Trust Board (business and risk)
Tuesday 31 October 2023 at 9.30am
Boardroom, Conference Centre, Kendray Hospital

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	**Paper**	2	To receive
9.33	**3. Questions from the public** *(received in advance in writing by e:mail to* <u>*membership@swyt.nhs.uk*</u> *)*	Chair	**Verbal item**	5	To receive
9.38	**4. Minutes from previous Trust Board meeting held 26 September 2023**	Chair	**Paper**	2	To approve
9.40	**5. Matters arising from previous Trust Board meeting held 26 September 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
9.58	**8. Chief Executive's report**	Chief Executive	**Paper**	7	To receive

With **all of us** in mind.

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
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 Board Assurance Framework grading process review	Director of Finance, Estates and Resources	**Paper**	5	To approve
10.20	9.3 Corporate / organisational risk register	Director of Finance, Estates and Resources	**Paper**	10	To receive
10.30	9.4 Sustainability annual report	Director of Strategy and Change	**Paper**	5	To approve
10.35	9.5 Patient safety incident response framework (PSIRF)	Chief Nurse & Director of Quality and Professions	**Paper**	10	To receive
10.45	9.6 Workforce equality standards report	Interim Chief People Officer	**Paper**	5	To approve
10.50	9.7 Assurance and approved minutes from Trust Board committees and Members' Council - Collaborative Committee 3 October 2023 - Audit Committee 10 October 2023	Chairs of Committees	**Paper**	10	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	- Quality and Safety Committee 17 October 2023				
	- Finance, Investment and Performance Committee 23 October 2023				
11.00	*Break*			10	
11.10	**10. Performance**				
11.10	10.1 Integrated Performance Report (IPR) month 6 2023/24	Director of Finance, Estates and Resources	**Paper**	20	To receive
11.30	**11. Integrated Care Systems and Partnerships**				
11.30	11.1 South Yorkshire update including and South Yorkshire Integrated Care System (SYICS)	Chief Executive	**Paper**	10	To receive
11.40	11.2 West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update	Director of Provider Development	**Paper**	10	To receive
11.50	11.3 Provider Collaboratives and Alliances	Director of Finance, Estates and Resources	**Paper**	5	To receive
11.55	**12. Governance**				
11.55	12.1 Constitution review	Director of Finance, Estates and Resources	**Paper**	5	To approve

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
12.00	**13. Strategies and policies**				
12.00	13.1 Progress against the Digital Strategy update	Director of Finance, Estates and Resources	**Paper**	10	To approve
12.10	**14. Trust Board workplan**	Chair	**Paper**	2	To note
12.12	**15. Date of next meeting** The next Trust Board meeting held in public will be held on 28 November 2023	Chair	**Verbal item**	2	To note
12.14	**16. Any other business**	Chair	**Verbal item**	6	To note
12.20	*Close*				

Trust Board 31 October 2023
Agenda item 2

Private/Public paper:	Public
Title:	**Trust Board declaration of interests, including fit and proper persons declaration**
Paper presented by:	**Chair**
Paper prepared by:	Andy Lister – Head of Corporate Governance
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the UK Corporate Governance Code, Monitor's (now NHS England / Improvement's) Code of Governance and the Trust's own Constitution in relation to openness and transparency.

Strategic objectives:	Improve Health		Please tick as appropriate
	Improve Care		
	Improve Resources		
	Make this a great place to work	✓	

BAF Risk(s):	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 Trust compliance with FPPT provides assurance to commissioners and partners that the Trust is Well Led.
Any background papers / previously considered by:	Previous annual declaration of interest papers to the Trust Board. Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality approved by Trust Board in March 2021. Declaration of Interest Paper submitted to Trust Board March 2023 The Standards of Business Conduct Policy (conflict of interest policy) to Trust Board in April 2023. Update to fit and proper persons test to Trust Board September 2023
Executive summary:	**Declaration of interests** The Trust's Constitution and the NHS rules on corporate governance, the UK Corporate Governance Code and NHS England / Improvement require Trust

| | Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Head of Corporate Governance (Company Secretary) so that the Register can be amended, and such amendments reported to Trust Board.

Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, Trust Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting.

There are no legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests is part of the Trust's Constitution.

The Head of Corporate Governance (Company Secretary) is responsible for administering the process on behalf of the Chief Executive of the Trust. The declared interests of the Chair and Directors are reported in the annual report and the register of interests is published on the Trust's website.

The Standards of Business Conduct Policy (conflict of interest policy) for staff was updated to align with the model policy and approved by Trust Board in April 2023.

The Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality was reviewed in March 2021 with minor amendments to titles referenced within the policy and remains compliant with the above.

Updates to register have been received from Associate Non-Executive Director Rachel Lee appointed in June 2023 and Dawn Lawson appointed in September 2023.

Risk appetite
The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this. |
|---|---|
| **Recommendation:** | **Trust Board is asked to CONSIDER the attached update, particularly in terms of any risk presented to the Trust as a result of the declarations made, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.** |

Trust Board 31 October 2023

**Updates to the register of interests of the directors (Trust Board)
From 1 April 2023 to 31 March 2024**

All members of Trust Board have signed a declaration against the fit and proper person requirement. All Non-Executive Directors have signed the declaration of independence as required by NHSE's Code of Governance, which requires the Trust to identify in its annual report those Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement.

The following updates to the declarations of interest have been made by the Trust Board since the Annual update in March 2023:

Name	Declaration
Associate Non- Executive Directors	
Rachel Lee – Associate Non-Executive Director	• Director of North Star Psychology Ltd, • Endorses a wellbeing product called Luma, this is a light that guides people through various breathing practices, based on scientific research.
Executive Directors	
Dawn Lawson – Director of Strategy and Change	No interests declared.

Minutes of Trust Board meeting held on 26 September 2023
Small Conference Room Wellbeing and Development Centre
Fieldhead Hospital

Present:	Marie Burnham (MBu)	Chair
	Mandy Rayner (MR)	Deputy Chair/ Senior Independent Director
	Mike Ford (MF)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Natalie McMillan (NM)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	David Webster (DW) (via MS teams)	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
Apologies:	Nil	
In attendance:	Miriam Heppell (MH)	Interim Deputy Chief People Officer
	Dawn Lawson (DL)	Director of Strategy and Change
	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:	Greg Moores (GM)	Chief People Officer
	Lindsay Jensen (LJ)	Interim Chief People Officer
Observers:	2 x Trust governors	

TB/23/78   Welcome, introduction and apologies (agenda item 1)

The Chair, Marie Burnham (MBu) welcomed everyone to the meeting. Apologies were noted as above, the meeting was deemed to be quorate and could proceed.

MBu outlined the Board 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 Dawn Lawson (DL), director of strategy and change, to her first Board meeting, and Miriam Heppell (MH) interim deputy chief people officer who is in attendance on behalf of the interim chief people officer. Today, David Webster (DW), Non-Executive Director, will be attending via Microsoft Teams.

MBu informed attendees that the meeting is being recorded for administration purposes, to support minute taking, and once the minutes have been approved the recording will be

deleted. 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 the members of the public there will be an opportunity for questions and comments, received in writing prior to the meeting, at item 3.

TB/23/79   Declarations of interest (agenda item 2)
There were no further declarations of interest for Board members in addition to those already made for 2023/24.

It was RESOLVED to NOTE no further declarations have been made since the last meeting.

TB/23/80   Questions from the public (agenda item 3)

No questions were received from the public.

TB/23/81   Minutes from previous Trust Board meeting held 25 July 2023 (agenda item 4)
Darryl Thompson (DT) noted some points of detail in relation to the Audit committee and a recent risk assessment audit, namely the "safety pod" reference on page 9/10 and advised he would send some revised wording to Andy Lister (AL) to update. Mandy Rayner (MR) noted on page 8 the word "bespoke" needed to be replaced with "extraordinary" in relation to the people and remuneration committee (PRC) meeting.

Action: Andy Lister

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

TB/23/82   Matters arising from previous Trust Board meeting held 25 July 2023 and board action log (agenda item 5)

TB/23/40c – Nat McMillan asked that the two actions be updated to reflect that updates have been scheduled for November due to the scheduling of the next safer staffing report on the Board workplan.

Action: Andy Lister

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

TB/23/83   Service User/Staff Member/Carer story (agenda item 6)
Carol Harris introduced Andrew Birkenshaw (AB) and Abby Downs (AD). Andrew is the team manager of the Kirklees learning disability team, and interim ward manager for the Horizon centre at Fieldhead, and Abby is the advanced nurse practitioner at Horizon. The Horizon centre is an assessment and treatment unit (ATU) for people with a learning disability (LD). The Horizon team have been undertaking an improvement programme which started as a result of some concerns that were raised by staff through freedom to speak up (FTSU), and a quality monitoring visit (QMV). AB and AD have been leading on this improvement work.

AB reported when work began the ward needed support, and the first thing identified was the staff team had low morale. This was the first area of focus, with a view to improving morale, and upskilling staff, by investing time and resources into the team and reviewing the clinical pathway.

AD spent a lot of time with the staff team, putting a supervision structure in place, in line with what staff consider to be best practice standards, and then implementing these standards, alongside a staff development programme.

A positive clinical leadership team has been developed with a new psychologist and an experienced occupational therapist (OT) in place for two days a week, who have a lot of experience of working in inpatient units, which has boosted the development of the staff team.

A clear training plan was developed including four key areas. The Oliver McGowan training, which is autism and learning disability training, positive behavioural support (PBS) training, and trauma informed training. The Oliver McGowan training and PBS training have been completed with trauma informed training to come next, and this will be followed by active support. These four areas of training will enable staff to take a holistic view of the patient, and as such provide a better level of care.

AB reported they have tried to adjust the attitude on the unit. Students on placements in the past have reportedly had negative views of the ward. Time has been spent with students and changes made, and students are now keen to work on the unit again.

AB reported changes to recruitment processes, to employ people who are passionate about LD, have significantly reduced vacancies on the unit. There are plans to develop band 5 staff to progress to band 6 in order to fill band 6 vacancies.

AB noted that some staff have moved on as a result of the changes, but with the changes that have taken place AB believes staff retention will be stable over the next couple of years.

AD reported that the ward is feeling positive and more stable, and restraints have come down considerably in the last six weeks. It is now a happy, positive place to work.

AB reported there are plans to develop further and the team want Horizon to become a centre of excellence for LD across the country.

MBu thanked AB and AD for excellent work they have carried out and opened up to the Board for questions.

MR asked how the Board can support their work so that it doesn't lose momentum?

AB reported the team need to make sure they have the right environment and facilities, and changes need to be carried out in a timely manner. The Board need to trust the team to take Horizon to a better place. When there is a request for something, there is a genuine reason for the request.

The view of the new staff is we are making a temporary home for our patients, and the staff that care for them, in the 12 hours they are on duty each day. There is also a plan to enhance occupational therapy (OT) provision to five days a week on a rotational basis.

Prof.Subha Thiyagesh (ST) noted how much change has taken place, and in particular the level of meaningful activities which seem to have had a positive impact.

AB reported they are trying to upskill the nursing team so that they are starting to challenge themselves about meaningful activities. There is now an activity chart on the wall outside each patient's room, showing them what is available each week. Creative practitioners are being used for four days a week at the moment, and there is a plan to recruit some assistant OTs so the team can offer seven days of activities.

Dawn Lawson (SL) queried what has been the most difficult part of the journey and which part has given the most reward?

AD reported the difficult part was deciding what to prioritise first and the scale of change to be tackled. AD added that AB and her worked really well together and broke the project down into small manageable parts. It has been rewarding to see patients getting better, and reaching their potential. We are now looking for active placements for some of our patients, which is really positive.

AB stated he had completed a "Kaizen" training programme (change management programme) in his previous Trust.AB stated they couldn't just tell everyone to change, they had to get staff invested in the change, and be part of it, and support them to do it. There was some initial resistance but once people saw what was being achieved the improvement began to grow.

Mike Ford (MF) queried how this good work could be shared across the Trust and DL reported it was her job to make sure this positive improvement story and process is shared.

MF also noted the FTSU concern being raised after the improvement had started and queried if this was resistance to the changes being made.

AB reported there was a lot of initial resistance to the changes.. To combat the resistance, AB filled people with kindness, and when resistance continued, more kindness followed. AB and AD were confident the changes were for the best interests of the patients and the Trust.

Mark Brooks (MBr) gave a personal note of thanks, reporting on a recent visit to Horizon with Carol Harris, they had spoken to 10 -15 members of staff who all seemed very happy and it was clear the culture had changed.
MBr noted it will be a challenge to maintain this good work. There has been a 45% reduction in LD nurses across the country since 2009, so for the Trust to start bucking the trend is positive. The Trust has spent time influencing partners with the need to complete physical health checks for people with a learning disability, and we need to focus on own services too.

MBu stated the work that has taken place is commendable, and thanked AD and AB for their contribution to the immense changes that have taken place.

It was RESOLVED to NOTE the Service User/Staff Member/Carer Story and the comments made.

TB/23/84   Chair's remarks (agenda item 7)
MBu reported the following items will be discussed in the private Board session in the afternoon:
- Complex incidents
- Full year financial forecast
- Assurance from Committees, minutes to be taken in private.
- Private updates from integrated care partnerships and provider collaboratives.

It was RESOLVED to NOTE the Chair's remarks.

TB/23/85   Chief Executive's report (agenda item 8)
Chief Executive's report
MBr asked to take the report as read and highlighted the following updates:

- The verdict of the Lucy Letby trial has taken place since the last Board meeting, and we have a separate Board paper on our own initial response. Our sympathies are with those families affected by her crimes.
- West Yorkshire (WY) and South Yorkshire (SY) integrated care systems (ICS) are required to make a 30% saving to running costs. Consultation processes with their staff have now commenced.
- The financial position across the NHS is deteriorating. The WY ICS is predicting it will not achieve its break-even target position for this financial year. This will increase focus on the system and providers within the system, including our Trust.
- Industrial action continues. MBr thanked the hard work of Trust teams, who continue to maintain safe care, adding this is taking a lot of planning and work.
- MBr welcomed Dawn Lawson to the executive team and Board as director of strategy and change.
- Winter is approaching and we are commencing our flu vaccine roll out and promoting Covid-19 boosters. Our Covid restrictions remain in line with national guidance.
- "Right care right person" is a joint working programme with the police and NHS.. Carmain Gibson-Holmes is leading on this work for the Trust, and we have an extended executive management team (EMT) input on this, this week. It will be important for the quality and safety committee (QSC) to look at this over the coming weeks.
- The Royal College of Surgeons has published a report about sexual safety in the workplace. We have carried out a lot of work on sexual safety in the workplace and continue to focus heavily on speaking up, but we must not be complacent. NHS England has recently published a sexual safety charter for trusts to sign. We intend to sign this charter.
- Overall performance in the Trust is holding up, but there are some areas of pressure in relation to some workforce metrics including mandatory training.

Erfana Mahmood noted the WY ICS deficit and queried if there is anything we can do or manage from a Trust perspective?

Adrian Snarr reported NHSE have a set of expectations regarding the control environment, which is integrated care system (ICS) wide. The control environment plan is for all providers within the ICS to comply. The Trust is on target to meet its financial plan. We are complying and supporting the system.

Nat McMillan (NM) noted the national suicide prevention strategy referenced in the paper and asked for Naomi Sutcliffe to the present this to QSC, following her presentation of the regional strategy in July.

Action: Darryl Thompson

NM queried if there is the option for the Board to support and lead on the vaccinations programme?

MBr reported there is a rolling vaccination plan, with one directors having their pictures published on social media as they receive their vaccination and all Board members are encouraged to do this.

NM posed a question for the integrated performance report item to follow; as a Board are we satisfied we are measuring the right things, and do we know where the challenges are?

A discussion took place about the WY ICS financial position and AS reported WY ICS have not changed their position, as their plan was submitted with an identified level of risk. They are now reporting this risk is coming to fruition.

Mandy Rayner (MR) raised industrial action, and asked how the joint junior doctor and consultants' industrial action is managed to mitigate the risks?

Prof.Subha Thiyagesh (ST) reported the risk is mitigated by the significant amount of planning that takes place beforehand. A joint operational approach takes place with senior leaders from all specialisms being involved. We look at the management of the bank to see how we can utilise people's skills effectively. We have also strengthened the on-call system across the Trust. The two key components to success are planning and communication. ST confirmed that the use of agency staff is not allowed to be used for cover gaps brought about by industrial action.

MBu noted there is a risk of the level of response to industrial action being accepted as normal practice, and this mustn't happen.

MR noted the number of good news stories included in MBr's report, which should be celebrated.

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

TB/23/86   Performance (agenda item 9)
TB/23/86a   Integrated performance report month 5 2023/24 (agenda item 9.1)
AS introduced the item and highlighted the following points:
- The Finance, Investment and Performance (FIP) committee met last week and were updated with a demonstration on the build "behind the scenes" of the IPR and how drill down into the data now takes place. This drill down facility provides assurance that the drill down data feeds go through to the operational management group (OMG), care group directors and wider.

MBu asked if would be possible for non-executive directors who are not part of FIP to be able to see the demonstration. AS agreed, to arrange this.
ACTION: Adrian Snarr
- Out of area (OOA) bed days have been an area of focus, there is cautious optimism in the reduction this month. There is caution as we are seeing an increase in people clinically ready for discharge. We have good links with our partner organisations to see where the peak points are.

Priority programmes
AS highlighted the following points:
- We have introduced a measure regarding completion of work to address ligatures this year. Previously we recorded every ligature point, but we have refined this, and we are recording category 2 ligature risks. Category 2 ligature risks are the highest category risks, that are dealt with quickly, this metric now shows we are dealing with the majority of these in the required 24 hour time period.
- Digital dictation was made part of the priority programs at the beginning of the year, we have just concluded the procurement process and are now moving on to the implementation phase.

Quality
DT highlighted the following points:

National indicators
- We continue to perform well against the majority of national metrics.
- Inappropriate out of area (OOA) bed days is reducing but we are still over target, with 11 people placed out of area at the end of August.

Local indicators
- Care planning – a person receiving care under the care programme approach (CPA) and is offered a copy of their care plan shows compliance at 87.4%. This is sustained performance above the 80% threshold since April 2023.
- For risk assessments, the August data shows an increase in performance from the previous month within inpatient services (88%) and community services (94.7%).OMG monitor risk assessment data.
- There were 16 information governance (IG) breaches in month, this is above threshold of 12. All incidents have been reviewed and there are no hotspots or themes.
- Pressure Ulcers – there is one category 4 pressure ulcer that has been associated with a lapse in care. The service is reviewing the incident to identify any learning.
- There has been an increase in band 2 colleagues joining the Trust bank from agency which should help further support safer staffing fill rates, which have improved this month.
- There have been 33 falls in August, the same as July and these are the lowest numbers in the last 12 months.
- Infection, prevention and control (IPC) – there were two outbreaks of Covid-19 in August, which reflects what is being experienced nationally with increased prevalence. Both affected wards have since re-opened.
- The Trust has responded to 100% of received complaints within 3 days.
- The backlog of complaints to be allocated to an investigator has reduced, and this continues to be part of complaints improvement work.

MF noted IG breaches and a target of 12, and queried if the Trust is an outlier and what the impact of these breaches is on the affected parties.

MR added to the query asking if there is a scoring process from the information commissioner's office (ICO) that is completed as a part of the risk assessment, along with duty of candour.

DT reported the Trust has an improving clinical information group (ICIG) which he attends as Caldicott Guardian and AS as Senior Information Risk Owner (SIRO).
IG incidents are reviewed through this group and any complaints received in relation to IG breaches are signed off by DT as Caldicott Guardian. The communications team and corporate governance team are pulling together the human impact of these incidents to be shared as real examples with all staff.

MBr reported IG breaches and associated stories are regularly part of the Brief. IG breaches tend move in peaks and troughs, and we will continue to work on Trust communications.We focus on ensuring our Trustwide IG mandatory training is at 95% every year for the data protection toolkit.
We categorise incidents, and at the moment they are relatively low level, but we need to maintain focus.
At ICIG we have teams presenting on how they have learnt from IG breaches.
In the last year we have been successful in recruiting many new staff from outside the NHS and they may not be as aware of the IG standards needed in NHS organisations. It is the ongoing learning and education that is important. Reporting is good, we were in the "mid-20s" each month, some years ago, and 12 -15 is quite low but one major incident could have a major impact.

MF queried if the threshold in the IPR of 12 is correct.

MBr reported that some years ago there was a suggestion that there should be zero tolerance in relation to IG incidents. Human errors do occur, and we must learn from them, and so need staff to feel confident they can report them.

Julie Williams (JW) reported every team subject of an IG breach iswritten to, and asked to produce an action plan.

NM noted paediatric audiology and the performance is expected to reach 99% in October 2023 and queried if this target is correct?

CH reported there has been a plan in place for the last couple of months. There was a dip in performance as a result of a capacity gap, but we have recruited and are expecting a return to performance in October. CH reminded the Board there are small numbers of children involved in this metric.

NM asked for an action to report back to Board that the required trajectory has been met for assurance purposes.

CH reported performance is monitored through the OMG action log and this can be presented to Board once achieved.

Action: Carol Harris

NM also noted OOA beds being a stubborn issue and despite improved performance it is still below trajectory, are we going to achieve this target? Are we looking at other mental health trusts to learn?

CH reported we are working with the Humber Teaching NHS Foundation Trust as our critical friend. One SWYPFT general manager is working on OOA beds two days a week. Information is being shared with both West Yorkshire and South Yorkshire systems on a regular basis, looking at ways to improve. There is increased focus from the clinical leads, we are looking at community pathways to make sure people are getting the right care at the right time. Colleagues in other Trusts are having more challenges than us but we continue to learn from each other. CH reminded Board members it was only recently that other trusts were learning from us about how we had reduced the number of out of area bed placements.

KQ noted on page 27 of the IPR the reporting of incidents and high levels of reporting. KQ noted previously 97% of incidents resulted in low or no harm, this is now around 95%, is this moving, is the severity changing. We need to monitor the trend.

DT reported the figure in last year's annual report was 97%, today's quarterly incident management report shows 96%, but the annual report is an average figure over the year. The quality team monitor this. Some incidents will also be regraded following review. All red and amber incidents are reviewed in the weekly clinical risk panel to explore opportunities for learning and ascertain the investigation level required.

People
MH highlighted the following points:

- On 20 July 2023, 27 appointments were cancelled as result of industrial action which included 14 individual inpatient reviews. There was also reported disruption to services in the Unity centre (Wakefield) and ward 18 (Dewsbury)
- On 21 July, 28 appointments were cancelled (includes 20 individual inpatient reviews)

- 1 older adult community patient had to be referred to community mental health team as they couldn't wait for an appointment after their clinical appointment was cancelled.
- The proportion of staff in senior leadership roles who are from BAME background and females, is now included in the IPR. Other protected characteristics will be included as data becomes available. Of the 1064 band 7 and above staff (including consultants, excluding bank staff) 126 (11.8%) are from BAME population. The number of women in these roles is 769 (72.3%).
- The Trust had 14 violence and aggression incidents against staff on mental health wards involving race during August, any increases are monitored by the patient safety team, and equity guardians are alerted to all race related incidents against staff.
- Our substantive staff in post position continues to remain stable and has increased slightly in August. The number of people joining the Trust outnumbered leavers in August. Year to date, we have had 281.9 new starters and 251.7 leavers.. Focus remains on recruitment and retention.
- Overall turnover rate in August was 13.1% and has been relatively static for the last three months and improved on the 22/23 position.
- Sickness absence in August was 4.7% and below local threshold, with a rolling 12-month position of 5.3%.
- Rolling appraisal compliance rate for August saw a deterioration, from 76.5% to 74.5%. An improvement trajectory of 78% was set by the Executive management team (EMT) in May, this will be reviewed at the end of September 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 92.5% compliance, which exceeds the Trust target of 80%, this has increased marginally from last month 92.1%. Cardiopulmonary resuscitation is the only area in month below the Trust target (79.9%). 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 reducing restrictive practice interventions (RRPI) training saw an increase in August to 82.6% from 76.2% reported at the end of July and is now above the 80% threshold.

EM noted the appraisal compliance rate and queried if it is a recording issue or are we behind with appraisals?

MH reported assurance is not in place that any paper-based appraisals are being recorded on the system.. The second issue is the system itself. We are looking at manual interventions in the interim. There is also a need to focus on the quality of appraisals.

NM noted the improvement in RRPI training is good to see, the sickness benchmarking is also good. NM questioned if this is sustainable, and queried if the staff sickness rate is decreasing, what are the quality outcomes of this change, and how do we reflect this in the IPR?

