011, all community and mental health-based services in Barnsley were transferred from the provider arm of NHS Barnsley to the Trust. In April 2013 the Trust took ownership of the estates assets and leases operated by them in Barnsley, significantly increasing the Trust's property portfolio.

The Trust employs over 4,700 staff in both clinical and non-clinical support services. 98% of the services provided by staff are delivered in service users' own homes or in centres located in the community. The Trust also delivers inpatient services.

The breakdown of staff by care group as at March 23 is set out below.

Table: Breakdown of staff

Care group	FTE	Headcount
Adult and older people mental health services	1500.74	1676
Barnsley integrated services	1047.03	1220
CAMHS and children	342.39	378
Forensic services	425.48	456
Learning disabilities and adult ASD and ADHD	181.59	205
Support services	688.74	794
Total	4185.97	4729

The Trust's mission is to help people reach their potential and live well in the community and as such has an emphasis on treating people in the community where possible. However, it is recognised that as part of this aim some people will need more help and this should be delivered in a "normalising" way i.e. people having access to their own space in which to live.

It is clear that the condition, position and type of estate is key to ensuring the Trust can work towards achieving their vision. Estate in the right place which is suitable for the delivery of services will play a key role in making the Trust the service of choice for service users. A fit for purpose estate will also provide a safe and pleasant working environment for staff which will help the Trust become the employer of choice.

The locations of all properties are included in map form at Appendix 1.

Calderdale

In Calderdale, the Trust provides mental health services, health improvement, learning disability and substance misuse services.

Mental health

The mental health service is configured as a series of pathways, each of which offers services designed for adults of working age or older people.

Community teams

Two community therapy teams exist in Calderdale – team A covering Hebden Bridge and the upper valley and team B covering the Halifax area.

There is a 14-bed residential rehabilitation facility – Lyndhurst in Elland.

Older people

Calderdale has 2 teams – east covering Halifax and west covering Hebden Bridge and the upper valley.

There are beds for older people on the Trust's main sites at Fieldhead and Kendray with provision also at the Dales, Priestley unit and the Poplars.

Acute pathway

Acute inpatient services are available for adults and older people at the Dales in Halifax. The acute pathway supports the other pathways and offers the service user more intensive treatment. The Dales provides inpatient accommodation for:

- Working age adults - 24 bed unit
- Older people - 16 bed unit

In addition to the above, The Dales is also home to one of the Trust's suites designed for assessing people who have been detained by police under Section 136 of the Mental Health Act.

The Trust also works in partnership with Calderdale Council to provide the Calderdale inclusion support service which aims to encourage individuals experiencing mental health problems to live independently and engage with other members of the community.

Learning disability

This service is available for adults and children in Calderdale who need specialist learning disability services. The service includes specialist assessment and intervention. There is no commissioned inpatient facility available in Calderdale.

Table: Services delivered in Calderdale by patient group

Working age adults	Older people's services	Community services	Learning disabilities
Community therapy and recovery services	Community team		Assessment and intervention
Residential rehabilitation	Acute		
Assertive outreach	Memory clinics		
Insight / early intervention team	Care home liaison		
Acute pathway, including intensive home based treatment			
Day services			

Kirklees

The Kirklees service offering is configured as a series of care pathways. These are:

- Adults
- Older people
- Acute services
- Learning disabilities
- ADHD

Adult services

There are two community therapy teams, one in the north and one in the south, that offer therapies for people suffering from milder mental health conditions such as anxiety or depression.

There are two care management community teams that provide services to people who have a diagnosis of psychosis including schizophrenia and bipolar.

Recovery

Enfield Down is a 31 bed rehabilitation unit.

The assertive outreach team and the early intervention in psychosis team (Insight) are also part of recovery.

Acute

Acute services for adults of working ages are provided on Ward 18 (23 beds) at the Priestley Unit at Dewsbury and District Hospital in the north and also on Ashdale Ward (24 beds) at The Dales for south Kirklees.

Intensive home-based treatment is sometimes offered as an alternative to admission to hospital.

Day services

Day services including functional, group and activity-based therapy is delivered through an integrated service between the Trust and Kirklees Council at Pathways in Mirfield. Pathways acts as the hub for the services; however a number of therapies are delivered in various community locations across Kirklees.

Psychological therapies

The psychological therapies teams are located in Folly Hall in Huddersfield.

Older people's services

There are two community teams providing support to service users with dementia or mental health conditions in their homes or in a residential setting. There is one community mental health team covering the north of the area and one in the south.

There are 30 beds at the Priestley Unit for older people – Ward 19.

The older people's service has a separate assertive outreach team.

Outpatient memory clinics are run out of the Priestley Unit at Dewsbury and District Hospital.

Learning disabilities

In Kirklees, specialist learning disability services are offered for both adults and children including a team supporting children with learning disabilities, a dedicated learning disability nurse working in the youth justice team and an assessment and treatment service.

There is also access to inpatient accommodation at the Horizon Centre in Wakefield.

Adult attention deficit hyperactivity disorder (ADHD)

A multi-disciplinary team offers assessment, ongoing management and interventions for service users with ADHD. This service is delivered in both Kirklees and Wakefield and is for adults and young adults.

Table: Services provided in Kirklees by patient group

Working age adults	Older people's services	Learning disability services
Community therapy	Community team	Community services
Care management team	Acute	Inpatient services
Residential rehabilitation	Memory clinics	
Assertive outreach	Care home liaison	
Insight / early intervention team		
Acute		
Day services		
Psychological therapies		
Intensive home based treatment		

Wakefield

In Wakefield, most services have been moved into the hubs at Drury Lane and Baghill House whilst some learning disability services have returned to Fieldhead during the pandemic due to space limitations. The future of these services at Fieldhead should be re-examined as community services should not stay on an acute location.

Acute services

Acute services are provided for the Wakefield district from Fieldhead:

- Acute working age adults (AWA): Stanley and Nostell wards
- Older people's services (OPS): Crofton ward
- Psychiatric intensive care unit serving Kirklees, Calderdale and Wakefield: Walton ward (5 beds)

All of the above form the new Unity Centre which was completed in 2019.

The Fieldhead site is the Trust's largest site providing a wide range of services.

Inpatient admissions for the Wakefield locality are received by Crofton ward for older people and by the Unity Centre for adults of working age. Upon assessment, treatment and stabilisation, patients may then remain an inpatient on one of the general AWA or OPS wards, be referred to a community mental health team or to a community-based service provided by the Trust based at Drury Lane.