MBu noted NM's comments and reported the data in the IPR is good but the interpretation and analysis of the content needs to be improved and MBu has spoken to AS about this as executive lead on the IPR.

MBr noted that typically sickness is lower in the summer, and there may well be an increase in the next few weeks given the recent increase in the prevalence of Covid-19.

MR suggested the People and Remuneration Committee (PRC) had received different information about appraisals and that the challenge is around people dropping off the system.

MBr reported that more intelligence has been received since the report to PRC and greater clarity has been established about what the issues are.

KQ noted RRPI, and cardiopulmonary resuscitation (CPR) mandatory training metrics and reported when you drill down into the care groups some of them don't use these interventions, and are they having an impact on overall Trust compliance rates?

CH reported the Trust prioritises the training places for new staff on the bank and staff that are working on our wards. Training does vary dependent on role. CAMHS for example, won't do the same RRPI training as other services.

KQ noted Barnsley general community services have 33% compliance against RRPI training, but this won't be required in stroke and neurological rehabilitation services, and the narrative needs to be adjusted to reflect this.

ACTION: Adrian Snarr

Care groups
CH highlighted the following points:
CAMHS
- There has been a dip in appraisal performance this month, the team have assured CH this is a dip in month, and not a trend.
- Eating disorders – 66.7% looks like we are not providing NICE concordant treatment for children that are in crisis. The detail shows this refers to one child out of three that hadn't had their appointment within a week, due to the need to re-arrange the appointment.
- There has been continued progress in reducing the wait for core CAMHS. Wakefield continues to present a hotspot, and the reason behind this is understood with actions in place across the system to address this.
- A neurodiversity summit has been arranged by Rob Webster from the WY ICS to look at access to neurodiversity services across the West Yorkshire system. Pressure in Kirklees remains, and the average wait time is around 12 months, even with the additional capacity we have in place.

Adult and older people's services
- Performance needs to be improved in relation to assessment within 14 days. There is work taking place to address hot spots. We are expecting a return to full performance by the end of quarter 3.
- Patients clinically ready for discharge on our wards has increased, our community teams are working hard to address this. This is a system wide issue.

Inpatient services
- Occupancy levels appear more positive than they are in reality, in acute services. Currently we measure occupancy levels across all of our bed-based services, including rehabilitation services. CH has requested that in the future only adult and older people services are included in this data set. Previous data will be adjusted so the data comparisons are like for like.
- We are seeing a slight increase in people whose discharge pathway is complicated by the additional requirement from the Ministry of Justice pathway.

- OOA has reduced.

Barnsley general community services
- For the two inpatient wards have for stroke rehabilitation and neurological rehabilitation, we are looking at the level of physical intervention training that the staff on these two wards require.

Learning disability (LD), autism spectrum disorder (ASD), attention deficit and hyperactivity disorder (ADHD)

- Clinically ready for discharge numbers are very high and this is a small number of people that impact on the percentage presented in the report. The percentage relates to four out of six people present on the Horizon Centre who will experience a delay in their discharge from hospital, which impacts on their life, as reflected in this morning's board story.
- We are really disappointed about the 18-week target taking a downturn. Performance has been impacted by an increase in demand in people transitioning from children's services into adult services, needing an assessment diagnosis for a learning disability.

Forensics
- There has been an appraisal rate dip due to staff availability in the summer.
- Sickness has improved but is still too high.
- Ready for discharge is showing green. There have been technicalities with discharges through the Ministry of Justice route which will affect future performance, and we are looking into this.
- Commissioners are concerned about occupancy in medium secure services. This is being discussed through the provider collaborative, because while we have people in out of area bed placements, we have 80% occupancy and so we are looking at who we can take back sooner. We are looking at our pathway so that we can be more flexible with our bed use.

EM requested the need for some more focus on single point of access (SPA) numbers and the current situation.

CH reported improving access is one of our priority programmes, one priority programme is our community mental health improvement programme. These two programmes will have an impact on single point of access processes.

MBu asked for CH to provide EM with a more detailed update in relation to SPA outside of the meeting and CH agreed to take a deeper dive to FIP.
ACTION: Adrian Snarr /Carol Harris

Finance
AS highlighted the following points:
- Revenue position is showing a surplus, we are slightly behind plan cumulatively.This current position and forecast includes the cost pressures associated with the pay awards for agenda for change and medics. The pressure from the pay award is recurrent and some of the mitigation for this year is non recurrent so it represents an increased challenge for future years.
-
- WY adult secure provider collaborative is in a surplus position, due to not using as many out of area placements as historically, but we shouldn't rely on this to offset the underlying Trust position.

- There is a high degree of confidence that we can achieve our break-even position for this year.
- Agency spend has reduced, but this has only taken us back to where we used to be. This is being tracked very closely through the agency scrutiny group.
- The financial sustainability plan is on track, but there are some potential challenges ahead towards the end of the financial year.
- The Trust cash position remains strong.
- Capital is showing as red this month, information management and technology projects are slightly behind, as are estates projects given supply chain issues and so options are being reviewed.
- Better payment practice code, the Trust have received positive feedback from NHS England – we are among the best in the country.

MBr highlighted that the Trust is having to absorb a £3.5m cost a year, due to the pay increase.

MBu concluded by summarising the data in the IPR is there, but analysis and interpretation could be better.

AS agreed, and reminded the Board to note the Trust turns this report around very quickly, August data is presented into September's meeting.

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

TB/23/87   Risk and Assurance (agenda item 10)
TB/22/87a Serious Incidents Quarterly report   (agenda item 10.1)
DT introduced the item and highlighted the following points:
- The Trust continues to have a robust incident management process.
- The report includes all incidents, serious incidents, and learning from healthcare deaths
- There is a new section in the report, learning from incidents, which used to be reported annually and will now be presented quarterly.
- The team have processed 3,733 incidents, 96% of which with low or no harm.
- There has been an increase in pressure ulcers in quarter one, and there is a deep dive paper going to quality and safety committee next month.
- There have been four serious incidents, no never events, and "physical aggression/threat no contact made" continues to be the highest reported incident.

MBu noted this is a good report as always, learning from deaths as a quarterly update is a positive improvement.

It was RESOLVED to RECEIVE the quarterly report on incident management.

TB/23/87b   Medical appraisal / revalidation annual report (agenda item 10.2)
Dr. Subha Thiyagesh (ST) presented the item and highlighted the following points:
- 150 doctors had a prescribed connection with the Trust as of 31st March 2023.
  - 98% of the doctors that were due to have their appraisal have successfully completed the appraisal process during 2022/23, which is a further increase on last year.
  - 11% of the doctors had late meetings or late submissions. One of these late submissions was not approved. The rest were approved by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate.
- 19 revalidation recommendations were made between 1st April 2022 and 31st March 2023.

- All 19 doctors had positive recommendations made.
- All of these recommendations led to revalidation of the doctors by the General Medical Council (GMC).
- There are no long-standing post-Covid-19 implications to the medical appraisal and revalidation process.
- We have had external review this year from Leeds and York Partnership Trust with very positive outcomes.
- The General Medical Council (GMC) requires five yearly feedback, we are doing this on a three yearly basis.

NM queried the risk around the voluntary status of appraisers if it allocated with their job plan.

ST agreed to share the detail with NM outside of the meeting.

Action: Prof.Subha Thiyagesh

MF asked for the numbers to be checked as to how many appraisals have been completed as there is differentiation in different parts of the report. ST agreed to share detail, and agreed the narrative of the report needs to be improved to reflect this.

Action: Prof.Subha Thiyagesh

It was RESOLVED to RECEIVE the report noting that it will be shared with NHSE, and the Board recognised that the resource implications of medical revalidation are likely to continue to increase year on year. It was RESOLVED to APPROVE the NHSE Designated Body Annual Board Report Statement of Compliance, attached as Annex D of this report, confirming that the Trust, as a Designated Body, is in compliance with the regulations.

TB/23/87c   Response to Lucy Letby trial and verdict (agenda item 10.3)

DT introduced the item, asking to take the paper as read, and highlighted the following points:
- Following the verdict, the Trust received a letter from NHS England describing their commitment to prevent something like this ever happening again.
- The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner, and improving data quality, making it easier to spot potential problems.
- This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS.
- The letter also reminds NHS leaders of the importance of listening to the concerns of patients, families and staff, following whistleblowing procedures, ande good governance.
- All staff should have easy access to information on how to speak up.
- Relevant departments and teams, such as Human Resources, and Freedom to Speak Up (FTSU) Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so.
- Boards should seek assurance that staff can speak up with confidence and whistleblowers are treated well.
- Boards are regularly reporting, reviewing and acting upon available data.
- The letter also reflected the strengthened Fit and Proper Person Framework which will bring in additional background checks, including a board member reference template.

MBr reported the purpose of paper is for the Board to have a discussion as to whether our speaking up processes are effective and appropriate. This paper provides an excellent summary of what we do as a Trust. We need to look at assurance compared to reassurance. It is FTSU month in October, and we are generating a staff communications campaign. It is important that we maintain a level of focus on people feeling confident to speak up.

EM noted there will be more information to follow from this verdict and the learning to be taken. As a Board do we need to look at our FTSU themes and what information we get.

MF reported as NED lead for FTSU most reports are about line management issues and internally focused issues, he had not seen any reports of harm to service users. When the annual report for FTSU was presented earlier in the year the Board asked for more thematic reviews of the information. MF queried whether analysis of serious incidents may be more insightful than FTSU.

MBr reminded the Board that FTSU is only one avenue to receive this type of information. There are many other ways in which staff are able to raise concerns and speak up.

MF reported that the relatively low numbers of issues raised through FTSU could be taken as positive as issues have been resolved through other means, such as line management, before they have reached this stage.

MBu noted the Board's focus on the integrated performance report and the detailed information included in relation to care groups should allow the Board to identify areas of concern.

EM agreed that FTSU does work well, and from quality monitoring visits it is clear that line management processes work well in the Trust. This could be strengthened by there being some focus for Board on where issues may arise.

MR noted the issues reported in the Lucy Letby case weren't about people speaking up, it was about the response they received when they had spoken up.

CH reported the executive trio review all incidents where concerns around the quality of care have been raised and review different sources of information and act upon them. Any of our staff are able to report an incident or concern through the Datix incident management system and managers receive these to review and act upon them.

KQ agreed the triangulation of the information at care group level from patients and carers through complaints and feedback, beyond the friends and family test feedback is limited. In the Lucy Letby case families were reporting issues as well as staff and were not being listened to. This is something that could be included in the IPR to help Board monitor issues at this level.

Action: Adrian Snarr

It was RESOLVED to RECEIVE the Trust response to the Lucy Letby trial verdict.

TB/23/87d   Consideration of CAMHS report for Tees, Esk and Wear Valley NHS Foundation Trust and associated learning (agenda item 10.4)
DT introduced the item and highlighted the following points:
- This was an external investigation into TEWV CAMHS inpatient unit.
- The paper is here to show EMT and services have reviewed this report, along with other national incident reports to make sure any learning is taken, and to ensure Trust practices are aligned to any recommendations.
- QSC have reviewed the full report in more detail.

- The QSC triple A report will feedback assurance to the Trust compliance with the recommendations of the report.

It was RESOLVED to RECEIVE the CAMHS report for Tees, Esk and Wear Valley NHS Foundation Trust.

TB/23/87e   Patient Experience Annual report (agenda item 10.5)
DT introduced the item and highlighted the following points:
- The report has recommended for approval to the Board by QSC
- The report highlights feedback from service users, carers, and staff, and this information is collected in a number of ways through our customer services team, MPs on behalf of constituents, and the family and friend's test.
- FTSU reports are dealt with through a separate annual report.
- More triangulation has been included in this year's report as previously requested
- The Trust received 758 items of feedback during 2022/23, which is a 2.5% decrease on the year before. Of these 86 were formal complaints, compared with 119 the year before.
- Performance in response to "closure of a complaint within 6 months of receipt" has deteriorated over 2022/23, with a range of factors impacting on this situation. An improvement approach is being utilised to address identified issues and this is detailed in the report.
- A backlog of complaints awaiting allocation to a complaints case handler has reduced from a peak of 61 in autumn 2022, to 40 at the end of 2022/23, with further and sustained reduction to 12 at the current time.

NM reported the improvement work in complaints is being monitored by QSC, and we need to see the trend continue to be fully assured. The report is an improvement from last year and we can now build on this improvement. The report needs qualitative data as well as quantitative data to confirm we are listening to carers, service users and families.
Action: Darryl Thompson

MF queried if benchmarking data is available to compare us to other trusts for complaints by service line?

It was confirmed that there are national indicators on complaints turnaround times, but not complaints by service line, but this something that should be investigated to see if it is possible.

MBr reported the emphasis needs to be on getting our own process right, and once we get into that position, we can start to do comparisons.

It was resolved to RECEIVE and APPROVE the annual report on Patient Experience (including complaints) and to NOTE the next steps identified.

TB/23/87f Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 10.6)

Collaborative Committee 8 August 2023
MF highlighted the following:
- Work is ongoing to review provider collaboratives against their original objectives.

Mental Health Act Committee 15 August 2023
KQ highlighted the following:

- The committee received an inequalities report and there is a need to link in with Equality, Inclusion and Involvement Committee (EIIC) on the findings of this report.

Action: Prof.Subha Thiyagesh/Dawn Lawson

Members' Council 16 August 2023
- MBu asked to take the report as read.

People and Remuneration Committee 16 August 2023
MR highlighted the following:
- The People directorate are under pressure given the number of recruitment applications and staffing levels

Quality and Safety Committee 12 September 2023
Kate Quail (KQ) reported the following:
- Patient experience annual report was recommended to Trust Board for approval.
- Medical appraisal and revalidation report was recommended to Trust Board for approval.
- The quarterly incident management report was recommended to Trust Board for approval.

Equality, Inclusion and Involvement Committee 13 September 2023
MBu highlighted the following:
- NM noted the WRES and WDES and how they triangulate with other reports and whether this is being dealt with by more than one committee.

Finance, Investment & Performance Committee 18 September 2023
DW highlighted the following from the September meeting:
- Future plans are required for future years' finances.
- Learning disability roles are a challenge to recruit into.
- OOA beds – the committee received detailed presentations and will come back to committee again in a couple of months as part of the monitoring process

WYMHLDA Collaborative Committees in Common 26 July 2023
MBu asked to take the report as read.

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

TB/23/88   Integrated Care Systems and Partnerships (agenda item 11)
TB/23/88a   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 items were discussed:
- Review of the Lucy Letby outcome and response
- Winter planning and readiness
- Industrial action
- Preparing operating models for the 30% cost reduction
- The mental health learning disability and autism (MHLDA) provider collaborative have recognised there will be updated national mental health strategy. They are also looking at how commissioning will work in the future and what the collaborative's role will be in commissioning.

MBr reported the following updates for Barnsley:
- Barnsley provided a focus on creativity during wellbeing week
- There was a proposal regarding two GP branch closures, which have been closed for a period of time during the pandemic.

It was RESOLVED to NOTE the SYB ICS update.

<u>TB/23/88b   West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnership update (agenda item 11.2)</u>

SR asked for the paper to be taken as read, highlighting the following points:
- There were similar key themes presented to those in South Yorkshire
- SR drew the Board's attention to the paper presented to the West Yorkshire integrated care board, with a focus on MHLDA, and in those papers is an overview paper by Sara Munro which provides an overview of the West Yorkshire priorities and shows as a collaborative where the areas of focus are.
- Despite financial challenges and service challenges a good level of focus remains on health inequalities.

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.

<u>TB/23/88c   Provider Collaboratives and Alliances (agenda item 11.3)</u>

AS presented the item and asked to take the report as read:
- Leeds and York partnership have been confirmed as the lead provider for the perinatal mental health collaborative.
- Outside of the specialist provider collaboratives, SWYPFT are to become the lead provider for maternal health, and there are plans for this to go live in 2024/25.

It was RESOLVED to RECEIVE and NOTE the Specialised NHS-Led Provider Collaboratives Update.

TB/23/89   Governance (agenda item 12)
<u>TB/23/89a   NHSE fit and proper persons (FPPT) framework (agenda item 12.1)</u>

AS presented the item and highlighted the following points:
- The paper presents the updated requirements of new FPPT requirements.
- The corporate governance team and people team are working through the changes.
- The rest of the paper summaries the FPPT changes.

It was RESOLVED to RECEIVE the revised Fit and Proper Persons Test (FPPT) revised standards.

<u>TB/23/89b   Trust Seal (agenda item 12.5)</u>

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

TB/23/90   Strategies and Policies (agenda item 13)
<u>TB/23/90   Customer Services Policy (agenda item 13.1)</u>

DT introduced the item and highlighted the following points:
- The policy has been recommended for approval by EMT.
- Customer services is the single gateway for people to raise issues about the Trust and its services.
- It sets out a framework for the management of complaints and feedback received into the Trust in line with obligations of the NHS constitution and the health and social care act.

- It has been updated to show clear expected time frames for responses, it has been informed by the improvement work that has been taking place in the customer services department.

MBu queried if the metrics in the equality impact assessment (EIA) need to appear in IPR as equality metrics. CH agreed but would need to look at how this would work practically.

MBr suggested we should assess what we have in the IPR already and look to identify any gaps.

Action: Carol Harris/Adrian Snarr

It was RESOLVED to APPROVE the updates to the policy.

TB/23/91   Trust Board work programme 2023/24 (agenda item 14)

It was RESOLVED to NOTE the work programme.

TB/23/92   Any other business (agenda item 15)

NM noted there is a lot of reference in the Board papers to improvement work taking place in various areas across the Trust and questioned if this coordinated in any way. NM queried how the Board knows that improvement is taking place in the right areas?

MBr reported EMT receive monthly updates on the Trust's priority programmes, so does this need to come to FIP or Board? EMT has regular oversight of this. It may be harder to capture local improvement work that happens every day as a result of teams discussing things, learning and improving their processes. This is happening all the time and we need to look at how we gather this. This will form part of DL's portfolio and priorities.

MF added there are updates in the IPR on priority programmes, but they don't have any rating as to their progress, is this something we could do?

ACTION: Adrian Snarr / Dawn Lawson

RL noted it would be useful to have something visual to see how it all fits together.

ST reported we have the quality improvement and assurance team who could provide information on local level changes along with the change management team and see how we capture that.

DT reported the annual quality account includes improvement work against the Trust's quality priorities, which DT accepted is retrospective.

MR noted "patient knows best" is an area of improvement that was noted in the Chief Executive report.

TB/23/93   Date of next meeting (agenda item 16)

The next public Trust Board meeting will be held on 31 October 2023

Signature: Date:

TRUST BOARD 26 September 2023 – ACTION POINTS ARISING FROM THE MEETING

☐ = completed actions

Actions from 26 September 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/81	Darryl Thompson (DT) noted some points of detail in relation to the Audit committee and a recent risk assessment audit, namely the "safety pod" reference on page 9/10 and advised he would send some revised wording to Andy Lister (AL) to update. Mandy Rayner (MR) noted on page 8 the word "bespoke" needed to be replaced with "extraordinary" in relation to the people and remuneration committee (PRC) meeting	Andy Lister	October 2023	Minutes updated prior to publication on Trust Website
TB/23/82	**TB/23/40c** – Nat McMillan asked that the two actions be updated to reflect that updates have been scheduled for November due to the scheduling of the next safer staffing report on the Board workplan.	Andy Lister	October 2023	Action log updated as requested
TB/23/85	Nat McMillan (NM) noted the national suicide prevention strategy referenced in the CEO paper, and asked for Naomi Sutcliffe to the present this to QSC, following her presentation of the regional strategy in July.	Darryl Thompson	November 2023	
TB/23/86a	Non-Executive Directors to receive the IPR demonstration shared with FIP members in September 2023.	Adrian Snarr	October 2023	The corporate governance team are making arrangements for a demonstration to take place after strategic board on 19 December.
TB/23/86a	CH to update if achievement of 99% compliance in relation to paediatric audiology was achieved in October 2023 to provide assurance to the Board.	Carol Harris	November 2023	

With **all of us** in mind.

TB/23/86a	KQ noted Barnsley general community services have 33% compliance against RRPI training, but this training won't be required in stroke and neurological rehabilitation services, and the narrative in the IPR needs to be adjusted to reflect this.	Adrian Snarr	October 2023	Care group level analysis to be picked up in enhanced dashboards section of the IPR.
TB/23/86a	EM requested the need for some more focus on single point of access (SPA) numbers and the current situation. MBu asked for CH to provide EM with a more detailed update in relation to SPA outside of the meeting and CH agreed to take a deeper dive to FIP.	Carol Harris/Adrian Snarr	November 2023	
TB/23/87b	Medical appraisal and revalidation item - NM queried the risk around the voluntary status of appraisers if it allocated with their job plan. ST agreed to share the detail with NM outside of the meeting. MF asked for the numbers to be checked as to how many appraisals have been completed as there is differentiation in different parts of the report. ST agreed to share detail, and agreed the narrative of the report needs to be improved.	Prof.Subha Thiyagesh	October 2023	Clarification shared with NM and will be taken into account for the next board report. The numbers have been checked and remain accurate. Differences are due to numbers connected to the trust and their appraisal periods that fall outside of the connection period. The narrative will be further enhanced to be clearer in future.
TB/23/87c	KQ agreed the triangulation of the information at care group level from patients and carers complaints and feedback, beyond the friends and family test feedback is limited. In the Lucy Letby case families were reporting things as well as staff and were not being listened to. This is something that could be included in the IPR to help Board monitor issues at this level.	Adrian Snarr	November 2023	

Min reference	Action	Lead	Timescale	Progress
TB/23/87e	NM reported the improvement work in complaints is being monitored by QSC, and we need to see the trend continue to be fully assured. The report is an improvement from last year and we can now build on this improvement. The report needs qualitative data as well as quantitative data to confirm we are listening to carers, service users and families.	Darryl Thompson	November 2023	
TB/23/87f	The MHA committee received an inequalities report on 15 August 2023 and there is a need to link in with EIIC on the findings of this report.	Prof.Subha Thiyagesh/Dawn Lawson	October 2023	The MHAC inequalities report has been shared with the lead director of EIIC to consider next steps.
TB/23/90	MBu queried if the metrics in the equality impact assessment (EIA) for the Customer Services Policy need to appear in IPR as equality metrics. CH agreed but would need to look at how this would work practically. MBr suggested we should assess what we have in the IPR already and look to identify any gaps.	Carol Harris/Adrian Snarr	November 2023	
TB/23/92	MF noted there are updates in the IPR on priority programmes, but they don't have any rating as to their progress, is this something we could do?	Adrian Snarr/Dawn Lawson	November 2023	

Actions from 25 July 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/70a	BAF 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" grading to be considered in conjunction with the full year financial plan	Adrian Snarr	October 2023	This has been considered in the review of the BAF presented to the October Board meeting.

TB/23/70b	EMT to objectively review ORR and BAF to make sure changes are reflected in both documents.	EMT	October 2023	This has been included in EMT discussion relating to the BAF and ORR
TB/23/71a	MBr suggested racial abuse incidents on wards should be an area of focus for equality, inclusion and involvement committee.	Sue Barton/Dawn Lawson	October 2023	Report on racial abuse on wards added to the agenda for the next Equality, Inclusion and involvement committee

Actions from 25 April 2023

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 (next scheduled Board meeting)	
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 (next scheduled Board meeting)	

Trust Board 31 October 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 most recent instance of industrial action in early October involved junior doctors and consultants at the same time.** In line with previous instances of industrial action, plans were put in place to ensure the provision of safe care and thanks are once again offered to our staff who have supported this by planning and providing cover. Trust Board members are reminded of the significant effort and commitment required to cover these days and the impact it has on other activity.

The focus of this Board meeting is on business and risk. Our Board Assurance Framework and Organisational Risk Register provide a good summary of the key strategic and organisational risks the Trust is facing and managing. By nature of the services provided there is substantial risk in the NHS and our own organisation which is a regular area of focus to ensure our controls and mitigations are as strong as possible. We are recommending some changes to risk scores this month, given the operating environment in which we are working.

There is also a paper on the work that has taken place in preparation for the launch of the new national patient safety health response framework (PSIRF) which will go live on December 1st. PSIRF represents NHS England's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety and further information is provided in the detailed paper.

October has seen the start of our annual flu vaccination campaign. We are providing the flu vaccination clinics ourselves and have thirty-five vaccinators registered with many clinics scheduled across our geography. Board members |

are actively supporting the campaign with pictures of them receiving their vaccination along with a quote appearing on social media. At the time of writing this report over 1,100 staff have been recorded as receiving their flu vaccine. Whilst we are not providing the autumn covid booster ourselves, front-line NHS staff and a number of others are entitled to receive it, so we are promoting it and sign-posting staff to how they can access it.

We have seen an increase in the number of outbreaks of Covid in recent weeks, including inpatient wards and other settings. There was one instance where thirty staff tested positive and a further thirteen colleagues were symptomatic. This illustrates the transmissibility of the current variant and serves as a stark reminder that we need to remain vigilant and follow good hygiene guidance. Offer and provision of the vaccine for our service users in inpatient settings will be a returning area of focus during the autumn and winter months as we seek to protect those who are most vulnerable.

The annual NHS staff survey has been launched recently. We are again actively promoting its completion and including examples of how we have used the survey results to bring about improvement within that promotion. At the time of writing this report just over 30% of staff have completed the survey. We fully recognise the benefits of feedback which can help us to continually improve our offer to our staff.

Operationally, whilst challenges continue, **it is pleasing to note a significant reduction in the number of people placed out of area**. Whilst it is too early for this reduction to be considered a sustainable pattern, it reflects greatly on the ongoing commitment and work of our colleagues to improve care and meet needs locally.

The Care Quality Commission has very recently published its annual state of health care and adult social care in England report for 2022/23. It notes the increased impact of staffing challenges, the cost of living crisis, and industrial action on care. Access to services and inequalities are identified as being a major challenge. From a mental health perspective 'recruitment and retention of staff remains one of the biggest challenges for the mental health sector, with the use of bank and agency staff remaining high and almost 1 in 5 mental health nursing posts vacant'. Furthermore, 'access to and quality of mental health care also remain key areas of concern with gaps in community care continuing to put pressure on mental health inpatient services struggling to provide beds.' These are issues we are very familiar with, and Trust Board is regularly informed on these issues and the work we are doing to recruit and retain staff, transform our community services, and improve mental health inpatient care.

The Trust has engaged with and promoted several awareness events during October. These have included national mental health day, freedom to speak up month, infection prevention week, and Black history month. A range of activities have included awareness via social media, staff wearing green on a Wednesday to promote speaking up, and themed food in our canteens. There are two national initiatives providing a focus for world mental health day.

The Solving Together Platform is hosting a month-long online conversation on children and young people's mental health seeking views and ideas on how waiting times can be improved and services made more accessible. The

Better Health – Every Mind Matters campaign provides NHS endorsed resources, tips, and advice for everyone to help those who are struggling with their mental wellbeing.

The Race Equality and Cultural Heritage (REaCH) network annual celebration event is taking place on October 27th. We very much want all our staff networks to thrive and recognise the important contribution they make. Our People directorate is working with the staff networks to identify how we can support them further.

Subject to parliamentary scrutiny and agreement, the Department of Health and Social Care intends for the Provider Selection Regime (PSR) to come into force on 1 January 2024. The aim of the PSR is to move away from competitive re-tendering as the default procurement process in support of a more flexible and collaborative approach to delivering services. An intent of this new regime is to make it more straightforward to continue with existing service provision where arrangements are already working well. It has been expected following on from the Health & Care Act 2022 and will introduce three provider selection processes that relevant authorities can follow to award contracts for health care services. These are the:

- Direct award processes (A, B, and C) - these involve awarding contracts to providers when there is limited or no reason to seek to change from the existing provider; or to assess providers against one another, because:
    - the existing provider is the only provider that can deliver the health care services (direct award process A)
    - patients have a choice of providers, and the number of providers is not restricted by the relevant authority (direct award process B)
    - the existing provider is satisfying its existing contract, will likely satisfy the new contract to a sufficient standard, and the proposed contracting arrangements are not changing considerably (direct award process C).

- Most suitable provider process - this involves awarding a contract to providers without running a competitive process, because the relevant authority can identify the most suitable provider.

- Competitive process - this involves running a competitive process to award a contract.

NHS England's new National Improvement Board has circulated a letter setting out their plans following their inaugural meeting. A universal self-assessment regarding how trusts approach improvement is now available for completion. When NHS Impact was first launched, we conducted an initial assessment on our own improvement approach and are completing this new self-assessment. **Our continued focus on and commitment to improvement remains and we will use any further opportunities identified within the self-assessment to enhance our own improvement programme.** When I visit services and teams, I am very frequently impressed by the local innovations and improvements that are being made as a matter of course and we need to ensure we continue provide our teams with the tools and freedom to keep doing this.

To help improve the lives and outcomes of people with a learning disability and autistic people, the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) in collaboration with NHS England, **have developed a set of guiding principles and an easy read version for integrated care systems and their local colleagues.** These principles cover a range of areas such as commissioning services, education, employment, and housing - setting out how partners in local systems should seek to work together. We very much welcome this as we strive to improve lives for people with a learning disability and reduce inequalities. At a recent Trust leadership meeting involving over 70 Trust leaders, Dr Sarah Talari and Fareena Rasaq invited all Trust leaders to consider how they can improve lives of people with a learning disability within their own services and roles.

Regarding inequality, new data published by the Office for Health Improvement and Disparities **shows that the premature mortality rate was five times higher for people living with severe mental illness during the Covid pandemic.** This report highlights the continued inequality experienced by people with living severe mental illness and reinforces the need for us to remain focused on improving the lives of the people we care for. Collaborating with partners on the provision of annual health checks for people with a learning disability and severe mental illness remains a priority.

With a general election anticipated in 2024 it is interesting to note what intentions each party has to health policy and what this might mean for the services we provide. The Labour party manifesto includes a commitment to open-access mental health hubs for children and young people, mental health support in every secondary school, and increased recruitment to reduce wait times. The prime minister has recently laid out a plan to effectively ban smoking by raising the legal age for smoking one year every year until it applies to the entire population.

Our annual members' meeting held in September was a great success. Over ninety governors, staff, partners, and members of the public attended to visit our market stalls, meet some of our staff and listen to our summary of what took place in 2022/23 and our ambitions for the future. Thanks are recorded, particularly to those involved in the organisation of the event, and everyone who attended and was involved.

On behalf of the Board, I would like to personally thank Sue Barton for her contribution during her period of acting up as the Director of Strategy & Change. Sue has provided great support in a very professional manner and ensured a smooth transition to Dawn Lawson starting in earnest with us.

I would like to recognise and congratulate David Yockney. David, who works in our Barnsley services, has been awarded the prestigious title of Queen's Nurse, which is available to nurses who have demonstrated a high level of commitment to patient care and nursing practice.

	At Trust Board we frequently recognise the challenges in our CAMHS services given the level of demand we are experiencing. One parent was nervous about what level of service her daughter would receive. The following feedback was recently received **'I genuinely feel that the interventions from your team and supporting organisations will continue to ensure she stays mentally well throughout the coming adolescent years as the tools she has learned will stay with her for the future. As a mum I will always be grateful for the service she has received.'**
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**

The Brief

28 September 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

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

For Fall Prevention Week we attended the falls awareness day at Barnsley market on 22 September – along with other local organisations we were on hand helping our local communities find out how they can avoid slips and trips this winter.

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With **all of us** in mind.

Our priorities for 2023-24

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Golden threads	Strategic objective	Priority
Recovery focused and trauma informed	**IMPROVING HEALTH**	Address inequalities involvement and equality in each of our places with our partners
Social responsibility and sustainability	**IMPROVING CARE**	Transform our older people inpatient services
		Improve our mental health services so they are more responsive, inclusive and timely
Equality, involvement and addressing inequalities		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: Stoptober is back to encourage and support smokers to quit for good. The theme for this year is 'when you stop smoking, good things start to happen'. The campaign will signpost to a range of proven tools that can help.

Improving care: "Dementia is Britain's biggest killer – there's a need to make it a priority in health and social care" says Dr Moe Kapoor.
Read our consultant in old age psychiatry's blog for World Alzheimer's Month on our website.

Improving health: We have been confirmed as the co-ordinating provider for West Yorkshire Maternal Mental Health Services. The plan is for this to go live in April 2024.

The national, regional and local context

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.

People from all walks of life and all parts of West Yorkshire are invited to join the group that's working to improve health and care services across the area. West Yorkshire Voice is a network that brings together individuals, groups, local panels, networks, and organisations to ensure the voice of people is at the heart of health and care decision-making in West Yorkshire.

Creative Minds, together with Artworks, the everybody school of art, have recruited 28 **creative practitioners** to work across our Trust inpatient wards, helping to support people through their recovery journey and improve wellbeing - read more on our website.

Watch this short film which has been produced as part of the Kirklees Health and Care Partnership and Men's Talk Digital showcasing men's mental health groups in Kirklees.

Our older people's mental health transformation is progressing well, with governance approval going smoothly and an expectation formal consultation to start this side of Christmas. More information will come in the next edition of the Brief.

A successful behavioural science project has launched at the Recovery and Wellbeing College in Barnsley. The team are implementing behavioural science to increase awareness and active attendance at the Recovery and Wellbeing College Barnsley. System leaders from across Barnsley attended the event. You can find more information on the intranet.

A group of young people, supported by our children's speech and language therapy team in Barnsley, have collaborated with one of the UK's leading stammering charities to raise awareness and acceptance of stammering in schools- Action for Stammering Children (ASC). They produced five new posters designed by the young people who stammer, with the aim of educating from the perspective of a young person.

Improving Health
Our performance in August

- **51.4%** of people completing Talking Therapies treatment and moving into recovery
- **99.8%** of Talking Therapies referrals beginning treatment within 18 weeks. **98.3%** within 6 weeks.
- **89.8%** of MH service users followed up within 72 hours of discharge from inpatient care
- **88%** of people with a risk assessment/staying safe plan in place within 24 hours of admission (for inpatients)
- **94.7%** of people with a risk assessment/staying safe plan in place within 7 days of first contact (for community)
- **81.8%** of people died in a place of their choosing
- **81%** in CAMHS services waiting less than 18 weeks for treatment

Our Trust marked **world suicide prevention day** on 10 September by reminding people that creating hope through action applies to us all. We shared what action we could all take to help prevent suicide, whether you have 5 minutes, 20 minutes or want to commit more time. Some of our teams also shared what actions they are taking to prevent suicide and why it is important to them.

Dr Moe Kapoor also wrote a blog on 'how to prevent suicide in a community that won't even talk about it?' which looks at stigma around suicide and mental health in the British South Asian community.

The **Oliver McGowan mandatory training on learning disability and autism** aims to save lives by ensuring the health and social care workforce have the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability. The Trust is taking a phased approach to rolling out the training, which is mandatory for all staff. The training is available via ESR.

To date 183 staff have accessed the training. Part two of the training is currently being developed and further updates will be provided in October. In the first year the target is for 60% of the workforce to complete the training.

Improving Care
Our performance in August

NHS South West Yorkshire Partnership NHS Foundation Trust
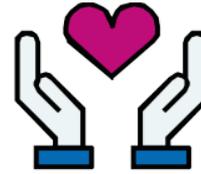
- **397** inappropriate out of area bed days
- **2** young people under 18 admitted onto adult inpatient wards
- **65.7%** waiting for referral to assessment within 2 weeks
- **5.7%** of service users clinically ready to discharge
- **87.4%** of service users on CPA offered a copy of their care plan
- **96.7%** of our service users have their ethnicity equality data recorded, **45.5%** their disability status, **44.8%** 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; **90%** in our mental health services, 100% CAMHS, **91%** for learning disability services, **75%** for ADHD and **100%** for forensic services.

Soon service users and inpatients will no longer be able to smoke in our hospitals, buildings or grounds. This includes our gardens and designated smoking areas. Service users and inpatients will need to go outside our grounds if they wish to smoke. You can read more about our smokefree environments for service users and inpatients on the intranet.

We are progressing on our **Triangle of Care** journey which means creating collaboration and partnership with carers in the service user and carer journey through our services. MS Teams drop in sessions are now available for staff to find out more about the Triangle of Care, what it means for them and our Trust, the self-assessment process and the support available to teams. Find out more on the intranet.

Personalised care planning – moving away from CPA. In line with national guidance, we are working on how we introduce a system of personalised care and support planning for adults and older adults community mental health services (some services will continue to use the CPA). This will build on the principles and the positive work of the care programme approach (CPA). We are looking to introduce this over 2024 - find out more on the intranet.

Improving Care
Incidents in August

In August we reported:
- **1,179** incidents – **765** rated green (no/low harm)
- **342 were rated yellow and 61 rated amber**
- **11** 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
- **41** patient safety incidents that resulted in moderate or severe harm or patient safety related death.

We had **146** restraint interventions in August, an increase from 145 in July. **90%** of prone restraints were 3 minutes or less. We continue to offer support and advice to teams around reducing restrictive interventions.

We had **33** falls in August, same as the previous month. There is an area of the intranet for falls prevention.

We had 42 pressure ulcers in August. One lapse in care has been identified.

September was falls prevention week which looked at the theme of 'from awareness to action'. Throughout the week drop in stalls were held across Trust sites, and wards and units held falls awareness activities. Our teams attended local events, and our falls coordinator Karen Greenbank shared her thoughts in a blog. You can read more about falls prevention on the intranet.

Think. Check. Share.

There were **16 confidentiality breaches** in August, up from 13 last month. All of us can reduce the number of patient data or sensitive information breaches.

Improving health
Vaccination update

NHS
South West Yorkshire Partnership
NHS Foundation Trust
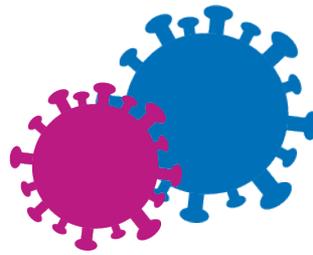
You'll soon be able to book to get your **flu vaccination**.

Even if you were vaccinated last year, it's important to get your jab again because the viruses can change year to year. The best defence is to get your vaccine before the virus starts circulating.

Deputy head of occupational health Jackie Dickens will be getting her jab this year. She said: "Working in occupational health, I know how important it is to keep all our staff healthy and well at work. I'll be getting my vaccination to protect my colleagues."

Keep an eye out in the Headlines, the View and in the intranet for more information on how to book.

We are seeing an increase in COVID infections across the Trust and in the community. We have also seen a new COVID variant emerge.

One way to protect yourself and those you are in contact with is to take up the offer of the **COVID booster vaccine**.

NHS front line staff can now book the autumn Covid vaccine.

Anyone eligible can book via the NHS website, by downloading the NHS App, or by calling 119 for free if they can't get online.

Vaccine information can be found on the intranet.

Remember to do everything you can to keep yourself and others safe. This includes good hygiene practices, ventilation and ensuring if you are feeling ill you speak to your line manager about what to do next. Guidance amd advice can be found in the COVID section of the intranet.

With **all of us** in mind.

Improving care
Our Trauma Informed (TI) journey

South West Yorkshire Partnership
NHS Foundation Trust

'This is focused on considering 'What happened to you'' and ''what do you need'' rather than 'what's wrong with you''.

Where are we now? Entering phase two to ensure the TI and recovery-focused 'golden thread' is woven through our priority programmes and everything we do.

To include:
- Monthly **Community of Practice meetings** to learn and share
- Continued focus on **staff health and wellbeing** as part of being a great place to work
- Facilitated **ROOTS self-assessments** to support teams and services on their TI journey
- Learn more about what **TI interventions and pathways** we already have and build on these
- Develop a mandatory **TI e-learning package**
- Develop **frameworks** to support **TI environments** and **writing TI policies**

Please join the next trauma informed community of practice session with staff health and wellbeing on Tuesday 10 October at 12pm to 1pm via Microsoft teams - find the login details on the intranet.

For staff who do not have direct access to a computer we will be setting up screens in meeting room one at Fieldhead and the Robin Norbury meeting room at Kendray Hospital to enable staff to view the session.

Find out more about our trauma informed journey on the intranet.

With **all of us** in mind.

Patient safety
Introducing PSIRF and LFPSE

Patient safety incident response framework (PSIRF)

- A new approach to responding to patient safety incidents.
- More focus on understanding how incidents happen, and the factors that contribute to them.
- Improvement in engaging and involving patients and staff in incidents.
- We will put effort into looking at where improvement could happen, rather than placing effort in areas where we already have plans to improve.

Our **PSIRF policy** will describe the systems and processes we develop to learn and improve following a patient safety incident. We will make sure that this is easy to understand.

Our **PSIRF plan** will set out how we intend to respond to patient safety incidents. This plan will be flexible and change depending on our learning.

Learn from patient safety events (LFPSE) service

- New central NHS service for recording and analysing patient safety events in England.
- It will initially provide:
  - the ability to record a patient safety event and contribute to national data
  - our Trust with access to data about recorded patient safety events to help us better understand local practice, culture and support our safety improvement work.
- We are in the process of upgrading Datix which will include embedding the LFPSE service.

Moving to LFPSE is a big project which will need support from Datix system managers.
Our patient safety team will be supporting the rollout period to make it a smooth transition.

Search for PSIRF and LFPSE on the intranet to find out more.

With **all of us** in mind.

Our Trust will start to use PSIRF and LFPSE from Autumn 2023.

Managing risk

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.

To ensure the safety of our staff every area must have a qualified **first aider**. It is important that you should know who your trained first aiders are in all areas. If you would like to become a first aider training opportunities are available. To apply complete an internal study leave form and submit it to learning and development.

Keep post safe and secure. Post items must only be opened if they are addressed to you personally or you have delegated responsibility to open post sent to a team or to a named individual. Read more on information governance. Keep an eye out for our IG case studies being launched soon.

Improving resources
Our finances in August

Performance Indicator	Year to Date	Forecast 2023/24
Surplus / (Deficit)	£1.2m	£0m
Agency Spend	£4.5m	£10.2m
Financial sustainability and efficiencies	£3.6m	£12m
Cash	£79.1m	£76.9m
Capital	£1.1m	£8.8m
Better Payment Practice Code	97%	

A surplus of £0.4m has been reported in August 2023, and a year-to-date surplus to £1.2m. This is £0.2m behind plan. Pressures need to be mitigated in order to secure the planned breakeven position.

Our Trust agency spend target is £8.7m and we are forecasting to spend in excess of this. Spend in August is £800k which is a reduction from the exceptional level reported in July.

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 £79.1m. This is higher than plan.

To date capital expenditure is £1.1m with spend profiled to increase in the coming months.

97% of all invoices have been paid within 30 days of receipt.

A great place to work
Our performance in August

- **4.7%** sickness rate for the month.
- The rolling 12 months sickness rate is **5.3%**
- In August we had new **64** starters to the Trust, and **62** leavers
- We currently have **4,311** substantive members of staff
- **74.5%** of staff have a completed annual appraisal

Consultants and junior doctors will both be taking part in **industrial action** on the same dates in October. Industrial will start at 07:00 on Monday 2 October and finish at 07:00 on Thursday 5 October, a total of 72 hours. Consultants taking part in strike action will provide an emergency care only level of service. The care and safety of our service users, and the wellbeing of our staff are our highest priorities. We value all of you and respect your rights to engage in industrial action. We welcome feedback from all our staff, please speak to your line manager, union representative, or raise a concern.

Our Trust supports staff to take an internal transfer. An internal transfer supports staff into a like-for-like job in our Trust, with the potential to learn new skills and gain new experiences. The scheme is open to anyone who has been employed with the Trust in a substantive post for more than six months. More information on the staff transfer scheme pages is on the intranet.

The annual **NHS staff survey** is a really important tool to give insights into staff experience. In 2022, 50% of staff gave their views and each service developed their local action plan. Actions taken since the last survey include further investment in our wellbeing support offer, promoting opportunities for learning and development, and supporting healthy team working. Please give your feedback to this confidential survey, help the Trust to improve staff experience and enter the prize draw to win one of 4 iPads.

Congratulations to our people directorate who were finalists at the HPMA Awards. They were all nominated for the great partnership work on delivering virtual recruitment fairs, as part of the West Yorkshire Health and Care Partnership.

#AllOfYou – This month Estelle Myers shared what Rosh Hashanah means and how it is traditionally celebrated. Read it in full on our website.

Speak Up Month: Your voice matters

NHS South West Yorkshire Partnership NHS Foundation Trust

Speak Up Month in October is an opportunity to raise awareness of how much we value speaking up in our organisation. We see Freedom to Speak Up as fundamental to how we work and we want to be part of making speaking up business as usual across healthcare.

Speaking up enhances all our working lives and improves the quality and safety of care. Listening and acting upon matters raised means that Freedom to Speak Up will help us be a great place to work.

SPEAK UP MONTH 2023

BREAKING BARRIERS

#BreakingFTSUBarriers

Freedom to Speak Up Guardian

To celebrate Speak Up Month guardians will be visiting teams, taking part in the flu jab campaign, and wearing green on Wednesdays to demonstrate support for freedom to speak up.

We would like to take this opportunity to thank everyone who has come forward to let us know what needs improving, without your input we are unable to make things better. Please reach out to the Freedom to speak up guardians – Estelle Myers, Ruth Neil, Eve Winstanley and Melissa Burgoyne.

Watch our speak up month _film_ to find out more.

Estelle Myers

Ruth Neil

Melissa Burgoyne

Eve Winstanley

Contact a guardian

guardian@swyt.nhs.uk

07795 367197

And you can also talk to our Exec Trio at their '_talk to the trio_' events. The next one is on Weds 11 Oct in the Laura Mitchell HWB Centre.

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.

Take up any vaccine offers to help you keep well and protect those around you.

Complete the Oliver McGowan mandatory training on LD and autism.

Look after other people's information and data as you would want your own to be. An IG campaign is coming soon.

Have your say and help us to improve by taking part in the NHS staff survey.

Find out more about our journey to become a trauma informed organisation by attending our community of practise.

Help us learn and improve by getting involved in speak up month.

Support your colleagues by becoming a trained first aider.

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

Trust Board 31 October 2023
Agenda item 9.1

Private/Public paper:	**Public**
Title:	**Board Assurance Framework (BAF) Quarter 2 – 2023/24**
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.

With all of us in mind.

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

Each quarter, as part of the head of internal audit opinion process, the Trust BAF is reviewed by the Trusts internal auditors 360 Assurance. Their review includes recommendations relating to the clarity of controls and assurance statements. These recommendations are then followed up and presented to the Board in the next version of the BAF.

On 5 October and 19 October 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 considered the external environment in which the Trust operates, including factors such as 30% reduction in running costs for both integrated care systems, high levels of acuity and complexity in presentation, , continuing industrial action in some sectors and the ongoing need to support staff wellbeing.

As agreed at April Board the Trust has 14 strategic risks for 2023/24 against the Trust strategic objectives:

Improving health – 4

Improving care – 4

Improving resources – 3

Make this a great place to work – 3

The table below shows the risk rating and no changes to grading between Q1 and Q2:

Strategic Risk Ratings	Q1 2023/24	Q2
Red	0	0
Amber	5	6*
Yellow	8	8
Green	0	0
Ungraded	1	0

(*2.4 grading to be approved in October Board)

In July 2023, a new strategic risk was presented to Trust Board:

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.

The potential grading of this risk has been discussed in detail by EMT, taking account of the following:

- Background
- Description
- Processes
- Governance
- Impact on patient care
- Impact on staff experience

EMT discussion identified that there has been a significant improvement in the amount of equality data being obtained by the Trust, but further work is required to coordinate and analyse this data.

EMT proposed an initial grading of Amber with high level action plan to be developed to reduce the risk to Yellow, with an update on progress to be presented to the January 2024 Board.

EMT has given careful consideration to all other strategic risks with a particular focus on the below:

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. EMT discussed whether this strategic risk is being impacted by changes in the financial climate, such as the cost reductions taking place across integrated care systems. It was agreed that at this time the risk would retain a grading of Yellow but will be subject to careful review as part of the 2024/25 planning process.

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. EMT discussed the potential to escalate the grading of this risk in light of the national staffing challenges. However, the Trust is able to evidence a strong position with regard to current successful onboarding of staff into key posts, demonstrated by the running of at least two welcome events for new starters each month. The risk is therefore to remain graded as Amber.

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 remains Yellow.