There is a dedicated suite at Fieldhead for assessment of people detained under Section 136 of the Mental Health Act.

Outpatient services

An outpatient facility operates from the main Fieldhead site and is jointly used by both AWA service and OPS.

Community services

Child and adolescent mental health service (CAMHS)

This service provides psychological, psychiatric and psychotherapeutic services to children and young people up to the age of 18 with emotional and psychological problems.

The CAMHS service is delivered from the Drury Lane Health and Wellbeing Centre and at Fieldhead. The primary intervention and children's crisis team for CAMHS is based in Unit 2 at Flemming Court in Castleford.

The Trust also runs a specialist CAMHS service, the forensic child and adolescent support service, which works closely with the youth offending team and is based at local youth offender unis at Adel Beck and Wetherby.

Health and wellbeing services

These services include:

- Nutrition
- Health and wellbeing development
- Health training
- Public health education
- Stop smoking service
- The 'safe@home' team and
- Self-management service

The health and wellbeing services for Wakefield are delivered from Drury Lane.

Community mental health teams

Community mental health teams (CMHTs) are a central component of most local services for people with mental health conditions. Composed of professionals from a wide range of disciplines, they are intended to provide an effective local community based mental health service that prioritises people whose problems are severe and long-term. CMHT members usually meet with service users in their homes or in other community locations. Some service users do, however, prefer to be seen in a clinic setting. This is done at the Drury Lane Health and Wellbeing Centre.

Both the older people's and working age adult services operate community teams.

Working age adults

Community mental health services for both older people and adults of working age are housed at Drury Lane and the service pathway is not currently due for a review.

Adult attention deficit hyperactivity disorder (ADHD)

A multi-disciplinary team offers a range of assessments and interventions for ADHD for Wakefield. The team is based at the Manygates Centre in Wakefield.

Learning disabilities

The Horizon Centre, located on the Fieldhead site, provides adult learning disability inpatient and therapy services. No learning disability services are delivered to children. Learning disability outpatient services are also delivered from Drury Lane and Fieldhead.

Table: Services provided in Wakefield by patient group

Working age adults	Older people's services	Community services	Learning disabilities
Community therapy	Community team	Stop smoking service	Inpatient
Assertive outreach	Residential	ADHD	Therapy
Early intervention / psychosis team		Recovery service	
Acute			
Day treatment			
Specialist psychotherapy			
Vocational treatment			
Talking Therapies (formerly IAPT)			

Barnsley place based services

Acute mental health services

Acute services are provided in the Barnsley district at Kendray Hospital.

- Intensive home based treatment team (mental health), which offers 24-hour assessment and treatment to clients experiencing an acute mental health crisis
- Acute care inpatient services for adults aged 18 and over; including wellbeing and exercise therapies - 32 beds
- Psychiatric intensive care unit (PICU) - 6 beds
- Section 136 suite which provides a place of safety under section 136 of the Mental Health Act
- The mental health liaison team, providing mental health assessments to patients of Barnsley Hospital NHS Foundation Trust
- Mental health physiotherapy team which provides a physiotherapy service to any adult with mental health problems who is unable to access mainstream services
- Older people's inpatient provision - 12 beds

Rehabilitation services (non-mental health)

- Neurology rehabilitation ward at Kendray - 12 beds
- Stroke rehabilitation services based at Kendray - 10 beds

Community mental health services

- Adult community mental health teams located across the district, with one team specifically for older people
- A district wide mental health access team for advice, assessment and treatment for people suffering from mild to moderate anxiety or depression
- An assertive outreach team which provides services to support and engage service users with severe and enduring complex mental health problems
- The criminal justice liaison service, supporting people within the criminal justice system with a mental health condition
- The community recovery team which enables, supports and encourages people to aim for the most independent level of living possible
- General community services

Table: Barnsley community services

Type	Service
Primary care and preventative	Community equipment and adaption service Neighbourhood nursing Urgent community response Neighbourhood rehabilitation Tissue viability Adult epilepsy Parkinson's services Cardiac rehabilitation Heart failure BREATHE Health integration team Tuberculosis (including Wakefield services) Musculoskeletal and physiotherapy Adult speech and language service Community podiatry service Community dietetics and weight management Supportive care at home, specialist palliative care In-reach, care home support and CPTs in training Integrated single point of access
Children's Services	Paediatric epilepsy nursing services Children's physiotherapy Children's occupational therapy Paediatric audiology Child health information service School age vaccination and immunisation service
Health and wellbeing	Yorkshire Smokefree (Barnsley, Doncaster, Sheffield, Wakefield and Calderdale). Live Well Wakefield In-reach to Urban House

Forensic services

The Trust's facility for secure services is located at Fieldhead and consists of 138 low and medium secure beds. The service's catchment encompasses the whole of the population of Yorkshire and the Humber.

The bed base includes low secure male rehabilitation, low secure male beds for people with learning disabilities and a medium secure unit catering from those suffering from mental health conditions and for people with learning disabilities.

The facility has benefitted from extensive investment in the past. The forensic estate remains mixed in terms of its condition with past development being a mix of refurbishment and rebuilding. This has led to some compromises in the estate which are a block to improvement, notably:

- Bretton Centre is not to the same standard as other wards in terms of privacy, dignity and safety
- Ryburn is outside the main fence line
- Gaskell ward remains as a vacant surplus ward of indeterminate need
- The demarcation between low and medium secure is not clear
- There is no flow across the estate provision
- Units remain physically separated

Following engagement with the service, it is felt that a wholescale review of forensic accommodation could garner significant staffing and service user benefits, including flexing the staff and accommodation to reflect changing needs. This will mean that the current plan to improve the Bretton Centre would be part of a wider approach to the provision of forensic estate.

Trust Support

Support services for the Trust are located at Fieldhead and Kendray. In addition, there is a receipt and delivery centre.

Table: Trust support services

Site	Service
Fieldhead	Board support Information technology Directors' suite Wellbeing and learning centre Estates and facilities Human resources Finance Performance and information Research and development Procurement
Kendray	Information services Finance Human resources Payroll Estates and facilities Procurement

Outlier services

The Trust provides smoking cessation services in "one stop" venues and community settings in Sheffield, Rotherham and Doncaster.