	The view of EMT is that the ratings of individual strategic risks for Q2 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 APPROVE the proposed grading for strategic risk 2.4.**

BOARD ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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

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

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

Strategic Objectives
Approved by Trust Board and reviewed

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

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

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

Strategic risks to the achievement of strategic objectives

Controls in respect of risks and strategic objectives

Assurances in respect of the controls and strategic objectives

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

Adherence with the NHSE Corporate Governance Code for NHS Provider Trusts

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

Exec Management Team

Individual director/Care Group assurance

Audit Committee
Annual report
Quarterly Risk Triangulation Report

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

Trust Board Committee
Advise, Alert, Assure reports

Closure of gaps
- Time bound responsibilities identified plus lead

TRUST BOARD

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

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	2023/24			
			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		TBC	A		
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		

Board Assurance Framework 2022/23

2

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

Board Assurance Framework 2023/24

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, QSC = Quality and 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, QSC, MHA, Trust Board, CC	Q4	Q1	Q2	Q3	Q4
				Y	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 partner in provider collaboratives regionally
- Coordinating provider for forensic child and adolescent mental health services (FCAMHS) for Yorkshire and the Humber
- The Trust is part of the Mental Health Learning Disability & Autism provider collaborative 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).
- The trust is part of the Provider collaborative established in Calderdale led by CHFT which focusses on climate, social value and integrated neighbourhood teams.
- 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 in Kirklees with a focus on inequalities.
- The Trust insight report feeds into the Executive Management Team meeting and Equality, Inclusion and Involvement Committee
- Integrated Performance Report (IPR) summary metrics month 5 23/24 - out of area beds – red, children and young people accommodated on an adult inpatient ward – 2 service users, learning disability referrals with completed assessment, care package and commenced delivery within 18 weeks – red, clinically ready for discharge (previously 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.
- 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.
- The Trust continues to improve   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 people's transformation in progress, preparation for consultation with the public to take place before the end of calendar year 2023.
- Compliance with the public sector equality duty.
- 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.
- 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 to Board on compliance with Equality Delivery System annually.
- Mandatory Freedom to speak up training in place 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 and reports into Finance, Investment and Performance committee quarterly.
- Chief allied health professional recruited and in place, 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.
- Waiting list management in SystmOne is complete and waiting list report is presented to the Finance, investment, and performance committee on a regular basis.

Strategic objective 2: Improve care		Lead Director(s)	Monitoring and assurance	Overall assurance level					
				2022/23	2023/24				
				Q4	Q1	Q2	Q3	Q4	
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, QSC, WRC, Trust Board	Y	A	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**	A

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.
- 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)

Rationale for current assurance level (strategic objective 2: improve care)

- Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 5 shows: Friends & Family (F&F) Test MH – Green F&F Test Community – Green, safer staff fill rates – green, IG confidentiality breaches – red.
- Improvement work around the FIRM risk assessment and care planning continues and the impact of work so far is showing positive change in performance. 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.
- Each care group has a data quality work stream.
- Improving access to care workstream is in place and reports to the mental health improvement group and includes a review of waiting list work which references health inequalities.
- 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, and quarterly analysis of all incidents through the incident management report through Quality and Safety Committee (QSC) and Trust Board.
- 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 – waiting list management audit and emergency preparedness, resilience and response audits have received significant assurance.
- 83% 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.
- 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.
- 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 QSC 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			
			Q4	Q1	Q2	Q3	Q4
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	Y	Y	Y		

Strategic risks – to be controlled, consequence of non-controlling and current assessment		
Ref	Description	RAG rating
3.1	**Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively**	Y
3.2	**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 – waiting list management audit and emergency preparedness, resilience and response audits have received significant assurance.
- Head of internal audit opinion for 22/23 was significant assurance.
- Integrated Performance Report (IPR) summary metrics have been updated to reflect the new strategic priorities for 23/24
- Cash balance at month 5 of 2023/24 is £ £79.1m.
- 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.

Rationale for current assurance level (strategic objective 3: improve resources)
- 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			
				Q4	Q1	Q2	Q3	Q4
Links to ORR (risk ID numbers): 1151, 1157, 1614, 1729		As noted below.	EMT, WRC, Trust Board	A	Y	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 is in place 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 of workforce data 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. Additional freedom to speak up guardians have been appointed (three posts)   - 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 build on and improve a positive partnership 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. Year to date recruitment continues with 281.9 WTE starters since April 2023.   - The inclusive leadership programme development was commissioned in May 2023, with a planned event to take place in November with extended EMT.   - 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.   - OD and wellbeing facilitator is in post from 11 September 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, 2.4
C02	Operational Management Group (OMG) meetings identify and rectify performance issues and learn from good practice 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 priority programmes 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 with actions in place (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 in place, with appropriate membership skills and competencies, 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, Quality and Safety Committee 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 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 to effectiveness reviews when required.	DSC/DPD	1.1
C188	South Yorkshire Mental Health Learning Disability and Autism Provider Collaborative now in place. Operating in private and meetings to be public for January 2024	DSC/DPD	1.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
In response to the need for ICS's to make a 30% savings to running costs, consultation processes with ICB staff have now commenced. In addition, re-structuring at NHS England is taking place with an aim to reduce its own running costs by 40%, and the potential to impact on the Trust's ability to achieve its strategic objectives and service provision across places will need to be reviewed when the consultation process is complete and cost savings achieved. To review for further update in January 2024.	January 2024	DSC/DPD

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
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. We 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. Reviewed in July and October 2023. Work continues further update to be provided in January 2024.	January 2024	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. The insight report is being updated following feedback from the Members Council. An inequalities measure is also in development. Review in January 2024.	January 2024	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, Quality and Safety Committee (QSC), Trust Board and Members' Council.	Annual unannounced and planned visits programme in place and annual report is now received directly by QSC Quality monitoring visits for 2023/24 have started and are reported into QSC. (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	Update reports from Barnsley, Calderdale, Kirklees, and Wakefield Integrated Partnership and Health and Wellbeing boards.	Update reports into EMT and Board eight times a year. (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, QSC 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

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, 2.4
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 priority programmes and work streams, overseen by EMT. (I)	DSC	1.1, 1.2, 1.3
C14	Project Boards for change programmes and work streams in place, with appropriate membership skills and competencies, 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, Quality and Safety Committee 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
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 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	Operational structure includes oversight of pathways across the organisation that reach into each place (P, N, I).	DSC/COO	1.2
C190	Place based plans 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

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)
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, Quality and Safety Committee (QSC), Trust Board and Members' Council.	Annual unannounced and planned visits programme in place and annual report is now received directly by QSC. Quality monitoring visits for 2023/24 have started and are reported into QSC. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A17	Update reports from Barnsley, Calderdale, Kirklees, and Wakefield Integrated Partnership and Health and Wellbeing boards.	Update reports into EMT and Board eight times a year. (P, N) (I)	DSC/DPD	1.1, 1.2
A20	Reports are reviewed by EIIC, QSC 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. "Quarterly Incident Management report" which includes learning from serious incidents(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 QSC 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. The Trust is looking to align its medium-term financial plan with the West Yorkshire ICS timetable and assumptions. Reviewed regularly through FIP. 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.	January 2024	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. New staff have started in post during Q2 and the people directorate is fully establishments. Induction processes are in place for new staff and the impact of new posts should be realised before the end 2023.	January 2024	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 priority programmes 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

	Controls (strategic risk 1.3)		
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. 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
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 to Trust Board and action plans produced as applicable. (P, N, I).	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 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 being used by some operational teams but needs to be fully embedded across the Trust Dashboard is in place, but work continues to further evolve this. A Trustwide implementation plan is now required.	January 2024	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

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)
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
A20	Reports are reviewed by EIIC, QSC 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
The Trust is building capacity (appointment made) to deliver equality and inclusion/diversity training and development. This will be rolled out over the next twelve months. Equality impact assessment (EIA) training continues 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, 1.4,2.4
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 2023/24 with actions in place (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, Quality and Safety Committee 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

Controls (strategic risk 1.4)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
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 to Trust Board and action plans produced as applicable. (P, N, I).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
C148	All services have a baseline Equality Impact Assessment (EIA) in place. (P) (I)	DSC	1.4
C185	Improving access to care priority programme established (P, I)	DSC	1.4
C186	Dashboard and business intelligence tools in place to help address health inequalities	DSC	1.4

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
In response to the need for ICS's to make a 30% savings to running costs, consultation processes with ICB staff have now commenced. In addition, re-structuring at NHS England is taking place with an aim to reduce its own running costs by 40%, and the potential to impact on the Trust's ability to achieve its strategic objectives and service provision across places will need to be reviewed when the consultation process is complete and cost savings achieved. To review for further update in January 2024.	January 2024	DSC/DPD
Health inequalities data and analytics are now available. The next stage of development is to educate to use the best to inform service change and development. 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, QSC 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 QSC .	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.4, 2.3
A34	Quality strategy review updates report into CG&CS Committee.	Routine reports into QSC 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 and 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

Controls (strategic risk 2.1)				
Control ref	Systems and processes – what are we currently doing about the strategic risk?		Director lead	Strategic risk(s)
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 initial rollout of waiting lists is complete. Stage 1 of the project has received significant assurance from the internal auditors. Substantive funding has been secured to continue rolling out and managing SystmOne waiting lists across the Trust. The project is now linked into the access to care group to determine areas of priority. Review further January 2024.	January 2024	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 which is reported into QSC. Data quality is also referenced 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 and governance processes.	OMG minutes taken 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, concerns and compliments. (I)		DNQ	2.2, 2.4, 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, are shared across Care Groups, including 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

Controls (strategic risk 2.2)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
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 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, Quality and Safety Committee (QSC) and the clinical governance group continue to monitor the embedding of learning and the evidence to support this. QSC continues to oversee the learning from SI action plans, with the committee continuing to further develop reports that evidence the links between the incident and the learning is the gap. Quarterly reporting is in place and expectations are for a more developed link between incidents and learning to be in place by the end of Q4.	March 2024	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
A	A Trustwide approach to shared decision making and co-production is in place to support the delivery of personalised care and innovation in response to NICE guidance (NG197). An action plan is in place.	Reports into EIIC, and QSC (E, I, P)	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. A new information governance communications campaign is to be launched which utilises incident stories with associated learning to help staff understand the real impact of information governance breaches. To review again in January 2024.	January 2024	DFR

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
Work on the inpatient priority programme is underway and is using learning to improve safe and effective care delivery, this is 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

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, 2.4
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, 2.4
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 2.4, 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, 2.4
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, 2.4
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, 2.3,2.4, 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, 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, 2.4, 4.1
C56	Quality improvement approach and methodology. (I)	DNQ	2.2, 2.3, 2.4
C63	Care Closer to Home Partnership Meeting and governance process. (I)	COO	2.3, 2.4
C64	Care closer to home programme incorporating whole system actions with out of area bed reduction reported against trajectory. (I, E)	COO	2.3, 2.4
C65	Safer staffing policies and procedures in place to respond to changes in need. (I)	DNQ	2.3, 2.4
C66	TRIO management system monitoring quality, performance, and activity on a routine basis. (I)	COO	2.3, 2.4
C67	Use of trained and appropriately qualified temporary staffing through bank and agency system. (I)	CPO	2.3, 2.4
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, 2.4
C69	Process to manage the CQC action plan. (I)	DNQ	2.3, 2.4
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one 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) (N)	DNQ	2.3, 2.4
C145	Service user survey results reported to Trust Board and action plans produced as applicable. (P, N, I).	DNQ	1.1, 1.2, 1.3, 1.4, 2.3, 2.4
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, 2.4

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Health inequalities data and analytics are now available. The next stage of development is to educate to use the best to inform service change and development. To review each quarter.	April 2024	DSC/DPD
The Trust currently does not have safer staffing establishments in place for community services, this is being developed as part of the community services 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

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

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)**
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, Quality and Safety Committee (QSC), Trust Board and Members' Council.	Annual unannounced and planned visits programme in place and annual report is now received directly by QSC. Quality monitoring visits for 2023/24 have started and are reported into QSC. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A33	Patient experience service reports to Trust Board (annual) and QSC.	Annual reports to Board / EMT and quarterly into QSC. (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
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
A88	Mental health improvement group has been put in place to have oversight of the improving care priority programmes	This group reports into EMT on a monthly basis (P, N, I)	COO/DNQ	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 usage remains an area of focus with improvements noted in August and September. The gap will remain until evidence of sustained reduction is seen.	January 2024	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. On 4 December the West Yorkshire ICS is hosting an autism summit the Chief Executive of the ICS to bring together partners and providers to identify the key issues. It is anticipated following this meeting a plan of shared approach will be established. Review further in January 2024	January 2024	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)**
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, 1.4,2.4
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, 2.4, 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, Quality and Safety Committee and Equality, Inclusion, and Involvement Committee. (E, I)	DSC / DNQ / CMO	1.1, 1.2, 1.3, 1.4, 2.4
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, 2.4
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Equality, Inclusion, and Involvement Committee. (I)	DSC	1.3, 1.4, 2.4
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, 2.4
C34	Provision of information, leaflets, and posters which meet the Accessible Information Standard. (I)	DSC	1.3, 2.4
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, 2.4, 4.1
C52	Patient experience reporting includes learning from complaints, concerns and compliments. (I)	DNQ	2.2, 2.4, 4.1
C53	Patient Safety Strategy developed to reduce harm through listening and learning. (I)	DNQ	2.2, 2.4, 4.1
C110	Values-based appraisal process in place with revised monitoring arrangements in place and monitored through Key Performance Indicators (KPIs). (I)	CPO	2.4, 4.1, 4.3
C115	Appointment of diversity and inclusion belonging lead established as part of the Trust's overall leadership and management development arrangements. (I)	CPO	2.4, 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, 2.4
C136	Inclusive Leadership Board Development (ILDB) programme on inequalities completed March 2022 with future board development programme being established. (P,I)	CPO	2.4, 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, 2.4
C155	Trust Board engagement with staff networks (P, I)	DSC	2.4, 4.2
C156	Appointment of Freedom to Speak up Guardians, Equity Guardians, Civility and respect champions, and diversity and inclusion lead roles (P, I)	CPO	2.4, 4.2
C157	Values based recruitment processes in place (P, I)	CPO	2.4, 4.2
C158	Values based appraisal system (I,E,P,N)	CPO	2.4, 4.2
C167	Insight programme – developing future Board members from diverse backgrounds (P, I, E)	CPO	2.4, 4.2
C188	The great place to work strategy acknowledges the diversity challenge in senior roles across the Trust for 23/24 (P,N,I,E)	CPO	2.4, 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	2.4, 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
C195	Clinical risk panel (executive trio membership) receive information on all incidents referencing protected characteristics, irrespective of grade. (P) (N) (I)	CMO/DNQ/COO	2.4
C196	Micro aggression guidance is in place, which includes reference to all protected characteristics	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, QSC 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 QSC .	Annual reports to Board / EMT and quarterly into QSC. (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 with support from staff network groups to be used to improve understanding of staff groups	Reported to the Improving Clinical Information Group (ICIG). As part of WRES and WDES, presented to PRC and Trust Board annually. (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
A89	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**
Analysis of processes has identified that the Trust receives equalities data and information in a number of ways but there is a need to co-ordinate all the data that we have and undertake a thematic analysis to identify what the key themes are.	April 2024	DSC
A high-level action plan is required to address themes which link to work already in place and clarifies how to progress the rating of this risk from amber to yellow. There is a requirement to continue with actions identified within current plans, including the equality, diversity and inclusion action plans, and people directorate plans.	April 2024	DSC

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, 3.2
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director with recent and relevant financial experience. (I)	DFR	3.1, 3.3
C133	Annual strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats. Strategic business and risk analysis reviewed by Trust Board. (P) (I)	DSC	3.1, 3.2

Controls (strategic risk 3.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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
C197	The Trust is aligned to the NHSE/ICB framework for enhanced financial controls. As a result agency scrutiny group established, documented vacancy controls in place.	DFR	3.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Trust has previously not fully achieved its recurrent CIP targets (Linked to ORR risk 1076). The Trust needs to have a fully developed CIP plan for 23/24 including QIA. CIP challenge for 23/24 is currently expected partially through non-recurrent measures. Plans need to progress to identify further recurrent schemes. Work is ongoing on value for money schemes in order to create financial efficiency – gap remains until the schemes are in place and delivering. Review further in January 2024.	January 2024	DFR / COO
The Trust is reviewing NHSE/ICB framework for enhanced financial controls. There is an undocumented process for non-pay controls. (expenditure over £10k) Documented process in development with an anticipated completion date of December 2023 – Review January 2024.	January 2024	DFR

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 QSC 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 usage remains an area of focus with improvements noted in August and September. The gap will remain until evidence of sustained reduction is seen.	January 2024	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. Establishment review has been completed and is still to be reviewed by EMT – a further update will be provided in January 2024.	January 2024	DFR

<table>
<tr><td colspan="3" align="center">Strategic risk 3.2
Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.</td></tr>
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	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 in place for 2023/24 with actions in place (I, E)	COO	1.1, 1.4, 3.2
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	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
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
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 is ongoing to establish the most effective way to compare finance establishment and workforce data. This is a longer term work plan for review in March 2024.	March 2024	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

Assurance (strategic risk 3.2)				
Assurance ref	Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)	Guidance / reports	Director lead	Strategic risk(s)
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
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 QSC and Trust Board. (P, N) (I).	COO	1.2, 3.1, 3.2
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
The inpatient improvement programme includes a range of actions to enhance the use of creativity and creative practitioner roles, in inpatient services. and this is expected to be in place by the early Q3 2023. The gap remain until actions are complete. Review January 2023	January 2024	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
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 bi-annually (P, I)	DFR	3.3
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	3.3

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 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, concerns and compliments. (I)	DNQ	2.2, 2.4, 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

Controls (strategic risk 4.1)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
C110	Values-based appraisal process in place with revised monitoring arrangements in place and monitored through Key Performance Indicators (KPIs). (I)	CPO	2.4, 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 October 2023. The operational planning changes for ICS's is impacting on the progress of this work. To review further in April 2024.	April 2024	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. Review in January 2024	January 2024	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)
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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 an Quality and Safety Committee (QSC) Committee.	QSC 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 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). Working with MHLDA group across the West Yorkshire MHLDA programme and a renewed focus on retention. Reviewed in April, July and October, progress on medical and nursing recruitment has been positive in certain areas of the Trust over the	April 2024	CPO

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
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 April 2024 given context of national and global issues.		

Strategic risk 4.2
Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively

Controls (strategic risk 4.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Established processes for gaining insight and feedback, including identification of themes, and reporting on how feedback has been used. (I, E) (ORR 773)	DSC	1.1, 1.3, 1.4, 2.3, 4.1,4.2 4.3
C101	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme. (I)	CPO	4.1, 4.2
C103	Education and training governance group 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, Civility and respect champions and diversity and inclusion and belonging 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 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. Work on completion of the WRES and WDES to provide meaningful action plans is ongoing and to be presented to Board in October. Following completion of this work consideration of an LGBT equivalent will take place. Review further in April 2024	April 2024	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 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 the implementation stage which will give insight into lead time and areas where efficiencies can be made. There has been a delay in this work, with phase 1 to be in place by November 2023, and efficiencies being realised by the end of the 31 March 2024..	March 2024	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	2.4, 4.1, 4.3
C116	Provision of appropriate personal protective equipment (PPE) in line with national guidance. (I)	DNQ	4.3
C117	Access to wellbeing apps. (I)	CPO	4.3
C118	Comprehensive Occupational Health Service offer.	CPO	4.3
C119	Integrated care system Workforce Support Hub 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 throughout the year (aligns to GMC fair to refer report 2019)	CMO	4.3
CXXX	The occupational health service have completed all aspects of the trauma informed pilot, including training and ROOTS assessments. Maintaining and developing practice underpinned by trauma informed principles remains a priority of the OH team.	CPO	4.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Staff sickness rates have increased from 4.6% in Q1 to 4.9% at the end of Q2 (Sep 23) which is line with expected and levels. 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. An internal audit on processes to manage of sickness/absence is taking place in March 2024.	April 2024	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 now targeted at areas of concern/ hotspot areas	Reports into the People and Remuneration Committee and EMT as part of the annual wellbeing review(P) (I)	CPO	4.3

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)**
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**
Outcome of the internal audit into the management of sickness/absence in the Trust is currently unknown. Internal audit will be complete by the end of April 2024, following which the outcome will be reported to PRC and Audit Committee.	July 2024	CPO

Private/Public paper:	Public
Title:	**Board Assurance Framework (BAF) Grading Process Review**
Paper presented by:	Adrian Snarr – Director of Finance, Estates and Resources
Paper prepared by:	Julie Williams - Deputy Director of Corporate Governance Andy Lister - Head of Corporate Governance
Mission/values:	The BAF is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values.
Purpose:	For Trust Board to review the proposed change to the grading process for the Board Assurance Framework (BAF) following presentation to the executive management team (EMT).

Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	

BAF Risk(s):	All risks
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Board Assurance Framework allows Trust Board to monitor risks against the Trusts strategic objectives and in doing so enables them to assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnerships and Integrated Care Boards, and place-based partnerships.
Any background papers / previously considered by:	Quarterly reports to Trust Board regarding the Board Assurance Framework Paper to the Executive Management Team 21 September 2023
Executive summary:	The Board Assurance Framework (BAF) provides the Trust Board with a simple but comprehensive method for the effective and focused management of the risks to meeting the Trust's strategic objectives.

Our four strategic objectives	
Improving health	**Improving care**

With **all of us** in mind.

Improving resources	Make this a great place to work

Trust Board (25 July 2023) requested a review of the RAG (red, amber, green) rating system on the Trust Board Assurance Framework.

The current Trust RAG rating system on the Board Assurance Framework is below:

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

The current grading system has been in place for a number of years, as a result of which the corporate governance team have liaised with 360 Assurance, the Trust internal auditor, and sought guidance on what is considered to be best practice.

The team have also reviewed other Trust Board Assurance Frameworks to consider their grading systems.

A selection of grading systems from the above research was presented to EMT on 21 September 2023.

One consideration of which grading system is that where a red, amber, green rating is utilised, evidence suggests the middle option will be chosen in the majority of cases, rather than a fully considered approach.

Some Trusts also use the 5 x 5 risk matrix, as utilised for the Trust organisational risk register. This was considered, however as the ORR framework is used ward to board it was determined that it is important for staff and managers to be able to see a clear difference between strategic risks and organisational risks.

The recommendation is therefore to utilise a system depicted below which provides an assurance rating with four options, and a risk likelihood grading with five options.

The benefit of this approach is that the risk and assurance ratings can move independently, giving a more comprehensive and dynamic view of strategic risk variation throughout the year.

Assurance Rating	Details
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk / Cause.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk / Cause and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Risk Likelihood	Details
RARE	This will probably never happen / recur
UNLIKELY	Do not expect to happen / recur but is possible
POSSIBLE	Might happen / recur occasionally
LIKELY	Will probably happen / recur, but is not a persistent issue
ALMOST CERTAIN	Will undoubtedly happen / recur, possibly frequently

On approval by Trust Board the new grading system will be introduced and presented in January 2024.

An example of this system in use is shown below, please note this does not form any part of SWYPT's Board Assurance Framework and is for illustrative purposes only:

BAF SUMMARY DASHBOARD	Current Aggregated Assurance Rating	Current Risk Likelihood Rating
Strategic Risk 1: Quality of Care - Fail to provide compassionate, effective and safe patient centred care that delivers the best clinical outcomes	LIMITED	LIKELY
Strategic Risk 2: Partnership and Engagement - Fail to take a proactive role and engage effectively with partners to transform services and improve the health of the communities we serve	ADEQUATE	POSSIBLE
Strategic Risk 3: Workforce - Fail to ensure the Trust can recruit and retain the right people to deliver patient centred services and the best clinical outcomes	LIMITED	LIKELY
Strategic Risk 4: Finance - Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision	ADEQUATE	POSSIBLE
Strategic Risk 5: Infrastructure - Fail to implement appropriate, cost effective and innovative approaches to digital and estate infrastructure that support our aspirations today and for the future	LIMITED	POSSIBLE
Strategic Risk 6: Sustainability - Fail to identify and maximise sustainable ways to deliver the Trust's strategic aims and objectives	ADEQUATE	LIKELY
Strategic Risk 7: Research, Education and Innovation - Fail to ensure the Trust has the ability to deliver excellent research, education and innovation	LIMITED	LIKELY
Strategic Risk 8: Well-led - Fail to ensure appropriate and effective governance arrangements are in place that support the achievement of our Corporate Strategy (Making a Difference – The Next Chapter)	LIMITED	LIKELY

(Sheffield Teaching Hospital NHS Foundation Trust Board Assurance Framework 2023)

Recommendation:	**Trust Board is asked to APPROVE the new Board Assurance Framework grading process for implementation in January 2024.**

Trust Board 31 October 2023
Agenda item 9.3

Private/Public paper:	**Public**		
Title:	**Quarter 2 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:		

With **all of us** in mind.

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

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

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

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

There are two emerging risks which will be reviewed and scored in preparation for Quarter 3 2023/24 risk report.

Emerging risks

Risk ID	Description
New risk	Risk that teams and individual members of staff do not feel confident that the Trust has a culture in which 'Speaking Up', is encouraged, that individuals are supportively heard, do not suffer personal detriment, and that they receive feedback on action(s) taken which demonstrate listening and learning.

Risk ID	Description
New risk	Risk that individuals do not feel safe from sexual harm. This includes being made to feel uncomfortable, frightened, or intimidated in a sexual way by any other person whilst being cared for, working for, or visiting the Trust.

Risk level 15+

Risk ID	Risk Owner	Description
1151	Chief People Officer	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.

The risk has been reviewed by the Executive Management Team (EMT) and they are proposing a reduction in likelihood from 4 likely to 3 possible which will reduce the risk score from 16 (red) to 12 (amber), due to the risk being mitigated by safer staffing and agency staff.

Risk ID	Risk Owner	Description
1530	Chief Operating Officer	Risk that demand, through acuity or numbers continues to rise placing further pressure on access to services and waiting lists

This risk has been reviewed by EMT and there is a proposal to update the risk description to reflect that demand can present through acuity as well as the number of people. The risk score will be reviewed in Quarter 3 2023/24.

Risk ID	Risk Owner	Description
905	Chief Operating Officer / Chief Nurse and director of quality and professions	Risk of a negative impact on quality of care due to low staffing levels and insufficient access to temporary staffing.

EMT are proposing a reduction in likelihood from 4 likely to 3 possible with the reduction in the overall risk score from 16 (red) to 12 (amber) due to an increase in control measures.

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

EMT are proposing a reduction in likelihood from 4 likely to 3 possible with a reduction in the overall risk score from 16 (red) to 12 (amber) due to the work undertaken to improve seclusion rooms.

Risk ID	Risk Owner	Description
1368	Chief Operating Officer	Risk that given demand and capacity issues across South & West Yorkshire and nationally, children and younger people requiring admission to hospital will be unable to access a Child and Adolescent Mental Health Services (CAMHS) bed. This could result in young people being care for on adult wards in the secure CAMHS estates or secure hospitals which could have an impact on the quality and experience of their care.

EMT is proposing to reduce the consequence from 4 major to 3 moderate with a reduction in risk score from 16 (red) to 12 (amber) as the risk is mitigated through the control measures in place, and is proposing to amend the risk description in relation to the impact of bed closures.

Risk level less than 15 which is outside the risk appetite

Risk ID	Risk Owner	Description
1757	Chief Nurse and director of quality and professions / Director of finance, estates and resources	Failure to fully maintain and monitor medical devices to the Trust agreed standards and in line with relevant legislation may lead to patient harm.

A review of this risk was conducted and presented to EMT by the chief nurse & director of quality and professions and director of finance, estates and resources. EMT were satisfied with progress against actions, and the risk score will be reviewed further in Quarter 3 2023/24. The risk score is currently 4 major (consequence) x 3 possible (likelihood) with an overall risk score of 12 (amber).

Risk ID	Risk Owner	Description
1689	Director of strategy and change	Risk that the Trust cannot evidence that it has mitigated against or addressed health inequalities in the provision of services potentially exacerbating existing health inequalities for our service users.

EMT have reviewed this risk and is proposing a change to the risk description to consider the impact of the risk.

Risk ID	Risk Owner	Description
275	Director of strategy and change/ Chief operating officer/ Director of provider development/ Director of finance, estates and resources	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.

This risk has been reviewed by EMT and there is a proposal to increase the likelihood from 3 possible to 4 likely with an increase to the risk score from 12 (amber) to 16 (red) as a consequence of Kirklees council funding reductions.

Risk ID	Risk Owner	Description
1159	Director of finance, estates and resources	Risk of fire safety. risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity. The risk of fire at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.

EMT have reviewed this risk and are proposing to amend the risk description to include reference to other causes of fire rather than just arson.

Risk ID	Risk Owner	Description
1585	Director of finance, estates and resources	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.

EMT have reviewed this risk and are proposing an increase of likelihood from 3 possible to 4 likely with an increase in the risk score from 9 (amber) to 12 (amber), this is in relation to the capital regime (Bretton).

Organisational risks within the risk appetite

Risk ID	Risk Owner	Description
1840	Chief operating officer / Chief nurse and director of	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.

	quality and professions	

EMT have reviewed this risk and is proposing an increase in likelihood from 3 possible to 4 likely with an overall increase in the risk score from 9 (amber) to 12 (amber). The appraisal target has not been met but there is work ongoing to bring appraisals on the Trust approved system (Workpal).

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.

EMT have reviewed this risk and is proposing a reduction in consequence from 4 major to 3 moderate with an overall risk score from 12 (amber) to 9 (amber). The impact has been reduced as actions to mitigate patient care are established.

Risk ID	Risk Owner	Description
1217	Director of strategy and change	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives, potentially resulting in the Trust or system not meeting service users' needs

EMT have reviewed the risk description and is proposing to add the impact of the risk.

Risk ID	Risk Owner	Description
1432	Chief people officer	Risk of lack of succession planning and talent management may lead to gaps in key roles and fail to promote diversity

EMT have reviewed this risk and are proposing an increase in likelihood from 2 unlikely to 3 possible with an overall increase in risk score from 6 (yellow) to 9 (amber), due to the length of time taken to progress the risk actions.

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 show a longer-term trend from January 2021 to October 2023. The risk score shows the current figures for October 2023 and the projection if the proposals are accepted by Trust Board.

A summary of findings are below:
- The number of risks remain the same as **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 currently **three red risks** aligned to **Improving Care** and if the proposals are accepted then this will reduce to **one red risk**.
- There are **two red risks** aligned to **Improving Resources** and this will reduce to **one red risk** if the proposed changes are accepted.
- There is **one red risk** aligned to **Making this a great place to work** and this will reduce to **zero red risks** if the proposed changes are accepted.
- The current accumulative risk score is **384** and this will reduce to **378** if the proposals are accepted, which is a reduction of **6.**
- The current average risk score is **10.97 (amber**). If the proposed changes are accepted, then the average risk score will be **10.8 (amber).** In Quarter 1 2023/24 the average risk score was 10.97 (amber).

Risk Appetite:	The ORR supports the Trust in providing safe, high-quality services within available resources, in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to REVIEW and COMMENT on the risk register and to confirm they are ASSURED that current risk levels are appropriate, considering the Trust risk appetite, and given the current operating environment.** **In addition, Trust Board is asked to:** • **AGREE to the reduction in risk score for risk 1151, 905, 1568, 1368, 1758.** • **AGREE to the change in description for risk 1530, 1368, 1689, 1159, 1217.** • **AGREE to an increase in risk score for risk 275, 1585, 1840, 1432.** • **AGREE that risk 1757 retains a score of 12 and be further reviewed in Q3.**

NHS
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.

	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**

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.

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
COO = Chief Operating Officer
DPD = Executive director of provider development

AC = Audit Committee
QSC = Quality and 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 2, 2023/24

Trust Board: 31 October 2023

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
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	QSC 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 Executive Management Team. • Reporting to the Board through Integrated Performance Report. • Datix reporting on staffing levels. • Strong links with Universities. • New students supported whilst on placement. • Regular recruitment plans and processes. • 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 and inclusion in all new business cases.	4 Major	4 likely 3 possible	16 12	8 - 12 Business Risk	• Proposal for On Boarding System to include recruitment/career Microsite with the view to complete testing and roll out (CPO, December 2023) • Exploring use of recruitment and retention premia in inpatient settings, paper to Executive Management Team (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, December 2023) • Internal transfer system to continue to be promoted (CPO Ongoing 2023) • Applicant Tracking System (ATS) to be fully delivered by December 2023 (CPO, December 2023) • Working through the NHS workforce plan to understand implications and actions (CPO, December 2023)	29 March 2024	Care Group (weekly) QSC PRC Executive Management Team (monthly) Trust Board	9	BAF Ref, SO 3, 4	30 November 2023 **Note for Trust Board: Reduced likelihood from 4 likely to 3 possible, reducing risk score from 16 (red) to 12 (amber). This risk is mitigated by safer staffing and agency staff.**

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
1530	Risk that demand, through acuity or numbers continues to rise placing further pressure on access to services and waiting lists	**COO**	QSC	• 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. • Escalation through the Operational Management Group (OMG) where demand cannot be met • Business continuity plans • 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. • Regular engagement with commissioners provides opportunity to consider changes in required capacity to meet demand.	4 Major	4 Likely	16	1 – 6 Clinical risk	• Operational teams will undertake further work with the Intelligence Change Partner to understand and measure all the factors that contribute to perceived demand increase (COO, December 2023)	29 March 2024	QSC Executive Management Team (EMT) (monthly) Operational Management Group (OMG) Trust Board	4	BAF ref SO 2	30 November 2023 **Note for Trust Board: Proposal to update the risk description to reflect that demand can present through acuity as well as the number of people. Risk scores remain the same pending the additional work.**

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
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. • Data Security and Protection Toolkit (DSPT) Cyber and Information	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, Q3, 2023/24) • Digital Task Action Group (TAG) and Improving Clinical Information Group (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 Executive Management Team, agreed to put on hold until 2024/25 plans are developed and agreed 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, Q4 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)	29 March 2024	IM&T Managers Meeting (Monthly) Digital TAG (Quarterly) Executive Management Team/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	30 November 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
				Governance met (substantial) and includes additional resilience to mitigate the risk presented by the Ukraine conflict • Cyber security enhancements to support move towards advanced monitoring capabilities 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										

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
				digital/IT solutions/services Cyber Essentials Plus re-accreditation achieved in 2023 • Deputy Senior Information Risk Owner (SIRO) now in place.										
905	Risk of a negative impact on quality of care due to low staffing levels and insufficient access to temporary staffing.	COO DNQ	QSC	• Recruitment and retention plan agreed • Monthly safer staffing reports to Board and Operational Management Group via Integrated Performance Report 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	4 Major	~~4 likely~~ 3 possible	~~16~~ 12	1-6 Clinical risks	• Roll out of Safe care ongoing throughout 2023/24 including review of effectiveness (DNQ/ CPO, March 2024 • Working with partners across Integrated Care System and the region continues as part of the inpatient service improvement programme (COO/ CPO, to review December 2023) • The focus on recruitment to inpatient areas continues (CPO, review monthly, December 2023) • A full review of inpatient ward establishments is underway and reporting through the inpatient service improvement programme (November 2023, DNQ)	29 March 2024	Executive Management Group (EMT) (monthly) Operational Management Group (OMG) Safer staffing inpatient and community group QSC Trust Board	6	BAF Ref, SO 2 & 3	30 November 2023 **Note for Trust Board: Propose to reduce the likelihood from 4 likely to 3 possible with the risk score reduced from 16 (red) to 12 (amber) due to increase in control measures.**

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
				• Bank recruitment now embedded • New roles group leads on the development of a range of options including ACP (Advanced Clinical Practitioner)										
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	QSC	• The leadership team monitor the use of seclusion across all areas • Seclusion rooms on different wards can be accessed if available. • Datix reporting and review process • Urgent estates response process • A costed plan being implemented against agreed standards • Seclusion and segregation oversight group reports to the clinical governance group. • clinical environment clinical safety group oversight.	4 Major	~~4 likely~~ 3 Possible	~~16~~ 12	1-6 Clinical risk	• Learning from the work in forensics, Horizon and other similar organisations, is being used to inform improvements in acute services and will be overseen by the clinical environment and clinical safety group (DNQ, November 2023)	31 January 2024	QSC Executive Management Team monthly Operational Management Group (regular updates) Clinical Environment clinical safety group Trust Board	4	BAF Ref SO 2	30 November 2023 **Note for Trust Board: Due to work undertaken to improve seclusion rooms, there is a proposal to reduce the likelihood from 4 likely to 3 possible.**
1368	Risk that given demand and capacity issues across South & West Yorkshire and nationally, children and younger people requiring admission to hospital will be unable to access a Child and Adolescent Mental Health Services (CAMHS) bed. This could result	COO	QSC	• Bed management processes • Community options explored. • Protocol in place for admission of children and younger people on to adult wards. • Child and Adolescent Mental Health Services (CAMHS) in-reach support to mental health wards and to acute hospitals • Regular report to board (Integrated Performance Report)	~~4 Major~~ 3 Moderate	4 Likely	~~16~~ 12	1-6 Clinical risk	• Wrap around in reach Child and Adolescent Mental Health Services (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 executive TRIO ensure appropriate escalation to partners where an appropriate solution for a child is not available (TRIO review November 2023) • Participation in the collaborative work continues (review January 2024)	31 January 2024	QSC Executive Management Team (EMT) (monthly) Operational Management Team (OMG) Trust Board (each meeting through integrated	4	BAF ref: SO 3	30 November 2023 **Note for Trust Board: There is a proposal to amend the risk description in relation to the impact of bed closures. There is a proposal to reduce the consequenc**

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
	in young people being care for on adult wards in the secure CAMHS estates or secure hospitals which could have an impact on the quality and experience of their care.			• Safeguarding team provides scrutiny of all under 18 admissions. • Leeds and York Care collaborative board and operational cell system wide (West Yorkshire) • System-wide panels review the demand and take action to address delays • Care, Education, Treatment Reviews (CETR) are in place for children with learning disability and autism. • Management and clinical supervision of staff							performance report)			**e from 4 major to 3 moderate (risk score reduces from 16 red to 12 amber) as this is mitigated through the controls in place that support the individual child.**

ORGANISATIONAL LEVEL RISK REPORT

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
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 Executive Management Team (EMT) oversight of progress made against cost saving schemes. • Active engagement in West Yorkshire and South Yorkshire Integrated Care Systems (ICS)s. • Active engagement on place-based plans. • Enhanced management of Cost Improvement Programme (CIP) programme. • Integrated change management processes. • Non-Executive Director led Finance, Investment & Performance Committee. • 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. • Operational and financial plan in place for 2023/ 2024 • 2023/24 financial plan presented to and	3 Moderate	3 Possible	9	1-6 Financial risk	• Draft longer-term financial sustainability plan presented to Board in Q2 (DFR) • Reinstatement of efficiency delivery and monitoring. (DFR, Ongoing review via Operational Management Group monthly) • Implement patient level costing for use by Directorates (DFR, March 2024) • Finalise longer term financial sustainability plan in line with Integrated Care Board (ICB)/ national requirements and Board feedback (DFR, Q4) • Implementation of Integrated Care Board (ICB) level cost controls should be fully in place by the end of Quarter 3 e.g. vacancy, agency and non-pay (DFR) • Staff engagement to develop efficiency ideas (Q3, DFR)	29 March 2024	Executive Management Team (monthly) FIP (monthly) Operational Management Group Trust Board (quarterly)	4	BAF Ref, SO 3	30 November 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
				approved by the Board in March 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)										
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	QSC	• The Electrical Biomedical Medical Engineering (EBME) equipment / infection prevention and EBME contract has been reviewed and awarded, part of the new contract. • COO has circulated communication to Managers reminding them about medical device requirement • Equipment register in place • Purchasing process • Appointment of project manager • Raised awareness in the Care Group governance meetings and the QSC (see assurance and monitoring column) • Partnership working with Mid Yorkshire NHS Trust • A blue light alert was shared across the organisation in July 2023. • Project manager is in post and contract has been extended to December (may extend this further to March 2024) • Medical devices and safety alert group monitor EBME compliance figures quarterly.	4 major	3 possible	12	Clinical risk 1 – 6	• Review Medical devices workload and review business case for trust wide medical devices officer (DNQ and DFR, November 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 Executive Management Team. • 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, review November 2023 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)	31 January 2024	Clinical governance / care group clinical governance QSC Safety and resilience Task Action Group Operational Management Group (OMG) Medical Devices Task Action Group Executive Management Team (EMT) Trust Board	2	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)	30 November 2023 **Note for Trust Board: Work is progressing and the risk score will be reviewed in the Quarter 3.**

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
				• Project manager reviews the EBME compliance figures monthly. • Medical devices/ new equipment request and approval form including trials has been updated. • Medical devices intranet pages updated. • Medical devices lifecycle flowchart has been produced (easy guide) and has been disseminated across all care groups/ intranet			9	1-6 Clinical risk				3		
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 acuity, could have a detrimental impact on the culture of a team which could then lead to patient harm.	COO CMO DNQ CPO	QSC PRC	• Agendas and terms of reference for Care Groups and Operational Management Group • 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 • Operational Management Group and PRC receive detailed reporting • Safer Staffing reporting into monthly Integrated Performance Report • 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	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, November 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 is underway on practice and reporting of supervision (DNQ, November 2023) • Progress the complaints improvement programme (DNQ, November 2023) • Inclusive culture and management plan in place and roll out commenced (CPO continuing, November 2023) • Developing an approach and policy to adopt just and learning principles across our employee relations, workshop arranged for 2023 and will involve the new Head of People Experience (CPO, review December 2023) • To explore new and innovative ways to deliver learning and development to enable staff to be released in shorter periods (Ongoing, CPO)	29 March 2024	Operational Management Group Executive Management Team Clinical Governance Group QSC PRC Trust Board	3	BAF Ref SO 2	30 November 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
				• An agency scrutiny group meet to look at reducing agency workers and increase bank recruitment.			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 guidance as part of the Workforce Support Hub. • Staff counselling. • Health lifestyle support on Stop Smoking and weight management. • Support and engagement from all staff networks. • Equality Impact Assessment of staff health and wellbeing offer and occupational health. • 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	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 2022/23 staff survey results are being implemented and a review of actions is being undertaken (CPO, November 2023)	29 March 2024	Safer staffing reports (monthly) Moving forward group PRC EIIC Operational Management Group Executive Management Team Trust Board	9	BAF Ref: SO 4	30 November 2023
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	QSC PRC	• All Datix which relate to staffing issues are presented to the weekly clinical risk panel and escalated to Executive Management Team 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	4 Major	3 possible	12	1-6 Compliance risk	• New roles processes are being explored across the West Yorkshire Mental Health Collaborative (DNQ, November 2023) • Further roll out considered of Tendable in Forensic and community services (DNQ, November 2023) • Safecare is being rolled out in the Dales, Ward 18 and Lyndhurst (DNQ Review December 2023)	31 January 2024	Operational Management Group Executive Management Team Trust Board QSC PRC Trust Board	6	BAF Ref SO 4	30 November 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
				• 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 guardians in place and expanded • 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 restraint when working with reduced substantive staff • 'Tendable' (outcome monitoring tool) is in place in Mental Health Inpatient Units • Safecare has been rolled out in Forensics and Barnsley Mental Health Inpatients in September 2023									
1689	~~Risk that the Trust cannot evidence that it has mitigated against or addressed health inequalities in both the provision and restoration of services.~~ Risk that the Trust cannot evidence that it has mitigated against or addressed health inequalities in the provision of services potentially exacerbating	DS	EIIC	• Joint Strategic Needs Assessment (JSNA) in each place • Integrated strategy and associated annual action plans • Workforce data including Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) • Equality Impact Assessments (EIA) including action tracker in place • SystmOne equality data accessible via the Intranet • Annual Equality Report	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) • 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, Quarter 3 2023/24) • Comms plan to be developed to share examples of impact more systematically following the production of the annual report (March 2024, DS)	29 March 2024	Recovery and reset monthly Executive Management Team EIIC quarterly meeting and bi-monthly sub-committee Executive Management Team Trust Board	6	BAF Ref SO 1 **Note for Trust Board: There is a proposal to change the risk description to consider the impact of the risk.**	30 November 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
	existing health inequalities for our service users.			• 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 • Making Data Count Change Manager recruited (DS) • Improving access to care priority programme established (COO) • Equality Impact Assessment (EIA) digital administration tool to disaggregate data and actions being taken is now in place • Equality Delivery System (EDS) • Training and awareness sessions in place • Working with partners in each place to address inequalities through place partnerships • 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 • Equality Impact Assessment (EIA) and equality and inclusion										

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
				themed development sessions and diversity training ongoing programme in place • Dashboard reviewed in EIIC as part of routine monitoring (waiting times and access)										
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	QSC	• 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 – attendance at contract meetings. • Monthly review through performance monitoring governance structure via EMT of key indicators and regular review at Operational Management Group (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 and Wellbeing board meetings. • Active involvement in the development and implementation of place based plans and priorities across West and South Yorkshire integrated care systems and place specific initiatives e.g winter planning.	4 Major	~~3 possible~~ 4 likely	~~12~~ 16	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 (31/01/24/ 31/05/24) • To work with partners in Kirklees specifically to mitigate the impact of council funding for children and young peoples mental health services (DPD, November 2023)	31 May 2024	Care Group (monthly) Executive Management Team (monthly) Operational Management Group (regular) QSC Trust Board (each meeting through integrated performance report) Annual review of contracts and annual plan at Executive Management Team and Trust Board	6	BAF Ref: SO 1, 2 and 3 **Note for Trust Board: Proposal to increase the likelihood from 4 likely to 3 possible as a consequence of Kirklees council funding reductions.**	30 November 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
				• Clinical and quality Trust representation now established in all place based quality committees										
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	QSC	• Coordinated approach to staffing the 136 unit between Intensive Home Based Treatment Team (IHBTT) and inpatient areas • Bed management processes • Staff rotas • Multi-agency 136 group (regular meeting) • Joined up work with the police and integrated systems is in place in all areas regarding Section 136. • Process for inpatient care delivery when someone is delayed in the 136 suite. • Datix reporting • Additional staffing capacity agreed (Barnsley) • Clinically ready for discharge escalation processes	3 Moderate	3 Possible	9	1-6 Clinical risk	• Work is progressing well across both Integrated Care System (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) • South Yorkshire Integrated Care System (ICS) are working through options for 136 provision for 16-18 year olds (COO, review January 2024)	31 January 2024	Operational Management Group (OMG) QSC Executive Management Team (EMT) Trust Board (each meeting through integrated performance report)	3	BAF ref: SO1	30 November 2023
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 South Yorkshire and West Yorkshire 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 West Yorkshire and South Yorkshire.	4 Major	3 possible	12	1-6 Financial risk	• Partnership agreement and risk share in South Yorkshire – discussions ongoing (DFR, end of March 2024) • Submitted benchmarking information as part of national return across the West Yorkshire providers (DFR, results expected December 2023 2023 • Progress sub-contracts to signature still outstanding. Collaborative committee have set target for December 2023 (DFR, December 2023) • Ongoing dialogue with NHS England to resolve contractual position in relation to South Yorkshire provider (DFR, review end of December 2023)	29 March 2024	CC Executive Management Team (monthly) Trust Board	4	BAF ref: SO1	30 November 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
				• 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 (West Yorkshire) and Clinical governance meeting in place to ensure oversight of any quality and clinical risks and mitigations • Clinical Lead roles in place West Yorkshire and Clinical Director in place for South Yorkshire. • 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)			8	1-6 Clinical risk				6		
1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	COO	QSC	• Incidents reported on Datix and reviewed through risk panel • First point of contact in all areas • Children waiting for a neurodevelopmental assessment with mental health needs are supported by core Child and Adolescent Mental Health Services (CAMHS)	4 Major	2 Unlikely	8	1-6 Clinical risk	• Escalate the need for additional capacity to be confirmed within Kirklees (COO November 2023) • Changes to delivery system in crisis and eating disorder pathway remain in place and continue to be monitored (COO, December 2023) • Actions relating to access to CAMHS services and reducing inequalities continue to be implemented as part of the Improving Access priority workstream (COO, Review December 2023)	31 January 2024	OMG QSC Executive Management Group – monthly Individual district performance reports	6	BAF Ref SO 2	30 November 2023