Specialist services

Dietetic service

The dietetic service offers assessment and treatment at a number of locations across Wakefield, Kirklees and Calderdale. Dietitians are based at Fieldhead, Beckside Court and Folly Hall. Dietetic treatment is predominantly inpatient-based although there is a dietetic community service for older people and dietitians work as part of the community eating disorders team.

The dietetic service in Barnsley is currently provided as a service level agreement with Barnsley Hospital.

Pharmacy services

The pharmacy service offers a broad range of prescribing and specialist advice services to clinical services both within inpatient settings and in the community. The Trust pharmacy is currently based on the Fieldhead site and supports clinical services across Wakefield, Kirklees and Calderdale.

The Barnsley service is currently being delivered by Lloyds pharmacy. Consideration is being given to this becoming an internal Trust service.

The pharmacy service is assessing its configuration into the future to ensure that it meets the demands of users across the organisation. It is important that any future changes to service delivery align closely with the estate strategy.

Service delivery locations

A full listing of services provided at each site can be found on the estate biographies which are located in Appendix 1.

Appendix 7: Current property profile

Introduction

The Trust runs services from 55 sites across the regions, some of which are wholly owned by the Trust whilst others are leased. This section provides a breakdown of the estate per care group.

The Trust is increasingly working to ICS (integrated care system) methodologies which may impact on geographical boundaries.

One page summary biographies for each property within the Trust's portfolio can be found in Appendix 1.

Geographically the Trust's services are divided into 4 ICS places:

- Calderdale
- Kirklees
- Wakefield
- Barnsley

To undertake a detailed analysis of the estate-based services in each area and to segregate parts of the estate that provide support services to all care groups or across the region, two further groups have been created:

- Forensic
- Support

The maps at Appendix 1 indicate properties where the Trust is the freehold owner, main leaseholder or is a major service provider at the property. The Trust also delivers smaller outreach clinics or collaborative services in other community buildings which are not owned or leased by the Trust. These properties are not shown on the maps but will be taken in consideration as part of any service reconfiguration work.

Estate portfolio summary

Breakdown by tenure of the sites from which services are delivered:

Table: Tenure

Tenure	No
Trust owned	17
Leased	30
LIFT	7
PFI (non-Trust)	1

Unoccupied property

The Trust has successfully divested itself of unoccupied property with the last major disposal at the Keresforth Centre in Barnsley in January 2023.

Property appraisal – surveys and PAM (premises assurance model) including new model hospital data

A six-facet property appraisal is a tool used by the Trust to monitor estate condition. The survey covers the condition of the properties (including the fabric of the buildings, fixtures and fittings and the electrical and mechanical installations), the functional suitability, space utilisation, quality, statutory compliance and environmental aspects of each property. The assessment process is being updated. It is anticipated that, whilst the removal of a number of properties has reduced the backlog, new items will be added to the surveys and costs will increase. The Trust last undertook a six-facet survey in 2019.

The PAM (premises assurance model) is a tool which has been used by the acute sector for a number of years and is now a requirement for all Trusts. The Trust has adopted the PAM model and reports to Board. The current assurance level is "Good".

The new model hospital has a section dedicated to estate costs which is driven by ERIC (estates reconciliation information collection) data. The data contained in this model will increasingly be used to performance manage the estate in terms of value for money.

An annual return on this model will become a normal report in the term of this strategy.

Current estate value

The total net book value, including land, buildings and external works for the estate can be seen in the table:

Table: Estate net book value

Estate	Value (NBV)
Fieldhead and Kendray	£80,903,000
Laura Mitchell	£6,197,967
Baghill House	£2,738,177
Priory Day Centre	£231,537
Airedale Health Centre (HC)	£390,000
Cudworth HC	£766,360
Hebden Bridge	£1,159,939
Lundwood HC	£887,310
Mapplewell HC	£623,046
New Street	£3,574,714
Penistone	£390,714
Ravensleigh	£335,000

Estate	Value (NBV)
Silkstone HC	£451,457
Wombwell HC	£549,387
Total	**£98,691,935**

The main high value sites within the Trust are the two hospital sites: Fieldhead and Kendray, followed by the owned hubs at Laura Mitchell, New Street and Baghill House.

Two other large inpatient sites serving the Trust are Dewsbury and District Hospital, where the Priestley Unit is located, and Calderdale Royal Hospital where the Dales is a free-standing unit built as part of the PFI hospital development (Calderdale and Huddersfield NHS Foundation Trust hold the head lease).

Neither of these sites are owned by the Trust and the mental health units are occupied as part of service level agreements and leases with the acute Trusts.

Whilst both of these sites present challenges to the Trust it should be noted that the Trust's occupation of these areas contributes significantly to the financial position of the two host Trusts. Should the Trust pursue its plans to provide alternative facilities at another site the implications to the wider ICS need to be captured and understood at that level to ensure that the whole system can absorb the change. This should not change the Trust's aim to provide high quality accommodation for service users.

Estate operating costs

Operating costs for the Trust have been obtained from the national ERIC (estates returns information collection) returns submitted to the Department of Health for 2021/22. The occupancy cost as defined for ERIC submissions includes:

- Fixed costs associated with the occupation of the building e.g. rent, rates, capital charge,
- Hard FM costs

Table: Trust occupancy costs (excluding backlog maintenance)

Locality	Size (sq.m)	Occupancy cost (£m)	Cost per m2
Calderdale	7,704	4.89	£633
Kirklees	11,928	1.02	£85
Wakefield	22.105	1.12	£51
Barnsley	23,372	4.77	£204
Forensic	9,696	0.7	£73
Total	**74,805**	**12.5**	**£167**

April 2023 costs

Table: Trust capital spend 22/23 (forecast)

Location	Spend
Calderdale	£454,000
Kirklees	£787,000
Wakefield	£1,980,000
Barnsley	£390,000
Forensic*	£830,000
Total	**£4,441,000**

Informal arrangements and rental income

The Trust is party to several integrated service delivery solutions with other local public sector and third sector services. A number of informal agreements are in place whereby the Trust delivers services but does not pay rent to use the space.

The Trust also receives income from tenants of several properties it owns as illustrated in the table below.

Table: SWYPFT rental income

Property	Amount	Received From	Notes
Hebden Bridge Health Centre	£40,941	Calderdale Council and Calderdale and Huddersfield NHS Foundation Trust	Formal Lease
Sessional use	£6,468	Barnsley Hospital NHS Foundation Trust	Informal
Oaks Park	£14,685	Barnsley Hospital NHS Foundation Trust	Formal lease
New Street, Barnsley	£14,532	Rotherham Hospital NHS Trust	Terms agreed
Airedale HC	£10,900	Dental	Formal Lease
Total	**£87,526**		

Appendix 8: A summary of The estate returns information collection (ERIC)

The ERIC for 2021/22 has been used in the following:

Age profile

The NHS Plan aims to ensure that NHS services are provided from a modern estate which is less than 15 years old. 60% of property used by the Trust has been constructed since the turn of the century. 25% of the current Trust estate dates back to pre-1984, with a further 15% aged between 70-35 years old (i.e. 1948 and 1984) To some extent, the age of the Trust's properties is reflected in their condition and this reflects where they are not "fit for purpose" in relation to delivering mental and community health services in the 21st century.

The Trust's investment in estate has mitigated these issues. The major developments in bedded estate at Fieldhead and Kendray, coupled with the recent hub building programme, means that the Trust estate is in mainly good condition which is reflected in very low backlog maintenance costs. However, significant parts of the Kendray site are inefficient and relatively expensive to run, notably the admin block and the Oaks building.

Risk adjusted backlog maintenance

Six-facet surveys have been undertaken on all properties where the Trust delivers services. These are in the process of being updated and the new information should be added to this strategy as an addendum when it has been received and analysed. The figures below are from the last six-facet survey in 2019/20 revised to remove risks from estate that has been sold.

Table: Six-facet survey 2019/20 results

Category	West Fieldhead	West community	South whole estate	Total
Significant	£760,000	£180,000	£152,000	£1,092,000
High	£2,500	£6,000	£0	£8,500

In addition to the risk adjusted backlog costs the six-facet survey also considers the suitability of the premises on a standardised score sheet. The results for the Trust in graph form are shown below.

Breakdown of overall grades based on GIA

Fieldhead

A. Good
Performing as intended **17%**

B. Satisfactory
Performing as intended, minor deterioration **83%**

C. Poor
Exhibiting defects and / or not operating as intended **0%**

D. Bad
Life expired and / or serious risk of iminent failure **0%**

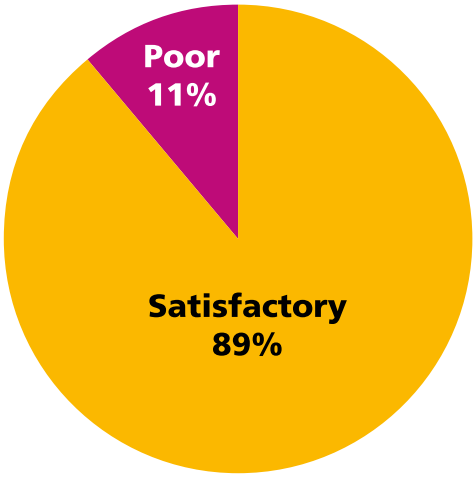
West community

A. Good
Performing as intended **0%**

B. Satisfactory
Performing as intended, minor deterioration **89%**

C. Poor
Exhibiting defects and / or not operating as intended **11%**

D. Bad
Life expired and / or serious risk of iminent failure **0%**



Barnsley estate

A. Good
Performing as intended **0%**

B. Satisfactory
Performing as intended, minor deterioration **76%**

C. Poor
Exhibiting defects and / or not operating as intended **24%**

D. Bad
Life expired and / or serious risk of iminent failure **0%**

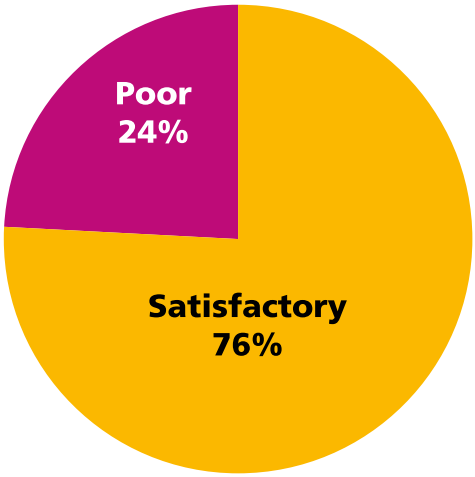


Table: Key to overall condition

Physical condition	Functional suitability	Quality	Statutory compliance
A – Good, performing as intended	A – Very satisfactory, no change needed	A – A facility of excellent quality	A – Complies with all relevant standards and guidance
B – Satisfactory, performing as intended, minor deterioration	B – Satisfactory, minor change needed	B – A facility requiring general maintenance investment only	B – Action required to comply with improved standards and statutory requirements post construction
C – Poor, exhibiting defects and/or not operating as intended	C – Not satisfactory, major change needed	C – A less than acceptable facility requiring major capital investment or replacement	C – Building requires areas of improvement to comply with some guidance
D – Bad, life expired and/or serious risk of imminent failure	D- Unacceptable in its present condition	D – A very poor facility requiring major capital investment or replacement	D – Building areas which are non-compliant with statutory requirements

Appendix 9: Detailed gap analysis

This gap analysis is based on the following challenges:

1. Does the accommodation enhance the service provision?
2. Does the accommodation meet statutory requirements?
3. Are the location and other aspects of the premises suited to service delivery?
4. Does the accommodation represent good value for money?
5. Does the accommodation enhance opportunities for service developments and initiatives?

The evaluations in the tables below are based on the data that the Trust has provided on costs, backlog maintenance etc., on the discussions held with Trust staff at the care group workshops and on the Willmott Dixon team's site visits and assessments.

Analysis by locality

Wakefield

Summary

Overall the adoption of the hub approach has meant that the properties for community services in Wakefield are in relatively good condition The Drury Lane hub, while non-Trust owned, has been built as a purpose-designed facility for the Trust.

Table: Assessment of Wakefield premises

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
Drury Lane Health and Wellbeing Centre	Y	Y	Y	Y	Y	The premises are a purpose-designed lease into which the Trust had major design input. There are concerns over the effective use of clinic space which need to be addressed. The agile working areas are at maximum occupancy.
Airedale Health Centre	N	N	Y	Y	N	This is a dated environment for delivering patient services. However, it is well located for the community it serves.
Baghill House	Y	Y	Y	Y	Y	The development into a hub has made this into a mainly modern base for both service users and staff.