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
				• Emergency response process for those on the waiting list. • Routine wellbeing checks and support is offered to children who are waiting. • Waiting list initiatives CAMHS performance dashboard • Active participation in Integrated Care System - CAMHS work • Ethnicity monitoring in place. • Technological solutions are embedded. • CAMHS Improvement Group • The Improving Access to Care Priority Programme						reviewed by care group Trust Board			
1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	COO	QSC	• Feedback through insight reports, customer service contacts and friends and family tests • Waiting lists reported through the care group meetings to Operational Management Group • 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 as appropriate for service users and carers. • Report to Financial Investment and Performance Committee routinely with exception report to Quality and Safety committee. • Waiting list initiatives • Ethnicity monitoring is now in place to monitor whether there is a disproportionate impact	4 Major	3 Possible	12	1-6 Clinical risk	Waiting list reports are provided on SystmOne and being rolled out to all areas and include hidden waits (COO/ DFR, review December 2023) • Deprivation data has recently been included alongside ethnicity data – reporting on analysis and understanding of this data will be improved through the waiting list report (COO, December 2023) • The executive trio are reviewing the clinical assessment processes to ensure that clinical risk is informed by any inequality issues (TRIO, Ongoing 2023) See comments	31 January 2024	Performance reporting to Operational Management Group QSC Executive Management Team monthly. Assurance report to QSC Committee. Individual district performance reports reviewed by Care Group. Trust Board	6	BAF Ref SO 2 Inequalities in terms of access, treatment and support (includes risk assessment) is a key focus in the priority programmes 'Improving Access to Care' and the 'Care Plan Risk Assessment Improvement Group'; and is one of the golden threads in all the others. This is being supported operationally by significantly improved data quality and wider access to	30 November 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
				for specific communities or groups. • Priority programmes report to Board, Executive Management Team and Operational Management Group • Internal audit									and understanding of this data on the front-line.	
1159	~~Risk of fire safety. risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.~~ The risk of fire 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 Senior Managers. • Quarterly review undertaken by Estates Trust Action Group. • 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 broken down by face to face and e-learning which is measured monthly at Operational Management Group. • 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.	4 Major	3 Possible	12	1-6 Compliance risk	• Task and finish group working on implementation of smoke free policy (CMO, November 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)	29 March 2024	Executive Management Team Estates Trust Action Group (monthly) Safety Trust Action Group (Quarterly) Operational Management Group (monthly) AC Trust Board	6	BAF Ref, SO 2 **Note for Trust Board: There is a proposal to amend the risk description to include reference to other causes of fire rather than just arson.** 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.	30 November 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
				• 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. • QSC and the Audit Committee are updated (AAA report) at each committee meeting as part of routine sub-committee updates (monthly, DNQ) • The use of vapes on acute wards to support the smoke free policy has been agreed and a specific manufacturer has been identified with supplies only being available through the Trust • The annual statement of fire safety compliance approved by Executive Management Team on 23 March 2023 • Updated Smoke free policy in place.										
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**	QSC	• Clear policies and procedures, and reporting in place, providing framework for the identification and mitigation of patient safety risks. • Appropriate Operational Management Group (OMG), Clinical Governance Group and QSC escalation arrangements in place. • Reducing restrictive practice and intervention (RRPI) improvement plan implementation. • Formulation of informed risk management (FIRM)	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, November 2023) • Complaints policy and metrics subject to further review with regards to quality and response times. Revised proposal agreed and under implementation (DNQ, November 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, November 2023)	31 January 2024	Performance & monitoring via Executive Management Team QSC Operational Management Group Trust Board Patient Safety report &	6	BAF ref: SO 2	30 November 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
				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 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 Reducing Restrictive Practice and Intervention (RRPI) team support learning with front line colleagues • RRPI Team are supporting a shared approach to the Collaborative Bank • Regular Patient safety learning events • Quality strategy approved. • Care group governance is aligned to ensure consistency.						incident report as well as monthly reporting in the Integrated Performance Report			
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	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 annual mandatory training target of 95% presented to Board in June 2023. • Designated Caldicott guardians and Senior	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 information governance 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, March 2024)	30 April 2024	ICIG Operational Management Group Executive Management Team AC Trust Board	4	BAF Ref, SO2	30 November 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
	leading to reputational and public confidence risk.			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 General Data Protection Regulation (GDPR). • Improving Clinical Information and Governance group in place which is the governance group with oversight of information governance issues reporting into Executive Management Team. • Communications and awareness plan e.g. use of blue light system to highlight specific breaches. • Data protection impact assessment process • Targeted approach to advice and support from Information Governance 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 • Comms in place to ensure services are aware of processes for ensuring					• To raise awareness internally due to data sharing via programmes such as Microsoft excel where appropriate safeguards haven't been built in to avoid information governance breaches (DFR, review December 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
				differences between addresses on SystmOne and the NHS Spine are actioned										
1319	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for Psychiatric Intensive Care Unit (PICU) or mental health adult inpatient treatment and therefore they will need to be admitted to an out of area bed. The distance from home will mean that their quality of care will be compromised.	COO	QSC	• Bed management process. • Ongoing partnership work with commissioners • Improving Mental Health Oversight Group • Improving Mental Health Partnership Group • Agreed governance structure • Workstreams in place to address specific areas • 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. • Clinically ready for discharge escalation through multi agency discharge events in each Place. • Specific leadership at associate director level for patient flow. • Patient flow dashboard	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 (COO December 2023) • Continue to ensure escalation of clinically ready for discharge issues through to the MADE process, (COO review December 2023) • Continue to use the West Yorkshire secondary care pathways work to consider implementation of a system wide approach to management of out of area beds to manage peaks in demand. (COO, review December 2023) • Teams continue to work with partners across the Integrated Care System to make best use of the available resources to support discharge. (COO, December 2023) • Maintain the option to block purchase beds, using the continuity of care principles, to support demand through 2023/24 (COO Review December 2023) • Determine assurance reporting for wider impact of reduce out of area use. (December 2023 COO) • Use learning from partners in relation to the continuity of care principles COO review March 2024)	31 January 2024	OMG QSC EMT Trust Board	4	BAF ref, SO 3 Out of area use has reduced significantly over August and September 2023. The improvement group are developing assurance reporting in relation to the wider impact of reduced out of area bed use.	30 November 2023
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	DFR	FIP	• Detailed internal capital planning and prioritisation process. • Integrated Care System (ICS) capital allocation process. • Internal cash availability. • Approved updated digital strategy. • System capital planning process.	3 Moderate	3 Possible 4 Likely	9 12	1-6 Financial risk	• 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, December 2023) • Capital costs are incorporated into the older peoples strategy which is due to	29 March 2024	Executive Management Team (monthly) FIP (monthly) Trust Board	4	BAF ref: SO 3 **Note for Trust Board: Proposal to increase the likelihood from 3 possible to 4 likely in relation to the**	30 November 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
	strategic objectives and priorities.			• Effective communication of Trust capital priorities to West and South Yorkshire Integrated Care System (ICS) partners. • Capital allocation for 22/23 meets out needs • The overarching Integrated Care Board (ICB) capital allocation and their tracking of system wide expenditure against it • Refreshed estates strategy ratified at July 2023 Trust Board • Estates strategy approved by Trust Board in July 2023					go to public consultation imminently (DFR, December 2023) • To consider the ambitions within the Estates Strategy vs available resources (DFR, March 2024)				**capital regime.**	
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 Equality Delivery System2 (EDS2), Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).	**CPO**	EIIC	• Annual Equality Report. • Equality Impact Assessment. • Staff Partnership Forum. • Development and delivery of joint WRES, WDES and EDS2 action plan with local implementation actions being developed • 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	3 Moderate	3 Possible	9	1-6 Compliance risk	• Equity Guardians to be further embedded across services (CPO and DNQ, November 2023) • Race Forward action plan to tackle harassment and bullying from service users and families and also colleague experience of micro aggressions, is being co-produced with the Race Forward Group and taken forward by the Diversity, Inclusion and Belonging Lead (DNQ, review November 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 November 2023) • Use of staff survey data to improve staff experience with a focus on feedback from all diverse groups (CPO, November 2023) • FLAIR survey concluded. Recommendations and actions now being taken forward by diversity and inclusion and belonging lead (CPO, November 2023) Head of People Experience undertaking a review of staff networks (CPO, November 2023)	29 March 2024	Executive Management Team (EMT) (quarterly) EIIC Committee (quarterly) Trust Board	6	BAF ref, SO 1 and 4	30 November 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
				• Civility and Respect Guardians in place to support cultural change and staff experience decision-making groups • Internal review panels in place for disciplinary and grievance cases related to discrimination on the grounds of race. • Race Forward programme is established with a series of meetings now in place • Ongoing engagement with regional partners and our regional lead from NHS England with regards to disparity in ethnicity representation across nurse bandings					• Development of equality dashboards for EIIC to track data, progress and improvements (CPO, ongoing)					

ORGANISATIONAL LEVEL RISK REPORT

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
1840	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	• 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 Integrated Performance Report • Local systems are in place to ensure completion and oversight of appraisals • People, Performance and planning lead has commenced • Supervision of the clinical workforce policy (next review December 2024)	3 Moderate	~~3~~ ~~Possible~~ 4 Likely	~~9~~ 12	8-12 Business Risk	• Full procurement exercise to be undertaken for Appraisal system by December 23 to ensure most suitable system is being utilised by the Trust which must interface with existing workforce systems (ESR) – March 2024 (CPO, March 2024) • Inpatient Lead supporting improvement work across the wards (COO, DNQ, January 2024) • Limited resources in the people planning performance function, additional resources to be sourced (CPO, estimated start date for November 2023) • Local arrangements being created to record appraisals, these need to be moved from paper based recordings to the Workpal system (COO, This continues to be reconciled, to review in November 2023)	29 March 2024	PRC Executive Management Team (EMT) Operational Management Group (OMG) Trust Board	6	BAF Ref: SO4 Systems interoperability (ESR does not link to the system so managers are not automatically assigned correctly) **Note for Trust Board: There is a proposal to increase the likelihood from 3 possible to 4 likely as the appraisal target has not been met. There is work ongoing to bring appraisals on the Trust approved system (Workpal).**	30 November 2023
1839	Maintaining people who are clinically ready for discharge in an inpatient bed impacts on bed capacity.	**COO**	QSC	• Patient flow processes establish barriers to discharge on admission • Routine multidisciplinary reviews • Care programme approach and care plans in place • Improving Mental Health Oversight Group • Improving Mental Health Partnership Group • Care Closer to Home steering group	3 moderate	4 likely	12	8-12 Strategic risk	• Continue to implement the improvement plan (COO review December 2023) • Clinically ready for discharge issues continue to be escalated through to MADE meetings ,improvement work and the partnership group. (COO December 2023) • Where MADE meetings have not reached a solution, a Gold command meeting will be established. (Ongoing, COO review December 2023)	31 January 2024	Executive Management Team Operational Management Group QSC Trust Board	6	BAF Ref: SO2	30 November 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
				• 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.					• 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 December 2023) • Review is underway in relation to the identification and reporting of people who are clinically ready for discharge in Forensic services (COO to review December 2023)					
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 Integrated Care Systems • Regular reporting to Operational Management Group and Executive Management Team • High level comms messages agreed. • Stepping down procedure agreed. • A separate strike committee was established to manage and consult with the British Medical Association on the terms and conditions for those doctors striking. This group can be reconvened as needed. • Silver command meetings to manage industrial action by	4 ~~Major~~ 3 Moderate	3 possible	~~12~~ 9	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) • Multi-disciplinary operational work in place to manage the impact of industrial action and mitigate risks (Ongoing, COO, CMO) • Trust will be kept informed via paper to PRC (COO/ CPO/ CMO, as required)	31 January 2024	PRC Operational Management Group Executive Management Team Joint Information Cell Task and Finish Group Trust partnership forum Trust Board	9	BAF ref: SO 2 **Note for Trust Board: There is a proposal to reduce the consequence from 4 major to 3 moderate. The impact has been reduced as actions to mitigate patient care are established.**	30 November 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
				junior doctors and consultants • Report to People and Remuneration Committee and Quality and Safety Committee by exception										
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy	DS	QSC	• 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. • Quality improvement process in place for all significant change. • Equality Impact Assessment in place Trustwide • 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. • Internal place integration group now established	3 Moderate	2 Unlikely	6	1-6 Clinical risk	• Close involvement in Barnsley place to monitor potential impact and take measures to mitigate. (DS and COO March 2024) • 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, March 2024) • Review and update all of you approach to support systematic impact and improvement (DS, March 2024) • To deliver priorities within the sustainability strategy, (DS, March 2024) • Develop and introduce sustainability impact assessments (DS, March 2024)	29 March 2024	EMT (monthly) Transformation board (monthly) Operational Management Group (weekly) QSC Trust Board	6	BAF Ref: SO1 & 2	30 November 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
				• 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										
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	QSC	• Progress on system and service transformation reviewed by Board and Executive Management Team (EMT). • Quality Impact Assessment process for Cost Improvement Programme and Quality Innovation Productivity and Prevention (QIPP) savings in place. • Alignment of contracting and business development functions • Bi-annual Executive Management Team and Trust Board investment appraisal report • Progress on system and service transformation reviewed by Executive Management Team and Trust Board. • Active engagement in West Yorkshire and South Yorkshire Integrated Care System (ICS) • Financial control process to maximise contribution. • West Yorkshire Mental Health and Learning Disability collaborative services board • Approach to collating and reporting insight from stakeholders place.	3 Moderate	2 Unlikely	6	8-12 Strategic risk	• On-going review with Integrated Care Boards of our plan during 2023/24 (DPD, 31 March 2024) . • To continue to develop Barnsley Integrated Health and Care Alliance with partners delivering on agreed plans and priorities (DS/COO, March 2024) • Consider the guidance on responsibility and partnership working and how we build capacity and capability to respond (DS/ DPD March 2024)	29 March 2024	QSC Executive Management Team (monthly) Trust Board	6	BAF Ref, SO 1 & 3	30 November 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
				• 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 Integrated Care System level quality boards (DNQ/CMO) • Trust have been involved in all Place based plans			6					6		
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	QSC	• 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 Integrated Care Systems and other place-based planning initiatives. • Equality, Involvement, Communication and Membership strategy. • Stakeholder plan developed with regular	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 March 2024 • Alignment of priorities through provider alliances and integrated care partnership (DPD, March 2024) • 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. QSC Trust Board reports as appropriate	6	BAF Ref, SO 1 & 2	30 November 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
				review through Executive Management Team • 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 • Trust transformation and significant change plans aligned with commissioner's plans as set out in local Integrated Care System place-based plans				9	8-12 Strategic risk						
1649	The current inconsistency in Speech and Language Therapist (SALT) provision could compromise the quality of care available in response to choking incident.	DNQ CMO	QSC	• Situation, Background, Assessment, Recommendation (SBAR) issued communicating importance of identifying choking risks • Choking awareness training slide pack produced and circulated • Multi-disciplinary Team choking risk assessment for all inpatient areas in place • The Trust secured the services of an independent Speech and Language Therapist (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	3 Moderate	3 Possible	9	8-12 Strategic risk	• Audit planned regarding compliance and quality improvement for the choking screening tool (DNQ, Undergoing audit, review January 2024) • 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 (November 2023, DNQ/CMO) • Trust central resource for SALT, next stage is confirming contribution from all care groups. Job descriptions have been developed (DNQ, November 2023)	31 January 2024	QSC Operational Management Group Executive Management Team (monthly) Trust Board	6	BAF Ref: SO 2	30 November 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
				• A learning event from the thematic review is also available to watch on the Trust intranet (information regarding choking) • All wards are delivering protected mealtimes. • Adult Dysphagia and Choking Policy has been approved by Executive Management Team • 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									
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	QSC	• 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 • Blanket restrictions are now in place where necessary as there are gaps under the fence where contraband can be placed under or through	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) December 2023 • Each area will maintain a risk assessment to understand the potential climb risks. (COO, ongoing, review quarterly December 2023) • Where appropriate, supervised access to garden areas is maintained. (ongoing, review quarterly (COO, December 2023) • The clinical environment safety group meeting will review this risk area and make a recommendation regarding future actions (DNQ, Review every 6 months, March 2024) • Operational, clinical and Estates teams are working together in the clinical environment clinical safety group to use learning from previous incidents to improve across all areas (COO/DNQ review November 2023) – see notes	29 March 2024	QSC Clinical Environment Safety Group Executive Management Team (monthly) Trust Board	6	BAF ref: SO 2 A full review of the risk action will be undertaken at the clinical environment safety group meeting in November 2023	30 November 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
				• Improvement work in the garden area at the Dales is complete.					• The clinical safety group will review the findings of the incident which took place in October 2023 and review the risk in November 2023 (DNQ November 2023)					
1217	~~Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.~~ Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives, potentially resulting in the Trust or system not meeting service users' needs	DS	AC	• Programme prioritisation processes. • Overall priority progress reports via monthly Integrated Performance Report. • Individual priority programmes via governance groups of change and partnership board, OMG and EMT. • Resources established aligned to programmes. • Annual planning process. • Leadership framework to build capability and to include change competencies. • Quality strategy approved and implementation plan established. • Integrated Change and Improvement Network established to develop critical mass across the organisation. • Development and implementation of interim executive leadership arrangements now in place • Additional capacity aligned to the Trust to support Alliance and partnership work in Wakefield, Kirklees and Barnsley • Additional capacity secured for identified programmes • The new Quality Strategy was approved	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 Institute for Healthcare Improvement (IHI), QSIR (Quality, service improvement and redesign programme) and other development programmes (DS, March 2024) • Discussions ongoing with each place Integrated Care Board (ICB) team to review opportunities for transfer of capacity as part of ICB operating cost review (DPD, December 2023)	31 May 2024	Quality Strategy update to QSC AC Operational Management Group (OMG) Executive Management Team (EMT) Trust Board	9	BAF Ref, SO 3 **Note for Trust Board: The risk description has been reviewed to consider the impact of the risk.**	30 November 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
				by Trust Board in March 2023										
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 • Streamline Internal transfer process established	3 Moderate	~~2~~ ~~Unlikely~~ 3 Possible	~~6~~ 9	8-12 Strategic risk	• ‑Develop our approach to diversity and leadership including our approach to talent management, (CPO, review November 2023) • Supporting Fellowship Programme across the system as opportunities arise (CPO, Ongoing 2023) • Organisational Development plan being developed (CPO, December 2023) • Review of succession plans following new Board appointments (CPO, December 2023) • Raising awareness via the staff network groups on opportunities and strategies (CPO, Ongoing) • Working with our places and systems to collaborate on integrated career pathways and opportunities (CPO & DNQ ongoing work) • Increase bank opportunities for all substantive staff through automatic enrolment on bank (CPO and COO, review November 2023)	29 March 2024	PRC Executive Management Team Trust Board	4	BAF Ref: SO 3 **Note for Trust Board: Proposal to increase the likelihood from 2 unlikely to 3 possible due to the length of time taken to progress the risk actions.**	30 November 2023

COVID-19 RISKS

Risk level <15 – risks outside the risk appetite

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1522	Risk 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	QSC	• 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. • Infection Prevention Control of infection support in place. • Agreed pathway with acute providers to access clinically appropriate support for Covid-19. • Situation, background, assessment, recommendation (SBAR) templates are produced to share learning from outbreak management investigations. • Timely delivery of flu vaccination programme • Routine reviews of IPC Board Assurance Framework reported to NHS England and NHS Improvement via QSC committee. • Ongoing review of IPC practice in line with regional and national guidance, and local feedback. • High risk groups / vulnerable patients, either due to underlying health	4 Major	3 Possible	12	1-6 Clinical risk	• Work ongoing around promotion of autumn vaccination programme to both staff and service users (DNQ, Ongoing) • Continuing monitoring and review for learning of any Covid-19 cases and outbreaks (DNQ, review ongoing) • Planning the autumn/winter flu vaccination programme 2023/24 (DNQ / CPO)	29 March 2024	QSC Executive Management Team (monthly) Moving Forward Group Operational Management Group Improving Clinical Information Group (ICIG) Trust Board	4	BAF ref: SO 2	30 November 2023

Risk ID	Description of Risk	Risk Owner	Nominated Committee	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
				conditions or certain protected characteristics (notably people from a Black and Minority Ethnic (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.										
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 the public inquiry.	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) • Reports to EMT, Audit Committee and Trust Board via AAA report.	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, November 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 colleagues.(DDCG, Review November 2023)	31 January 204 The completion date has been extended due to modular approach to inquiry (NHS Trusts module 3 to commence 2023 (continue to review on a monthly basis)	AC Moving Forward Group Covid Inquiry Task and Finish Group Operational Management Group Executive Management Team Trust board	6		30 November 2023

Appendix 1

<div align="center">

Trust Board
31 October 2023
Organisational Risk Register (ORR)
Quarter 2 analysis, January 2021 – October 2023

</div>

This heat map includes figures from the current Organisational Risk Register from January 2021 to October 2023 as well as the proposed changes.

Total number of risks from January 2021 to October 2023
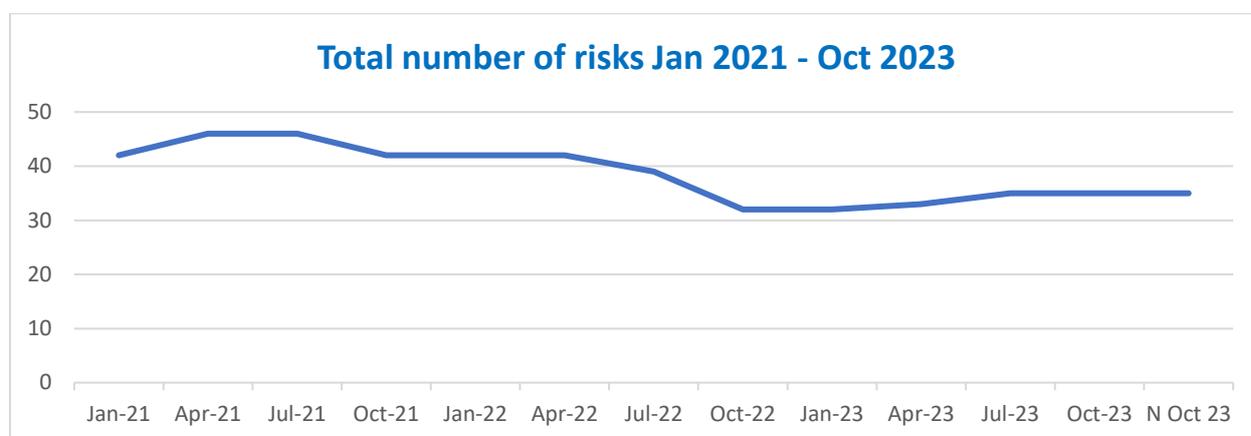
Proposed changes = N Oct 2023

Total risk score by grading from January 2021 – October 2023
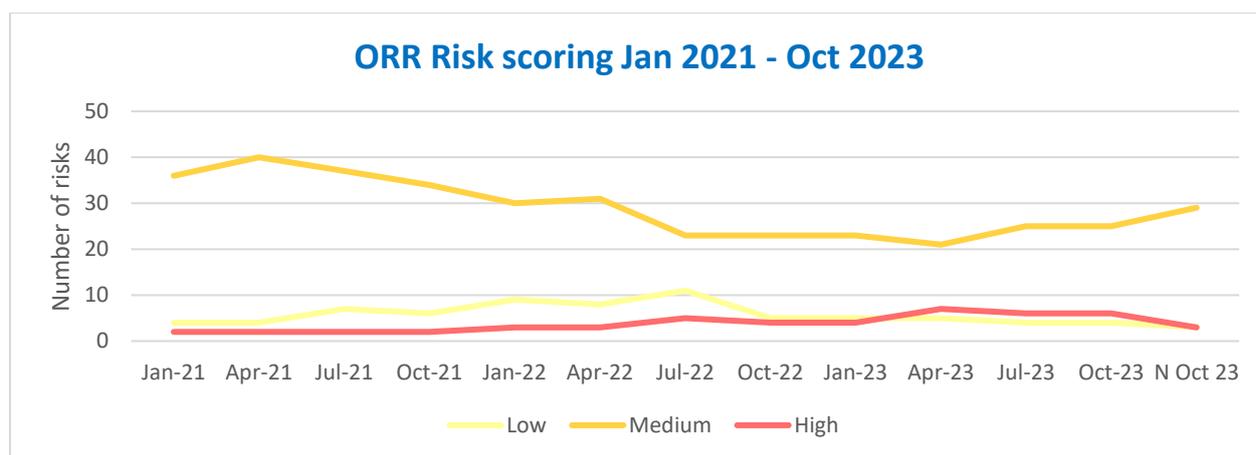
Proposed changes = N Oct 2023

A current breakdown of Trust objectives ORR Quarter 2 2023/24

**Risk scoring by Trust objectives
ORR Quarter 2 2023/24**

Trust Objectives

- Making this a great place to work
- Improve Resources
- Improve Care
- Improve Health

0 2 4 6 8 10 12 14 16 18

Total risk

Low Medium High

Proposed changes

**Risk scoring by Trust objectives
ORR Quarter 2 2023/24 (proposed)**

Trust Objectives

- Making this a great place to work
- Improve Resources
- Improve Care
- Improve Health