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
South Kirkby Health Centre	N	N	Y	Y	Y	These premises provide a local service but are no longer a main team base.
Unit 2 Flemming Court	Y	Y	Y	Y	N	This is an office base only. The building is becoming crowded.
The Poplars	N	Y/N	Y	Y	N	The building is suitable but the location and factors highlighted in the OPS transformation will require a review of future use.
Manygates	Y	Y	Y	N	Y	This site houses ADHD services. It is on a lease and represents good value for the Trust as it is isolated from other services in order to improve outcomes for this group.
Fieldhead (non-forensic)	Y/N	Y	Y/N	Y	Y	There are a wide range of services including support functions on the site. The development of the Unity Centre has removed the last of the lower quality ward space and replaced it with high quality space which represents a considerable improvement.

Kirklees

Summary

Kirklees has a large population that looks to Huddersfield in the south and Dewsbury/Batley in the north for the provision of community-based services.

There is currently one ward for adults of working age in South Kirklees at the Dales in Calderdale. Overall, the Dales suffers from an upper floor location which limits access to the outside. Observation and flexibility are poor. The rooms meet the mixed gender requirements but not all are en suite. The co-location with an acute hospital has some benefits but does provide pressure on facilities for staff such as parking.

Adults of working age care and older people's care for north Kirklees is provided in the Priestley Unit on the site of Dewsbury and District Hospital. Priestley Unit has been upgraded and consists of 2 separate wards of 15 beds for older people. Adults of working age have a mixed gender ward of 23 beds.

Most of Huddersfield community services are provided in Folly Hall and therefore meet modern standards that are appreciated by patients and staff. Accommodation for learning disabilities is also in this building and is considered fit for purpose. Room utilisation at the site should be reviewed as more services continue to be offered from the location.

Enfield Down provides longer term inpatient care. As the service is under review it should be revisited within the strategy at the end of the review. The building is local authority owned and is in need of major expenditure in even the short term. If it is to have a future as a service location, options need to be properly considered.

The community accommodation for north Kirklees is mixed; Ravensleigh Resource Centre is the main location for service delivery and, as a former dwelling, is not an appropriate setting for a modern community service. The quality of the office accommodation is mixed, and some is poor. Pathways at Mirfield is an old property with access issues for some service users and internal deficiencies which make it not fit for purpose. Based on these findings and the fact that the North Kirklees hub was not delivered in the previous strategy the accommodation in North Kirklees requires a total review.

Table: Assessment of Kirklees premises

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
Beckside Court	Y	Y	Y	N	N	This is good quality but expensive office accommodation.
Culling-worth Street	Y	Y	Y	Y	Y	Learning disability team base and consultation space. Fit for purpose.
Ravensleigh Resource Centre, cottage and annexe	N	N	N	N	N	This is a former dwelling with a series of outbuildings. As such it has been converted with difficulty for the services it is required to deliver, whether office or consult/treatment areas. It does not provide a long-term solution.
Pathways (Mirfield)	N	N	Y	Y	N	This building offers an integrated service although it is difficult to access for some service users. It is not considered to be fit for purpose in the medium to long term.
Folly Hall	Y	Y	Y	Y	Y	Includes staff base, individual consultation, and group meeting rooms for South Kirklees. Represents major recent investment by the Trust. There are some perceived space pressures.
Enfield Down	N	Y	Y	N	N	The building is not fully fit for purpose; the longer-term inpatient service in Kirklees is under review.
Fox View	Y	Y	N	Y	Y	The building is fit for purpose. The shape of the service is currently under review.

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
Priestley Unit	Y/N	Y/N	N	Y	N	There are two wards at Priestley plus office and consulting space. They have been upgraded. There is also office and consulting accommodation, some of which is not appropriately located on a hospital site.
The Dales	N	Y/N	N	N	N	There is one acute ward in use at The Dales. It is on an upper level and is subject to the constraints of the layout.

Calderdale

Summary

Inpatient care for adults of working age and older people is delivered from wards in the Dales. This building has an inflexible design that inhibits the delivery of care in terms of many areas including sex segregation, observation, access to the outside and the provision of activities.

Longer term care is provided at Lyndhurst which, although well located, is not a suitable building for delivering care. As the property is not in Trust ownership it should not be considered as a medium or long-term solution and its future should be resolved early in the new strategies term.

Community services are well integrated with the construction of the Laura Mitchell Health and Wellbeing Centre. They are housed in a modern purpose designed building which has a life considerably beyond the term of this review. As with other large hubs room usage survey reviews should be considered.

Table: Assessment of Calderdale premises

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
Laura Mitchell Health and Wellbeing Centre	Y	Y	Y	Y	Y	Modern building designed specifically for the services housed in it.

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
The Dales and ECT suite in main hospital building	N	Y	Y/N	N	N	The Dales has a number of significant drawbacks for inpatient services including lack of access to the outside, poor observation, and lack of flexibility. It is an inappropriate setting for psychological services. Rooms cannot be upgraded to en suite.
Hebden Bridge Health Centre	Y	Y	N	Y	N	Property is limited for improvement opportunities

Barnsley

Summary

Barnsley care group provides the widest range of services from a large number of settings, including GP premises where there is a good level of joint working.

The main site in Barnsley is Kendray hospital which houses a wide range of services, and which has benefitted from historic investment in bedded accommodation. The site needs to be further assessed with particular emphasis needed on providing improved accommodation and removing some of the older premises.

Community sites fall into a number of categories. There are seven LIFT sites that are of good quality, offer the scope for community-wide service integration and clearly have a long-term future. There are a number of team base only sites that are of variable quality. There are a number of Trust premises that are old and could be considered for integration into other premises. There are GP led premises where the Trust provides services and leases a part of the building. There are clinic premises that are fit for purpose. Finally, there are sites that fall below current standards and require separate attention, namely the Mapplewell, Wombwell, Penistone, Silkstone and Lundwood Health Centres.

Table: Assessment of Barnsley premises

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
Kendray Hospital	Y	Y	Y	Y	Y	The site has almost reached its maximum capacity.
170A Sheffield Road	N	N	Y	Y	N	The building is probably fit for purpose, but services could be reviewed for alternative accommodation.

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
Cudworth Clinic	N	Y	N	Y	Y	The potential for absorbing the services elsewhere could be considered.
Lundwood Health Centre	Y	Y		Y	N	Well used, however, its future should be reviewed in relation to capacity at nearby LIFT buildings and its poor design.
Mapplewell Health Centre	Y	Y		Y	N	Well used following a refurbishment into a learning disability base.
New Street Health Centre	Y	N	N	N	Y	This building has had recent major works which have particularly enhanced CAMHS provision. The services provided here are a mix of services needing a town centre location and those that are there simply because it is geographically extremely well placed. The original building, whilst safe and fit for purpose, is reaching end of life. A potential exit may free up the site for alternative use.
Penistone Clinic	N	N	N	N	N	This is a converted 1901 Sunday School. It is not fit for its purpose and the Trust should consider a wider public estate-based solution working with other partners.
Silkstone Health Centre	Y	N	N	N	N	The Trust does not particularly use this site well and its future should be linked to the Penistone development.
Wombwell Health Centre	N	N	Y/N	N	Y	This building is technically fit for purpose but is a very poor building in terms of design.
Cudworth Centre LIFT	Y	Y		Y	Y	Modern fit for purpose accommodation.
Goldthorpe Centre LIFT	Y	Y	Y	Y	Y	Modern fit for purpose accommodation.
Grimetho-rpe Centre LIFT	Y	Y	Y	Y	Y	Modern fit for purpose accommodation.
Thurnscoe Centre LIFT	Y	Y	Y	Y	Y	Modern fit for purpose accommodation.

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
Worsbor-ough Centre LIFT	Y	Y	Y	Y	Y	Modern fit for purpose accommodation.
Round-house Centre LIFT	Y	Y	Y	Y	Y	Modern fit for purpose accommodation.
Hoyland Centre LIFT	Y	Y	Y	Y	Y	Modern fit for purpose accommodation.
Apollo Court	Y	Y	Y	Y	Y	Nurse base within a GP surgery. Use to be reviewed at end of lease in 2027.
Garland House Surgery	Y	Y	Y	N	N	Modern fit for purpose accommodation. Use to be reviewed at end of lease in 2029.
Oaks Park Medical Centre	Y	Y	Y	N	N	Modern fit for purpose accommodation. Expensive lease which should be reviewed at termination in 2027.
Victoria Medical Centre	Y	Y	Y	N	N	Modern fit for purpose accommodation. Expensive lease to be reviewed at termination in 2024.
Chapelfield Medical Centre	Y	Y	Y	N	N	Modern fit for purpose accommodation. Expensive lease to be reviewed at termination in 2027.

Forensic

Summary

The forensic service is a major part of the Trust service offer. The forensic care group accommodation at Fieldhead is currently undergoing an expansion and upgrading programme. Whilst there are deficiencies in some aspects, for example, a lack of en suite facilities in some units, this accommodation represents a fixed point in the Trust's estate.

Table: Assessment of forensic premises (Fieldhead)

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
Block 01 - Bretton Centre Low secure bed base	Y	Y		Y	Y	Good environment despite the lack of en suite bathrooms. Some corridor widths present a risk.
Block 12 – Ryburn Low Secure rehab – outside the secure perimeter	Y	Y		Y	Y	Good environment.
Block 02 - Oasis Centre Recreation	Y	Y		Y	Y	Opportunity to use more intensively.
Block 15 – Newhaven Low secure	Y	Y		Y	N	Very large for the number of patients.
Block 27 - Newton Lodge - Clinical Resource Centre	Y	Y		Y	Y	
Block 27 - Newton Lodge - Bronte	Y/N	Y		Y	N	
Block 27 - Newton Lodge - Common Areas	Y	Y		Y	Y	

Property	1 Enhance service provision	2 Statutory require-ment met	3 No stigma	4 Value for money	5 Service develop-ment and initiatives	Comments
Block 27 - Newton Lodge – Gaskell	N	Y		Y	N	Needs refresh. No potential for en suites.
Block 27 - Newton Lodge - Priestley	Total refurb planned					
Block 27 - Newton Lodge - Waterton	As Priestley					
Block 27 - Newton Lodge - Hepworth	Y	Y		N	Y	Refurbished and extended in 2014.
Chippen-dale and Appleton	Y	Y		Y	Y	New facility.

Summary

Trustwide support office accommodation is provided at Fieldhead and Kendray.

This strategy presents proposals for the estate across a 10-year span. It addresses the discrepancies between the current estate and the criteria by which the Trust has agreed to evaluate its premises. Essentially this means that the estate must provide a setting that enhances the services that the Trust provides and demonstrate the value that it puts on all of the people who encounter the Trust as patients, visitors or staff. The proposals that are set out below embrace the two overarching principles of quality and value for money and recognises that value for money encompasses making best use of staff resources, investing for long term not short-term benefits, and ensuring that all investment identifies and achieves tangible benefits to the overall Trust business plan and objectives.

There are some underlying concepts underpinning all of our proposals:

- **Consolidation:** In crude terms space equates to money. For community services the balance of space occupied by the Trust is office accommodation rather than direct service delivery accommodation. Whilst integration with other providers including any public sector provider is a driver behind the number of sites within the Trust, history and accident also play a part.
  The situation was drastically improved by the hub programme. However, whilst the Trust adopted an agile policy it became clear during the Covid pandemic that vastly differing ways of working are possible through the adoption of technology. It then becomes possible to make more intensive use of space and avoids having available space in the wrong places. In addition, consolidation will enable the Trust to address some of the shortfalls demonstrated in the 6 facet surveys. Currently availability constraints result in

service delivery spaces that have erratic occupancy with high levels of downtime; hybrid working with appropriate use of technology can help facilitate much better utilisation rates of clinical and non-clinical spaces.

- **Agile and hybrid working:** The Trust has embraced the concept of agile working.
- **Valuing people:** All of our proposals are based on the principle of modern high-quality design and the sense of being valued that this can impart to patients, staff and visitors. Within the NHS, space and particularly personal space, is often taken as a proxy for valuing people.
- **Focusing on services not property:** We recognise that the geography and demographics within the Trust must be reflected in the service model as it seeks to provide local services that meet local aspirations. Throughout the estates strategy exercise, we have sought to start with the service and not be constrained by existing buildings or the urge to "fix" services in long term premises just because they are there. The Trust has a dynamic approach to the range and organisation of services and the estate needs to be as nimble and "future ready" as possible in response to this dynamic service landscape. It is important to provide facilities that enhance the service model, and ownership of those facilities is not essential where leasing offers a better location or flexibility.
- **Collaboration with other partners:** There are natural areas of collaboration in terms of service delivery within the Trust and many of these are already well developed.