0 2 4 6 8 10 12 14 16 18

Total risk

Low Medium High

Trust Board (Business and Risk) Heat map 31 October 2023
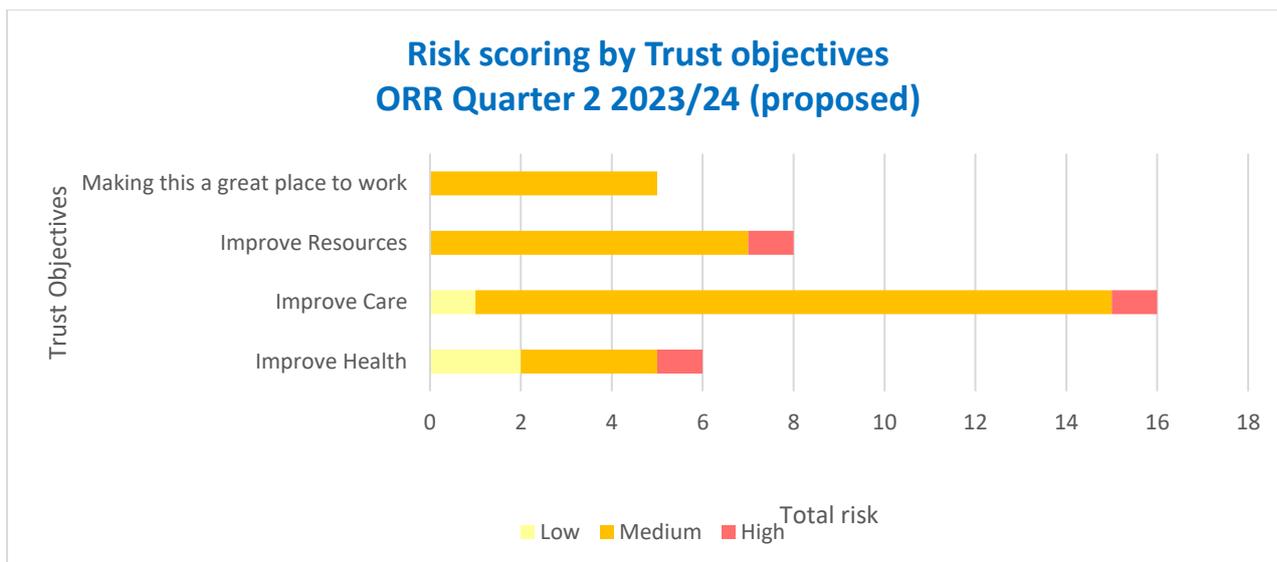
Total number of risks by Trust objectives ORR Quarter 2 2023/24

**Total risk score by Trust Objective
ORR Quarter 2 2023/24**
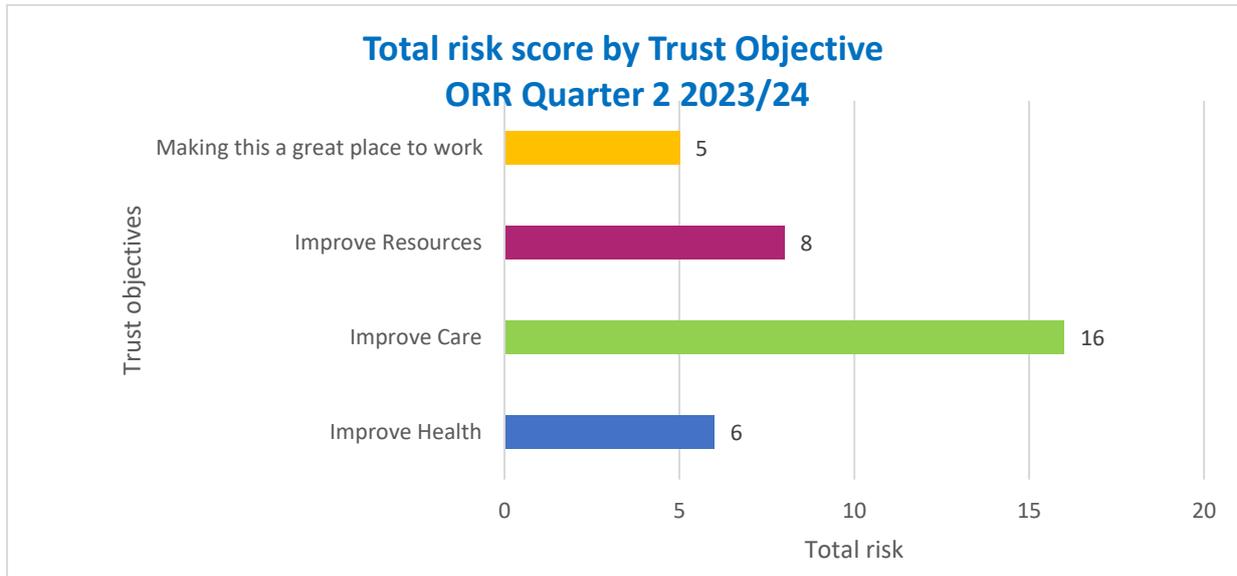
There have been no changes to the number of risks held by **objective** in line with the proposed changes submitted to Trust Board.

With **all of us** in mind.

Trust Board 31 October 2023
Agenda item 9.4

Private/Public paper:	Public
Title:	Annual Report - Social Responsibility & Sustainability Strategy/Green Plan
Paper presented by:	Dawn Lawson, Director of Strategy and Change Sue Barton, Deputy Director of Strategy and Change
Paper prepared by:	Sue Barton, Deputy Director of Strategy and Change Tony Wright, Sustainability Change Manager Nick Phillips, Deputy Director: Estates and Facilities
Mission/values:	The proposals are in line with the Trust's mission and values
Purpose:	To update the Trust Board on progress following the adoption of the Social Responsibility & Sustainability Strategy and to provide the annual update on the Trust's Green Plan.
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	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 1.4 - 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 3.1 - Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively 3.3 - 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 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 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

With **all of us** in mind.

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Social Responsibility & Sustainability Strategy was developed through extensive consultation with partners. It is aligned to work across the integrated care system.
Any background papers/previously considered by:	Social Responibility & Sustainability Strategy agreed at Trust Board in July 2022. Trust Carbon Footprint 2021-22 presented to Trust Board in October 2022.
Executive summary:	**Background & Introduction** Since the Trust Board agreed the Social Responsibility & Sustainability Strategy (SRS) in July 2022, lots of work has taken place. This report provides an update to Board on the achievements and next steps. The SRS is now a golden thread through all our strategic priorities and everything we do in the Trust. The SRS aims to use the levers we have to maximise the benefits South West Yorkshire Partnership NHS Foundation Trust (the Trust) delivers to local people, communities and places, especially those facing challenge and disadvantage. The SRS identified five areas as headline initiatives and therefore areas of focus to be delivered in partnership with staff, services users and their families and carers. These are: • Partnerships, culture and civic role • Role as an employer • Procurement of goods and services • Management of environmental impacts, our estate and assets • Engagement with less advantaged and diverse communities to maximise the responsiveness, value, inclusiveness and uptake of our services **Key Achievements** The report contains details of achievements. A few are summarised here as key achievements in line with the SRS: • Development of a new role and recruitment to the post of Sustainability Change Manager • Development of structures to support delivery and governance • Development of metrics and measures to measure impact of the SRS • Employer role - linking with the priority programme on inclusive recruitment and retention • Procurement – supporting the move from 5% to 10% minimum social value rating and the development of the Waste and Repurposing group • Partnerships – developing a wide range of partnership relationships and signing up for initial exploratory stages of Wakefield heat network

- Environment/Assets (Green Plan) – planting 500 trees and enabling the planting of an additional 1200 more planned before the end of 2023 Establishment of new responsibilities from December to support development of Net Zero Carbon Road Map (The Green Plan)
- Medicines optimisation – supporting the pharmacy team to embrace sustainable prescribing such as increased medications reviews and the green bag scheme
- First ever Trust use of Sustainability Impact assessment (SIA) as recommended by WYICB as part of organisational change process with the Older People Transformation programme
- Purchased eBikes and developed procedures for a pilot of their use
- Made all the preparation for an October launch of the SWYPFT Green Team with over 150 staff signed up to be involved
- With the support of Learning and Development have made "Building a Net Zero NHS" ESR module accessible to all interested staff
- Raised the SRS profile via iHub, staff engagement sessions, comms plan, Excellence award, Annual Members Meeting

Next Steps

Three aims are identified for the next 12 months:

1. To deliver the headline initiatives in line with the agreed plans and monitored through the metrics and measures with focus on:
   a. Recruiting a more representative workforce
   b. Developing the work on waste and repurposing
   c. Developing a net zero carbon road map
2. To continue to carry out a series of activities to develop the culture of increased sustainability and social responsibility across the organisation in line with the SRS and our integrated change approach with focus on:
   a. Development of the Green Team
   b. Continued development of outside spaces
3. To continue to develop mechanism to support and embed social responsibility in all that we do and all our partnerships with focus on:
   a. Sustainability Impact Assessments (SIAs)
   b. Capital expenditure
   c. Wakefield heat network

Recommendation:	**Trust Board is asked to RECEIVE this update and NOTE the progress made.**

Trust Board 31st October 2023

Agenda item – 9.4

Annual Report - Social Responsibility & Sustainability Strategy/Green Plan

1. Introduction

The purpose of this paper is to update the Trust Board on progress following the adoption of the Social Responsibility & Sustainability Strategy and to provide the annual update on the Trust's Green Plan.

Since the Trust Board agreed the Social Responsibility & Sustainability Strategy (SRS) in July 2022, lots of work has taken place. One year in, we are full of hope, energised and excited by the progress we have made already and the plans we have in place. It was rewarding to see the investments made in developing the strategy receive recognition from being shortlisted in the new Social Responsibility & Sustainability Excellence awards category at the Trust's Excellence Awards. The SRS is now a golden thread through all our strategic priorities and everything we do in the Trust.

2. Background

2.1 The Social Responsibility & Sustainability Strategy

The SRS aims to use the levers we have to maximise the benefits South West Yorkshire Partnership NHS Foundation Trust (the Trust) delivers to local people, communities and places, especially those facing challenge and disadvantage.

The Trust is a large organisation rooted in the areas we serve – what is often described as an 'anchor organisation.' The care and services we provide make a vital contribution to the health and wellbeing of people and communities across those areas in line with our vision of providing outstanding physical, mental and social care in a modern health and care system, but the difference we can make does not stop there as every aspect of what we do can make a positive contribution to local people, economies and the environment. That includes how and where we procure goods and services; the people we employ and how we employ them, how we manage our buildings, land and resources and the way we interact with partner organisations and stakeholders across the public, private and third sectors. The SRS is about maximising the difference all those things make to reducing disadvantage and inequalities, improving our environmental impact and achieving the Trust's mission of helping people to reach their potential and live well in their communities.

The strategy recognises that the Trust already has policies and approaches in place that support these goals, including through our green plan; our equality and inclusion action plan and our equality, involvement, communication and membership strategy. The approach is to build on and integrate with these, adding value where opportunity arises but avoiding duplication. The delivery of the strategy is a long-term, wide-ranging piece of work which requires input from internal stakeholders and external partners.

The SRS identified five areas as headline initiatives and therefore areas of focus to be delivered in partnership with staff, services users and their families and carers. These are:
- Partnerships, culture and civic role
- Role as an employer
- Procurement of goods and services
- Management of environmental impacts, our estate and assets
- Engagement with less advantaged and diverse communities to maximise the responsiveness, value, inclusiveness and uptake or our services

3. Key areas of progress against the strategy

3.1 Introduction

Following the approval of the SRS and the identification of resources for a post to lead the work, a recruitment process was undertaken to appoint a Sustainability Change Manager. The post was designed to provide a focal point for leading and co-ordinating the strategy. To ensure the approach continued to align to the Trust's integrated change framework, the post was located within the strategy and change directorate. Tony Wright was successfully appointed into the role in September 2022.

In April 2023, the SRS was a subject of an internal audit investigation by 360 assurance and it received a report of **significant assurance.**

We have undertaken focused work around each headline initiatives which is reported below. In addition, there have been many other positive initiatives which have either come out of the launch of the strategy or are directly linked to it. This update includes a summary against these.

3.2 Formal launch

The strategy was formally launched at a face-to-face session of the extended EMT with a high-profile external speaker. The launch was reported in all the key Trust communication mechanisms.

3.3 Structures and ways of working

Since the approval of the strategy, we have undertaken significant work to establish the structures and ways of working to ensure we deliver the agreed aspirations. The approach uses quality improvement methodology as its basis.

A driver diagram was developed with three primary drivers:
1. Delivery mechanisms, governance and reporting
2. Strategy – commence work on headline initiatives
3. Establish change approach

These were used as the structure for an action plan with milestones and responsibilities identified.

We have undertaken a sustainability impact assessment as recommended by West Yorkshire Integrated Care Board (WYICB) as part of organisational change process with the Older People Transformation programme. This has enabled us to understand how the proposed changes will impact on sustainability.

We have established the following structures and ways of working:
- Agreement that the SRS reports into the Equality, Inclusion and Involvement Committee (EIIC) on a six-monthly basis - every June and December. Early reports have been well received.
- Identification of a senior lead person for each headline initiative with clarity on the expectations of the role and actions to be taken.
- Regular catch-up sessions with Trust Deputy Chair in her role as Board lead for Social Responsibility & Sustainability.
- Reports as required into Executive Management Team (EMT) and/or Operational Management Group (OMG).
- Development of a steering group. Membership of the group includes headline initiative lead, and key representatives from Communications, Strategy, Equality and Inclusion and Data Intelligence.
- Links into each of our four places and the two integrated care systems (further details are provided later in the report).
- An SRS communication and engagement plan.
- Regular reporting to Staff Side via the Trust Partnership Forum.
- Adoption of SRS as a golden thread in Trust strategic priorities.
- Attending team/service meetings to engage staff.
- Attendance at the Annual Members meeting.
- Presence at future Trust welcome events.

3.4 Metrics and measurement

A lot of consideration has been given to how we measure the impact of the SRS across each headline initiative, acknowledging that the impact we are seeking will not happen quickly. We have agreed a set of positive changes that we want to see and have established metrics to be able to demonstrate impact. We are also collecting stories and examples of changes that are taking place. This is particularly crucial as part of the delivery of our cultural and creative initiatives as it allows us to fully appreciate the impact of this work through the triangulation of service user, carer and staff feedback, alongside the governed reporting metrics.

The desired positive changes we have identified are:
- Reduction in local health inequalities that relate to air quality such as cases of asthma and respiratory illnesses.
- Increase in the numbers of local people who apply for work and volunteering opportunities within the Trust. Increase in the numbers of local people who we employ.
- Increase in the volume of waste that people choose to recycle responsibly.
- Uplift in numbers of people who switch to for environmentally friendly travel options such as eBikes/cycling or walking. Increase in percentage of people who use a more sustainable vehicle
- Socially responsible commissioning and procurement practices.

A summary report of overall progress against the strategy has been developed and shared with the EIIC. The reporting format includes the presentation of case study examples and the reporting of relevant metrics. Each of the headline initiatives has three associated metrics which form the primary reporting mechanism - further detail on these is presented below under each headline initiative.

In line with the quality improvement approach, the trend data is regularly monitored by headline initiative leads.

We also submit sustainability related data to the Greener NHS initiative on a quarterly basis.

3.5 Headline Initiative: Our role as an employer

We are undertaking work on a recruitment and retention initiative to benefit both existing staff and the communities we serve. We are currently investigating existing data to highlight areas which are not providing us with as many staff as we would hope they would. We will then work with the relevant service managers and other supporting staff to look at how we can engage with those communities and encourage more local people to come and work for the Trust. The current measures we have identified are listed below, however, to ensure we can provide agile and meaningful reporting data, these measures remain under review for further expansion and development as needed.

Current Measures:
1. The percentage of employees residing in a postcode covered by Trust core services with the aim of ensuring that the Trust is offering positive recruitment opportunities within its local population areas.
2. The percentage of employees residing in areas covered by the Trust core services, which are defined as being in the most deprived 20% in England based on the index of multiple deprivation (IMD) data. The aim of this measure is to ensure the Trust is engaging with and supporting employment opportunities within local communities. This is an area which is under review since the measure currently reports Trust-wide level data. It is hoped that by reporting at a place level, we will be able to identify areas requiring a more focused approach.
3. The percentage of staff undertaking external study within the last 12 months. The aim here is to provide a focus for encouraging broader development opportunities and to tackle issues with staff retention. We are considering the future development of this measure. External study offers a broad area to examine, however, we are also keen to consider the internal opportunities that may influence staff retention and/or progression e.g., appraisal completion rates (per care group) compared to staff retention, to determine whether there is any direct correlation between the two.

3.6 Headline Initiative: Social Value Procurement

Increasing the social value element in the procurement of goods and services is a big focus for the Trust and our newly enhanced approach to sustainability focused procurement is increasing the emphasis on the purchase of environmentally friendly and sustainable products such as recycled paper, eco-friendly cleaning supplies and energy-efficient office equipment.

Examples of this work in practice are:
- Supporting the move from 5% to 10% minimum social value rating.
- Operational Management Group (OMG) have agreed guidance for the sustainable procurement and purchase of promotional items.
- Procurement and the estate department are developing a contractor framework that has sustainable activity as a clear part of delivery including the use of local resources as part of the ongoing measurement on performance.
- We have established a Waste and Repurposing Group. The group has responsibility for identifying improvements in our practices when ordering items. This includes considering how to recycle or best dispose of unwanted items and how to reduce waste from packaging. The

group is developing a clear process which can be applied every time anyone wants to order anything.

- A waste segregation scheme is in place which breaks waste down further into specific streams which improves downstream recycling. This has reduced waste cost to the Trust making it largely self-funding.

Measures:
1. The percentage of contracts awarded by the Trust which meet the newly increased minimum 10% rating for social value procurement. The aim of this measure is to allow us to monitor the commitment to social value across all our contract providers.
2. The number of orders placed with local suppliers more than £10k - this is so we can give particular focus to our efforts to use local suppliers wherever possible.
3. Consideration is being given to how we can best monitor existing contracts to ensure that the commitments made on social value procurement are adhered to. Once agreed, details of how this will be monitored will be included in future reporting.

3.7 Headline Initiative: Net Zero Carbon Road Map (The Green Plan)

To enable management of environmental impacts, our estate and assets, we are developing a net zero carbon road map. In advance of this, we continue to work towards the agreed Trust Green Plan. We have renamed this work the zero-carbon road map in line with national directives and to separate it from the Green Team (see 4.1). We have identified a new lead for the development of the Trust's road map and will have a costed model with milestones identified by March 2024.

Key projects for the year are as follows:
- In year, the emphasis is on improving controls on the main sites where we expend energy which are Fieldhead and Kendray. To this end, the building management systems are being upgraded at both sites and linked to a central controller - this will immediately improve the ability to regulate temperatures on some of the more recently refurbished buildings. It will also provide improved reporting of temperatures so we can monitor these against a set of agreed values which will be developed in year for wider consultation.
- The rollout of energy efficient LED lighting continues with significant investment in year for ward-based schemes. This lighting has a longer life with more control applications which are being explored. This will give improved lighting control and therefore provide environmental improvements as well as efficiencies.
- Continued monitoring of the Trust carbon footprint with a view to achieving further reductions through efficiencies including those already described.
- The owned fleet is expanding its use of EV's (electrical vehicles) with a larger commercial van entering the fleet for use and evaluation purposes as a precursor to wider rollout as existing vehicles become ready for renewal. The Trust also has a hybrid vehicle for longer runs as part of this move to ZEV and LEV fleet (zero and low emission vehicles).

The Trust continues to measure its carbon output for the estate and fleet which has seen a reduction from the base year of this year's table is at figure 1.
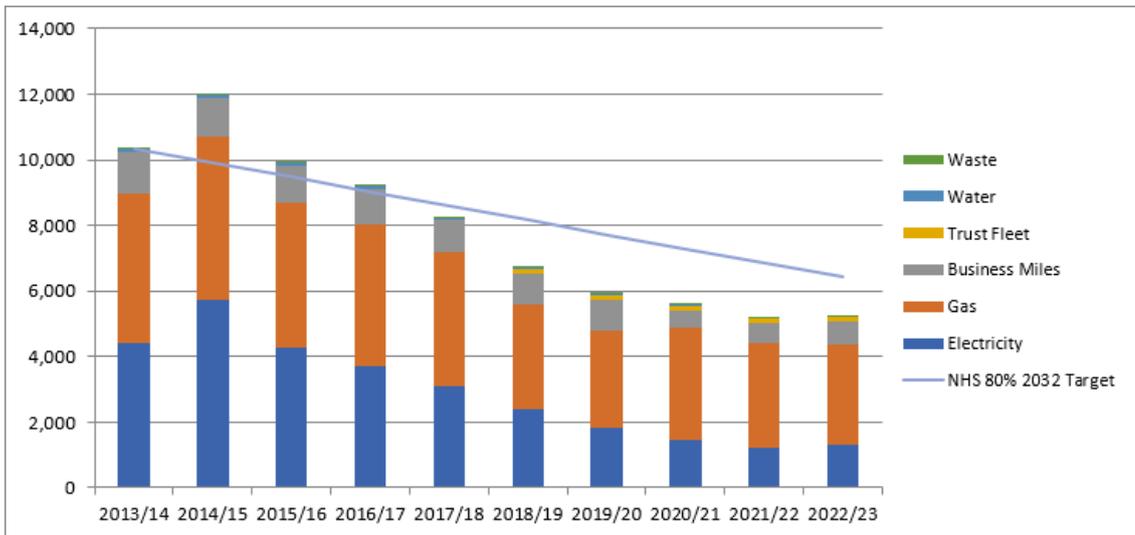
Fig 1 **SWYFT Carbon Footprint tonnes CO_2e**

The table indicates that we are levelling out in our carbon reduction plan and in fact there is a 0.9% increase in emissions which is in the largest part made up of improved measurements on the sites at Dewsbury and the Dales where we now have better access to actual figures. In addition, business miles continue to increase in line with increased activity. We do remain ahead of trajectory in our plan to reduce emissions in line with the national NHS targets.

Measures:
1. The impact of staff travel/business miles through the close monitoring of CO2 levels. Our aim is to use the data to help us monitor the effective and responsible use of transport and travel in our work as an NHS Trust.
2. Consideration of how we can monitor, understand and influence staff choices which contribute towards a sustainable culture. This includes ensuring all our working environments promote and maximise opportunities for social responsibility and sustainability.
3. Food waste – we are working closely with the catering team and the Trust services they supply to look at ways of reducing monthly food waste, specifically at the Fieldhead and Kendray sites. We have already seen significant reductions in food waste since the work commenced.

3.8 Headline Initiative: Cultural and Creative Collaborations

To fulfil our commitments around engagement with less advantaged and diverse communities, we are working with our Creative Minds team. Our aim is to maximise the responsiveness, value, inclusiveness and uptake for our services within the local community, with a specific focus on cultural collaboration.

Measures:
1. The number of new live projects.
2. The number projects becoming peer led or sustained in the last 6 months.
3. The number of projects peer led or having peer led elements.

3.9 Headline Initiative: Social Prescribing and Medicines Optimisation

The pharmacy team has undertaken significant work to enable a more sustainable approach to prescribing. This includes work internal to the Trust as well as across our wider systems at West Yorkshire and South Yorkshire. Examples are increased medications reviews and the Green Bag scheme (see below).

Measures:

1. The number of pharmacists completing structured medication review training, which will help us ensure that the Trust has a competent and trained workforce, and to create opportunities for progression for existing staff.

2. The number of medicines optimisation reviews carried out with pharmacists as part of a multi-disciplinary team on inpatient wards and by specialist mental health pharmacy teams in primary care. The aim of this is to ensure that our service users have optimised medication regimes.

3. Promotion of the Green Bag programme. This is a pharmacy led initiative which helps with increasing the use of patients own medicines on admission to hospital. This saves money and reduces waste. It also improves patient safety by ensuring that our service users can manage their medicines at home and reducing the risk of missed or delayed medicine doses when people are admitted to hospital.

3.10 Local Partner/ICB Engagement

We have built further on the engagement which was undertaken to co-produce the SRS. There is now extensive engagement with local partners in all four of the localities we cover. We play a key role in all the relevant local sustainability/social responsibility/climate/anchor organisation groups.

This includes us being part of the following groups and initiatives:
- Barnsley 2030 Board
- Barnsley Alternative Fuels and EV task group
- Barnsley Positive Climate Partnership
- Barnsley Affordable Warmth Charter
- Barnsley Cold Weather Collaborative
- Calderdale Climate Action Partnership
- Calderdale social value workstream
- Kirklees Environment strategy
- Picture of Kirklees Partnership
- Wakefield District Partnership for Net Zero
- Wakefield District Partnership to Net Zero Summit

Whilst it can be challenging to ensure that we give sufficient attention to the ongoing discussions in the four places we cover as an NHS Trust, we use the time and resource we have to focus on the areas we feel are vital to help us progress the strategy, whilst playing our part as a large local employer and anchor organisation.