The advent of the ICS model should be seen as a start point for improving this collaboration and potentially removing the barriers which exist, notably financial in terms of cross charging etc.

Vision for inpatient services

Inpatient facilities must be able to meet the challenge of the increasingly acute patients who are using the service. In addition, they should incorporate best practice with regard to privacy and dignity and principles such as access to outside space including for exercise purposes, flexibility (particularly in relation to mixed gender requirements), and ease of observation by staff.

Vision for community services

The Trust vision of a hub and spoke principle with the hubs being developed where possible from first principles has been met mainly with success. The majority of development for this has happened but there are still gaps in provision which need to be addressed, notably North Kirklees hub. These spaces must:

- Be accessible to service users, carers, and the public
- Have flexibility and adaptability to changing needs
- Incorporate agile working
- Have multi-functional space
- Be a stigma free, therapeutic environment
- Offer co-location of staff and service user facilities

Proposals by care group and location

Wakefield

Properties and services for Pontefract and the surrounding area

The development of hubs at Drury Lane and Baghill House have covered the majority of the needs of the Trust. The accommodation at Airedale and Flemming Court should be subject to improvement to bring it up to modern standards. In each case this can be done through the minor capital bids process as the Flemming Court lease has been regularised into the Trust's tenure.

Inpatient Accommodation for Wakefield

The development of the Unity Centre at Fieldhead has transformed inpatient accommodation in the care group. This will remain the case for the life of the strategy.

The Poplars unit remains isolated both clinically and geographically its future will be determined by the outcome of the OPS transformation and formal consultation.

Kirklees

South Kirklees community accommodation

Folly Hall provides the main clinical and staff accommodation for south Kirklees; The Trust occupies the majority of the site through eight separate but co-terminus leases expiring in 2025.

The Trust is already working with services around the future accommodation needs. This work will inform decisions around whether the Trust renews some, all or none of these leases by looking at all alternatives. The Trust will engage with partner organisations to ensure all available alternatives are considered.

Table: North Kirklees community accommodation

Property	Lease cost	Capital charge	Depreci-ation	Running costs	Total revenue	Six-facet survey cost to condi-tion	Net book value	Fitness for purpose
Raven-sleigh		9,854	4,558	128,966	143,378	223,608	277,626	Poor
Beckside Court	72,852	673	2,357	118,970	194,852		34,958	
Pathways		2,219			2,219	145,702		Council owned
Sub totals	**72,852**	**12,467**	**6,915**	**247,936**	**340,449**	**369,310**	**312,584**	

Links with the local authority are very well developed and there is a pattern of shared premises and properties that are available to the Trust rent free. Based on current market rents it has been estimated that Pathways would attract a rent of £45,900.

Beckside Court is the main office base and the service facing facilities are at Ravensleigh and Pathways. These create a mixed picture; Ravensleigh is not particularly accessible and is a former dwelling with the usual disadvantages of a complex and inefficient layout, lack of lift, and an inappropriate setting for modern healthcare. Pathways is mainly used for the Recovery College and talking therapies, is not accessible for all patients, and has disadvantages for more vulnerable patients.

It is proposed that consolidation into a hub should be considered, with the services from Ravensleigh, Cullingworth Street and Fox View at its heart. Agile working must underpin the assessment of office type accommodation to achieve best value. In addition, there is recognition that partnership working with the local authority is a key element in the organisation of services in Kirklees and this should underpin any planning for a hub, particularly in relation to exiting Pathways.

Inpatient accommodation for Kirklees and Calderdale

The Dales design can compromise the safety of staff and service users, it has poor external facilities, and the rooms just meet the required standards. It is a PFI (Private Finance Initiative) building and as such it is expensive to own and alter.

Priestley Unit at Dewsbury and District Hospital is leased from the acute Trust. Inpatient accommodation is a core activity for the Trust and fit for purpose, securely tenured accommodation is therefore essential. Whilst Priestley has undergone a programme of upgrading, it is not a purpose designed unit consisting of some large ward sizes, lack of en suites and the layout is not flexible. In addition to the wards a number of office and outpatient facilities are provided at Priestley.

The AWA ward for south Kirklees is located at The Dales in Calderdale. The Dales has a highly idiosyncratic design with a number of deficiencies including first floor inpatient accommodation with severely limited en suite sanitary provision, poor therapy provision, limited access to the outside, poor observation and an inflexible layout.

Calderdale

Inpatient accommodation

This is inextricably linked to the number of beds in Kirklees.

Community facilities in Halifax

The accommodation in Halifax is in the relatively modern Laura Mitchell Health and Wellbeing Centre which is fit for purpose.

Community facilities in the west

The communities in the west are relatively remote from Halifax and are currently served from the Hebden Bridge Health Centre. The team at Hebden Bridge also works across Calderdale.

There is clearly a need to provide local services for this area. However, it is not clear that a location in Hebden Bridge has a particular logic for services with many consultations being undertaken at the Dales in Halifax, and the property is relatively expensive to run. In addition, it is cited as a barrier to recruitment. A review of the future of Hebden Bridge is an early requirement in the strategy in partnership with Calderdale and Huddersfield NHS Foundation Trust and local authority.

Barnsley

LIFT Premises

Barnsley had an active LIFT programme that transformed the GP landscape and enabled the integration of care group, GP and local authority services.

These buildings are high quality and as such should be as heavily utilised as possible. They offer the opportunity to release other lesser quality premises around the care group. Properties that could be considered for integration into shared estate buildings or redevelopment are Wombwell and Lundwood. Other premises which could be re-provided in some manner for example Penistone and Silkstone clinics.

It is proposed that a rigorous review of activity and engagement is undertaken to instigate a programme of potential consolidation so that the Trust withdraws from poor quality premises which are relatively low cost but poor value for money.

Cost of co-location in GP premises

The care group has inherited a number of agreements with GPs for use of accommodation within new premises. The costs of these agreements are outside of the range of cost of even the LIFT arrangements, and these should be reviewed and alternative arrangements identified. However, it should be noted that in some cases the contribution from the Trust is making the buildings affordable for primary care services located there.

Table: Cost of co-location in GP premises

Property	Rooms	Cost £
Apollo Court, Barnsley	5 clinical, 6 offices	95,070
Garland House Surgery, Barnsley	5 clinical , 2 offices	93,522
Oaks Park Medical Centre, Barnsley	6 clinical , 2 offices	185,004
Victoria Medical Centre, Barnsley		95,070
Chapelfield Medical Centre, Barnsley	1 clinical room, 2 offices	103,240

New Street Clinic

While New Street has had considerable investment, it does require more expenditure to bring the whole space to the same standards. It remains a very convenient town centre location. It is anticipated it will be a key location in the new neighbourhood model. However, the local authority in Barnsley is currently seeking to reinvigorate the centre of town and the Trust should maintain engagement in this to ensure it can understand any benefits. In this scenario, New Street could be reviewed as part of this partnership approach.

Hospital sites

The main hospital site at Kendray has housed services relocated from a number of locations in Barnsley. As such, it is reaching saturation and the infrastructure such as parking and power is under pressure. All the ward areas have been either purpose designed or extensively altered so that they provide high class space which meets the Trust bedroom standards. The stroke unit particularly provides excellent accommodation to people with mobility issues.

The ancillary accommodation is dated with some being well over a hundred years old. These areas do not lend themselves to alteration to accommodate the flexible and hybrid working patterns that are increasingly being used.

The site would benefit from a wholesale strategic review with the potential for some support services to relocate subject to engagement.

Forensics

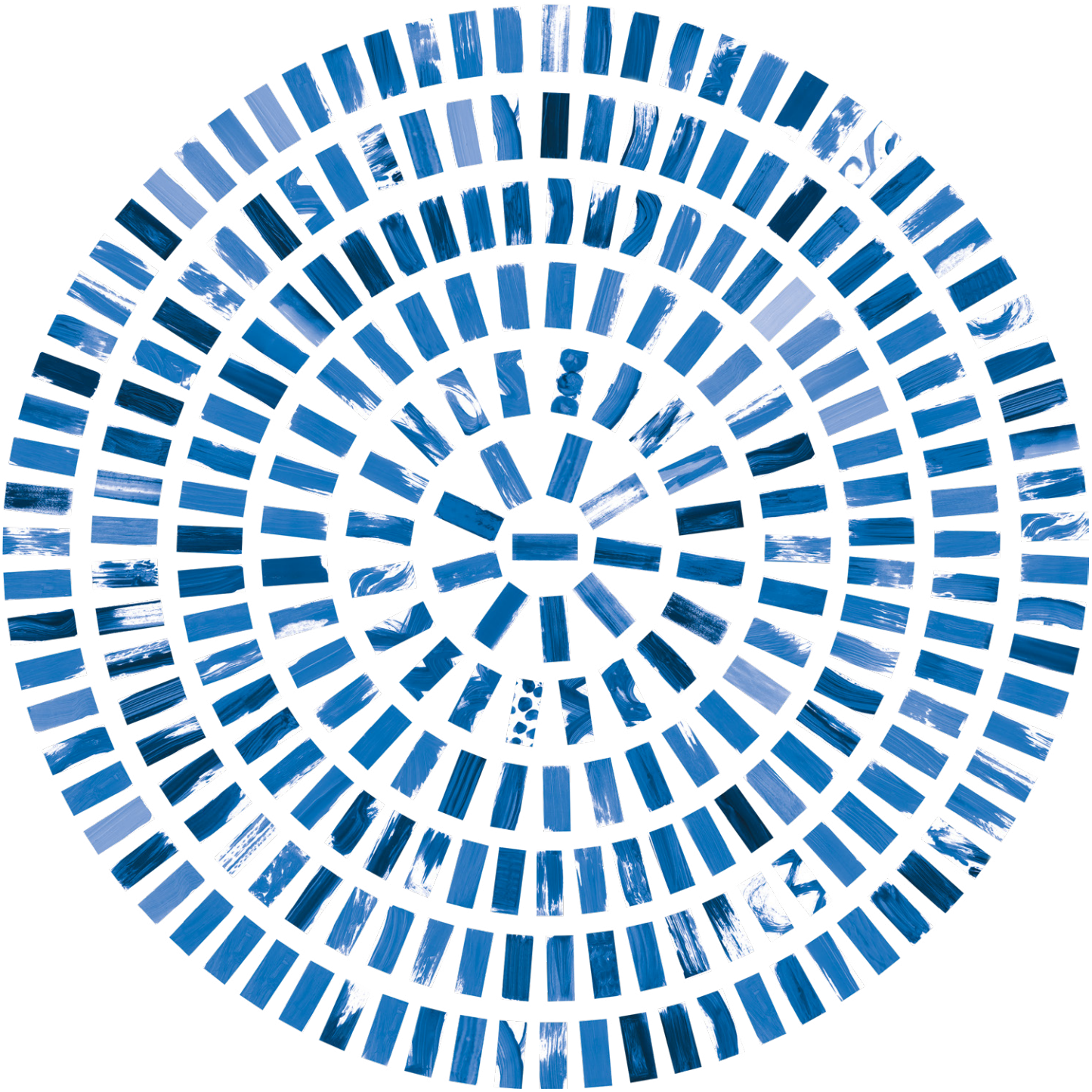
The forensic accommodation has been the subject of considerable recent and ongoing investment. The key to the future is flexibility so that the service can adapt to changing patient needs, particularly in relation to acuity without changes to the building.

Any investment on site in AWA accommodation, particularly on the Fieldhead site, should ensure that there is flexibility to cope with low secure acuity levels. It should also feature a design that integrates both low and secure service streams to provide a secure campus.

The Gaskell ward, whilst of a relatively low standard, is a key component in achieving this strategy. It has been used as a decant ward and will be needed for that purpose as part of a longer-term campus development. As such, it should be considered for early refurbishment to support this before it is brought into any other use as part of changes in commissioning.

Support accommodation

The support accommodation has been consolidated mostly at Fieldhead and Kendray, given the pressure on hospital accommodation it should always be reviewed to see if it is in the right place. However, at both sites it does represent particularly good value against a rented solution and keeps overheads down. It needs investment to facilitate the Trust's hybrid working aspirations as it is mostly cellular office space.



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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							✘					
Incident management 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 *(June 2023)*
- 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 *(integrated into GPTW strategy)*
- 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)*