We are also fully engaged at ICB level, including:
- South Yorkshire ICB Sustainability Meeting
- West Yorkshire ICS Climate Change Operational Network
- North of England Sustainable Travel & Transport Network
- West Yorkshire ICB Climate Change Workstream which is hosted by the Calderdale Provider Collaborative

3.11 Other achievements

The focus of the SRS is delivering the headline initiatives, however, there are also other key achievements that have taken place:

a) In the Spring of this year, supported by several staff volunteers, our gardening staff planted 500 trees on the Kendray and Fieldhead sites. In addition, we have an agreement with the White Rose Forest third sector organisation for a further 1,176 trees to be planted on the Fieldhead site in the Autumn. Our hope is to plant trees on every square metre of Trust land which is not required for other purposes and won't affect the day to day running of the Trust.

b) We have purchased four eBikes and supporting equipment. Our pilot of free eBike loans to staff will commence in October. We have already had lots of interest from staff wishing to take advantage of what we are offering. This ranges from staff wishing to use the bike purely for leisure purposes, to staff planning to use them to travel to and from work and as part of their roles in the community. Any member of staff taking out a Trust eBike will be offered safety and competency training as well as full supporting kit such as safety helmet, lock, lights and panniers for carrying light luggage. So that we can monitor usage, each bike is fitted with GPS tracking device which will enable us to collect quantitative data.

c) We have made all the preparation for an October launch of the SWYPFT Green Team. Signing up to the Green Team will give anyone connected to the Trust the opportunity to be involved in supporting the work of the strategy, through raising and taking forward positive ideas around sustainability in their workplace, wherever that might be and whatever their role. Over a hundred and fifty staff have already been contacted after they have shown interest in being involved in pushing forward the green agenda in the Trust. The work of the Green Team will be captured in strategy reports and examples of the green initiatives, ideas and engagement will be regularly highlighted via Trust comms in the coming months.

d) Delivery of elements of the SRS communications and engagement plan to raise the profile of the SRS. This includes via iHub, staff engagement sessions, Excellence award, Annual Members Meeting.

e) We have developed a plan for training and development in sustainability and carbon reduction. This includes:

- Making "Building a Net Zero NHS" ESR module accessible to all interested staff
- Including carbon literacy training in the training needs assessment
- Planned Sustainability training for OMG

4. Next steps

The following areas of focus have been identified for the next 12 months in line with the SRS.

Aim one: To deliver the headline initiatives in line with the agreed plans and monitored through the metrics and measures.

Areas of focus for 23/24:

i. Recruit in ways which help to make our workforce more representative of the areas we serve and provide opportunities for those facing challenge to gain employment with us. This area of work also links with the inclusive recruitment retention and wellbeing priority

ii.   Develop the work on waste and repurposing to reduce carbon impact and reduce cost

iii.   Develop a net zero carbon road map and deliver the high priority actions identified within it

Aim two: To continue to carry out a series of activities to develop the culture of increased sustainability and social responsibility across the organisation in line with the SRS and our integrated change approach.

Areas of focus for 23/24:

i.   Development of the Green Team
       The Green Team will have an educational role. To help educate and inform those taking up the role, they will be offered carbon literacy training, which will also help us as a Trust meet the West Yorkshire ICB commitment to all West Yorkshire NHS staff receiving such training in the next 3 years On a separate level, as far as we are aware, we are one of the first NHS trusts in the country to organise carbon literacy training specifically aimed at the senior managers via the operational management group which will be taking place soon. This could also be arranged for the Board too! There are many examples of how those becoming involved can support the aims of the strategy, these include areas such as:

       a)   Energy conservation and encouraging staff members to turn off lights, computers and other electronic equipment when not in use.
       b)   Waste reduction and encouraging the use of digital documentation and communication whenever possible to reduce paper waste.
       c)   Implementing recycling programmes for paper, plastic, and other recyclable materials.
       d)   Promoting sustainable transportation by encouraging the use of public transportation, carpooling or cycling to work and continuing to promote video conferencing and remote working options to reduce travel-related emissions.
       e)   Water conservation and promoting responsible water usage by encouraging staff to turn off taps tightly, fixing leaks promptly and the introduction of water-efficient appliances.

       Early signs of engagement and enthusiasm give us confidence that in the coming months and years we will be seeing many excellent examples of how our staff and others connected to the Trust are thinking greener to help us be the sustainable organisation we need to be.

ii.   Continued development of outside spaces
       Some of our sites have fantastic outdoor space with lots of potential and we are encouraging anyone who wants to be involved to participate in gardening or landscaping initiatives to create green and sustainable areas. To add to the tree planting and other gardening activities, we are also in the process of applying for funding from various charitable sources to help us take a sustainable approach to further developments of the grounds we have.

Aim three: To continue to develop mechanism to support and embed social responsibility in all that we do and all our partnerships.

Areas of focus for 23/24:

i.   Sustainability Impact Assessments (SIAs)

To embed the use of SIAs into key processes, building on the learning from the pilot work undertaken, including the use within the Older People inpatient mental health transformation programme.

ii.   Capital expenditure
Develop a plan to deliver the sustainability element of the capital programme, in line with Trust processes!

iii.   Wakefield heat network
The Wakefield heat network has the potential to be a significant positive step with many benefits for the Trust and the local community. Bringing together local partners from both the public and the private sector, the initiative is looking to develop a heat network which would cover the city centre and with agreement from our Trust and our neighbours Mid Yorks Trust, the Pinderfields and Fieldhead sites. As well as introducing the use of heat pumps, the scheme would involve drawing up heated mine water from old mine workings which lay beneath most of the local area. We are involved in early discussions about this idea.

5. Conclusion and recommendation

Significant progress has been made in the delivery of the strategy but we are aware that we have a long way to go. Small changes can make a big difference when it comes to sustainability and we know that by fostering a culture of environmental consciousness and encouraging staff to take part in these initiatives our NHS organisation can make great strides towards a greener and more sustainable future.

Trust Board is asked to: Receive this update and note the progress made.

Trust Board 31 October 2023
Agenda item 9.5

Private/Public paper:	**Public**
Title:	**Patient Safety Incident Response Framework (PSIRF) plan approval**
Paper presented by:	**Darryl Thompson - Chief Nurse/Director of Quality and Professions**
Paper prepared by:	Helen Roberts, Patient Safety Specialist
Mission/values:	Our patient safety strategy is aligned to the Trust's values, which are fundamental to delivering safe health care for patients: • 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 purpose of the paper is to request approval of the Trust's Patient Safety Incident Response Framework plan. An accompanying describes background information and a summary of the work undertaken to develop the plan and policy.

Strategic objectives:	Improve Health	✓	Please remove as appropriate
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	

BAF Risk(s):	2.2 - Failure to create a learning environment leading to lack of innovation and to repeat incidents.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The benefits of the outputs we expect to see from the implementation of PSIRF in the longer term (it is recognised by NHS England that changes may take some time to embed) are: • Improved use of resources by focussing on the areas where we want to identify new learning for improvement (i.e. what we don't understand well) • Increased time to focus on delivering improvement work • Reduced time and cost of investigating and reviewing incidents that tell us what we already know • Improved involvement and engagement of those who are affected by patient safety incidents
Any background papers / previously considered by:	Trust Board has received regular updates about PSIRF as part of the quarterly and annual incident management reports.

	The PSIRF plan and the accompanying background paper were reviewed in Quality and Safety Committee on 17 October 2023, where the plan was recommended for approval at Trust Board.
Executive summary:	The purpose of the accompanying background paper is to provide a brief summary of the Patient Safety Incident Response Framework and a summary of the work undertaken during the last 13 months to prepare for its implementation. PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement by: • advocating a co-ordinated and data-driven approach to patient safety incident response • prioritising compassionate engagement with those affected by patient safety incidents • embedding patient safety incident response within a wider system of improvement • prompting a significant cultural shift towards systematic patient safety management We have undertaken a wide range of work in line with the national guidance, including: • in depth data analysis to identify our patient safety priorities • developing our understanding of the framework and what this will mean in practice • understanding our capacity for responding to patient safety incidents • assessing our current systems against the new standards • developing our approaches to engaging and involving those affected • reviewing our governance arrangements to support PSIRF • ensuring our systems support a just culture We have ensured alignment with the Trust's strategic objectives and priorities and believe that PSIRF will enhance our work to improve care, improve the use of our resources where opportunities for learning and improvement are the greatest, and improve engagement and involvement of those affected by patient safety incidents, thereby improving staff experience when involved in incidents. Our data analysis and learning from previous incidents has helped us to identify three areas that require investment of resource to aid our learning about the system and subsequent improvements needed: • Suicide prevention • Clinical risk assessment (Formulation Informed Risk Assessment (FIRM)) • Pressure ulcer clinical documentation

	We will do this through thematic patient safety incident investigation (PSII) projects (scope to be defined during set up).
	We will also undertake other types of learning response for incidents (individual incident or thematic) where we want to identify new learning for improvement. However, a patient safety incident investigation will not be required in many cases, where we have related improvement work already underway.
	The culmination of the work summarised above, has been the development of a PSIRF plan and policy for the Trust, in line with national guidance. NHS England anticipated that not all work will be completed by the time of transition, so we have detailed our ongoing work areas in our plan.
	We recognise that our plan may need adapting as we learn how implementation of PSIRF looks in practice after we start to transition to this new model. We have, therefore, built in an interim review period at around 12-18 months to check our plan and policy are working effectively and to make any revisions as needed.
	The PSIRF plan requires Trust Board and Integrated Care Board approval. Our ICB colleagues in both West Yorkshire and South Yorkshire have agreed to the content of the Trust's plan and our proposed start date of 1 December 2023. Our Chief Nurse/Director of Quality and Professions is our executive lead for PSIRF, and they have been briefed on progress throughout.
	The PSIRF policy will proceed separately through the policy approval process.
Recommendation:	**Trust Board is asked to RECEIVE the update paper, note the continued progress with these patient safety developments, and APPROVE the plan.**

Patient Safety Incident Response Framework (PSIRF) approval October 2023

Purpose

The purpose of this paper is to provide an update on the work undertaken to prepare for the implementation of the Patient Safety Incident Response Framework (PSIRF) in line with NHS England guidance. We have prepared the documents below that will guide us with implementation of PSIRF in the Trust with a start date of 1 December 2023.

- Patient Safety Incident Response Framework Plan
- Patient Safety Incident Response Framework Policy

We will give a brief summary of the background to PSIRF to aid understanding in this paper, however more detail about our journey can be found in previous papers. A summary of the work and consultation we have completed will be given.

Background summary

The Patient Safety Incident Response Framework (PSIRF) was released by NHS England on 16th August 2022, with a preparation guide to support NHS Trusts with the work required before implementation. It was anticipated that this would take at least 12 months to complete the preparations. NHS England issued a series of documents to support preparation which are illustrated in Appendix A.

The framework sets out NHS England's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.

PSIRF will replace the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'serious incidents'. As such it removes the 'serious incidents' classification and the threshold for it.

Instead, PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement. The PSIRF is not a different way of describing what came before – it is intended to fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. What is does is:

- Advocates a co-ordinated and data-driven approach to patient safety incident response
- Prioritises compassionate engagement with those affected by patient safety incidents
- Embeds patient safety incident response within a wider system of improvement
- Prompts a significant cultural shift towards systematic patient safety management

PSIRF Headline changes include:

- PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of **learning and improving patient safety**.
- Replaces the Serious Incident Framework and removes the 'serious incident' classification and threshold for it.
- Embeds patient safety incident response within a wider system of improvement.
- Prompts a significant cultural shift towards systematic patient safety management
- Patient Safety Incident Investigations will not replace 'Serious Incidents', they will look at areas we want to identify **new** learning
- There will be a new National [template for a PSII report](), which will differ from the format we are familiar with
- PSIRF is not a different way of describing what came before
- Our plan will set out how we will respond to our identified priorities
- Not completing a learning response will be acceptable and more common
- Work will be undertaken to reduce the information collection burden, so we move towards demonstrating improvement, rather than compliance with prescriptive, centrally mandated measures

Summary of preparation work

PSIRF implementation group

Through the last 18 months, we have had a PSIRF implementation group to support planning, workstream, direction of travel and review of components and end products. We have ensured alignment with the Trust's strategic objectives and priorities. We believe that PSIRF will enhance our work to improve care through our learning, improve the use of our resources where opportunities for learning and improvement are the greatest, improve engagement and involvement of those affected by patient safety incidents, thereby improving staff experience of being involved in incidents. PSIRF will also support work towards quality priorities, in particular safe and responsive care through learning from incidents and work on improving clinical risk assessment and risk management. We will work closely with colleagues in quality improvement to ensure alignment with patient safety.

Communications plan

We have a communication plan through out, and initially this was to start small with introducing PSIRF and the principles that this would bring. We agreed that to try to communicate too much information at an early stage, when the answers where not yet evident to us, would have caused confusion. As our plan and policy are nearing finalisation, the focus will shift to communicating with staff about what the changes mean in practice to prepare for 1 December 2023. We have been formulating Frequently Asked Questions throughout all our communications with staff. We will continue to provide information as we move towards transition on 1 December 2023 to support staff with the changes.

Learning from others

We have used learning from other organisations throughout our journey through our attendance at multiple patient safety networks at place, region and national level. This has been incredibly useful in finding new approaches, creative ideas along with things that haven't worked so well for others.

Reporting

Since PSIRF was released in 2022, we have shared regular updates about PSIRF through the clinical governance group and regular reports on progress through the quality and safety committee.

Summary of work completed
A summary of work undertaken is included below:

We have:	
Identifying our patient safety priorities	• Examined our patient safety data to describe our patient safety priorities • Identified our existing improvement activity • Mapped our services to ensure that the shape and structure of our plan reflects patient safety concerns for the variety of services provided • Reviewed the learning response methods and considering what we will use for the priorities identified
Understand our capacity for responding to patient safety incidents	• Reviewed our capacity to respond to patient safety incidents for learning and improvement – at a corporate level and within Care Groups
Assessing our position against the Standards	• Reviewed the SPIRF standards and undertaking a gap analysis • Reviewed our current SI process to ensure it will align with PSIIs • Undertaken PSIRF level 3 training, delivered by Consequence UK • Developed a plan to achieve compliance with the standards
Work on Engaging and Involving those affected by patient safety events	• Reviewed the guidance and undertaken a gap analysis and created a plan • Begun developing guidance for staff for inclusion in our standard operating procedure.
Governance arrangements	• Continued to work on changes needed to transition from our existing clinical risk panel to the patient safety oversight group so that it aligns with the ethos of PSIRF. Our PSIRF plan sets out the circumstances in which a learning response is required and suggests what that learning response might be, hence this decision making will no longer required from clinical risk panel, with the exception of escalations. PSIRF advocates that traditional panels for decision making cease, moving towards a focus on improvement rather than compliance and thresholds. This shift towards oversight will focus on engagement and empowerment rather than the more traditional command and control. • This remains under development.
Just culture	• Reviewed our systems for ensuring open and transparent reporting of patient safety issues • Worked with colleagues in the People Directorate to understand the work to support the development of a just and learning culture
Policy development	• Developed our policy based on the NHS England template. • Developed an Equality Impact Assessment which will support the subsequent standard operating procedures as they develop. The EIA has been approved. • Consulted on our draft policy with a range of stakeholders. It has been shared and presented at the Clinical Policies Ratification

	Review Group, receiving approval in September 2023. The policy will proceed to Executive Management Team for approval through the policy route as well as this. • Shared our draft policy with our ICB and provider collaborative colleagues who have accepted this.
Plan development	• Developed our plan based on the NHS England template. • Shared a summary of our plan content with internal and external stakeholders (as detailed in the plan) for comments. • Received positive and helpful feedback and incorporated into our next revisions. • Shared our draft plan with ICB and provider collaborative colleagues • Met with ICB and provider collaborative colleagues to discuss our progress and plan and policy development in the last 3 months as our draft documents came together

Gaps

NHS England recognised that working through the preparation guide would be a dynamic process and that not all elements required would be in place at the point of commencing. They asked that we include any gaps in our plan, which are also detailed below for ease of reference. Plans are in place to address all areas by the anticipated date:

Development Area	Anticipated completion date
PSIRF training on engagement and involvement of those affected by patient safety incidents by external trainer.	January 2024
PSIRF Standards – strengthen some areas of compliance with the standards	October 2024
Develop in-house training package on PSIRF principles, local learning response methods and engagement and involvement	Initial delivery by end of March 2024
Patient Safety Partners recruitment process	December 2023
Clinical Risk Panel transition into Patient Safety Oversight Group	May 2024

Plan and policy review

As shown in both the plan and the policy, we will have a full review in 4 years from our start date. This will include detailed analysis of our data and evaluation of improvement work to make sure this is delivering the desired results. This timescale is advised by NHS England to allow time for change to embed.

We recognise that our plan may need adapting as we learn how implementation of PSIRF looks in practice. Feedback from NHS England and early adopters has been that we should expect to find elements of our plan that do not work in practice, and this will be an iterative process of amendments. We have therefore built in an interim review period at around 12-18 months to check our plan and policy are working effectively and to make any revisions as needed. This is also why our standard operating procedure and associated guidance are held separately, to enable minor changes to be made more easily. Examples of changes may be that we find we have missed an important patient safety issue or improvement activity; we develop new improvement work so a learning response is no longer required; or we have suggested the wrong learning response method for an incident).

We will publish any updated versions of our plan on our website.

After six months use of our new learning response methods, we will audit the quality of the outputs using a recognised tool[1]. This will be included in the CASE audit programme for 2024/25.

Effective start date

We are working towards PSIRF coming into effect from 1 December 2023. NHS England have stressed they are not concerned about the date, rather that the process is robust.

The PSIRF implementation group have discussed the date with our ICB colleagues and they agree with the rationale for 1 December 2023. Below is the schedule of dates/events:

Meeting/event	Date
Executive Management Team Note: EMT also receive the policy through the policy ratification process	5 or 12 October 2023
Quality and Safety Committee (patient safety specialist attending)	17 October 2023
Trust Board	31 October 2023
Patient safety support team conclude work on the standard operating procedures including consultation	October 2023
Procedures to Clinical policies ratification review group	7 November 2023
Patient safety support team deliver training delivery to staff who will conduct learning responses under PSIRF	November 2023
Patient Safety Incident Response Framework plan and policy comes into effect The Serious Incident Framework no longer applies to new incidents. Historic cases are followed through to conclusion	1 December 2023

Conclusion

The Quality and Safety Committee and Trust Board are asked to approve the Trust's first Patient Safety Incident Response Framework plan and policy and agree with the proposed start date of 1 December 2023. Our ICB colleagues in West Yorkshire and South Yorkshire agree with the proposed timescale and the content of our plan and policy.

Helen Roberts
Patient Safety Manager/Specialist
28 September 2023

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[1] Learning response review and improvement tool (hsib.org.uk)

Appendix A Patient Safety Incident Response Framework documents and outputs

Patient Safety Incident Response Framework

| Compassionate engagement and involvement of those affected by patient safety incidents | Application of a range of system-based approaches to learning from patient safety incidents | Considered and proportionate responses to patient safety incidents | Supportive oversight focused on strengthening response system functioning and improvement |

Supporting documentation

Engaging and involving patients, families and staff following a patient safety incident

Guide to responding proportionately to patient safety incidents

Response tools, templates and guides

Oversight roles and responsibilities specification

Patent safety incident response standards

PSIRF preparation guide

Output

Patient safety incident response **policy** [template]

Patient safety incident response **plan** [template]

Patient safety incident response plan

Effective date: 1 December 2023

Estimated interim review date: 30 June 2025

Full review date: 30 November 2027

	NAME	TITLE	SIGNATURE	DATE
Author	Helen Roberts	Patient Safety Specialist		
Reviewer	Emma Cox	Associate Director of Nursing, Quality and Professions		
Authoriser	Darryl Thompson	Chief Nurse/Director of Quality and Professions		

V1.25

Contents

1)   Introduction

The Trust is committed to providing high quality, safe, effective and accessible care to help people reach their potential and live well in their community. Delivering services safely is our key priority and the vision of our patient safety strategy and the NHS Patient Safety Strategy (2019)[1]; where we continuously improve patient safety through developing a patient safety culture and a patient safety system.

This document supports the requirements of [NHS England's Patient Safety Incident Response Framework (PSIRF)][2] and the NHS standard contract. This patient safety incident response plan sets out how South West Yorkshire Partnership NHS Foundation Trust (the Trust) intends to respond to patient safety incidents over a period of 12 to 18 months. Patient safety incidents are defined as any unintended or unexpected events which could have, or did, lead to harm for one or more patients receiving healthcare.

PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. Its four key aims are:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

The plan is not fixed and can be reviewed or changed to consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

2)   Scope

There are many ways to respond to a patient safety incident. This document covers learning responses (see Appendix A) conducted only for system learning and improvement.

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[1] https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/
[2] https://www.england.nhs.uk/patient-safety/incident-response-framework/

Patient safety incident response plan

For clarity, other reviews, investigations and responses that are conducted for the reasons listed below, differ from the aims of a patient safety response and are therefore outside the scope of this plan, but we acknowledge a learning response may be shared to support other processes as needed.

- Complaints management
- Claims handling
- Human resources investigations into employment concerns
- Professional standards investigations
- Coroner's inquests
- Criminal investigations

This plan should be read in conjunction with the Trust's [Patient Safety Incident Response Framework (PSIRF) Policy](). We are developing procedures to support the policy, including incident reporting and management, and responding to incidents. A glossary of terms used in included at the end of this document.

3)   Our services

South West Yorkshire Partnership NHS Foundation Trust (the Trust) provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. We also provide medium secure services for West Yorkshire and local low secure services.

Our vision, mission, values and strategic objectives

PSIRF aligns closely with the Trust's approach to be a values-led organisation. Our vision, mission and values (figure 1) are well established and are recognised and endorsed by the people we work with and the people who work in the Trust.

Figure 1 South West Yorkshire Partnership NHS Foundation Trust strategy house and 2023/24 strategic objectives and priorities

Our values guide us each day to ensure we provide the best possible care for local people and underpin the approach of our staff in providing this care. Our values reflect the openness and transparency of the organisation, clearly and succinctly:

- 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

The plan is aligned with the Trust's strategic objectives and priorities, and will enhance the work to improve care, improve the use of our resources where opportunities for learning and improvement are the greatest, and improve engagement and involvement of those affected by patient safety incidents, thereby improving staff experience when involved in incidents. The plan will also support work towards the Trust's current quality priorities, in particular safe and responsive care, through learning from incidents and applying this learning to clinical risk assessment and risk management.

Patient safety incident response plan

Our organisation

The Trust is a complex system with many interrelated components that are crucial in ensuring that everything works well. We reviewed our local system to understand the people who are involved in patient safety activities across the Trust and those who work with us (external stakeholders), as well as the systems and mechanisms that support them.

Our clinical services are structured into five care groups consisting of:

- Barnsley integrated services care group
- CAMHS and children's care group
- Adults and older people mental health care group
- Forensic care group
- Learning disabilities and adult Autistic Spectrum Disorder ASD)/Attention Deficit Hyperactivity Disorder (ADHD) care group

Our place in the health and care systems

To help people live well in their communities we understand that services need to be joined up, responsive and delivered as close to people's homes as possible. We know that to achieve this, we need to work together across the whole health and social care sector. We are committed to helping join up care wherever possible and are working in partnership on a local level in each of our areas to make this happen.

The map below (figure 2) shows the areas we operate in and the partners we work with:

Patient safety incident response plan

Figure 2 Trust geography and partners

Forensic services also available in Adel and Wetherby

Wetherby

Adel

Bradford & Airedale

Leeds

York

Calderdale
Hebden Bridge Halifax
Todmorden Sowerby Bridge Brighouse
Elland
Ripponden Huddersfield

Cleckheaton Batley
Liversedge
Dewsbury Mirfield

Normanton Castleford Knottingley Pontefract
Ossett Featherstone
Horbury **Wakefield**
Crigglestone
Hemsworth

Honley **Kirklees**
Meltham
Holmfirth

Darton Cudworth Shafton
Barnsley Goldthorpe
Dodworth Darfield
Dunford Bridge Penistone
Birdwell Wortley

Doncaster

Sheffield

Rotherham

In Barnsley, Calderdale, Kirklees and Wakefield we work with local partners, including:

- Integrated care systems
- Integrated care boards
- NHS acute hospital trusts
- Local authorities
- Healthwatch
- community and voluntary sector organisations
- GP federations
- Housing providers
- And other NHS providers

Yorkshire Smokefree services also available in Sheffield and Doncaster

Integrated care systems

We are partners in the West Yorkshire Health and Care Partnership and the South Yorkshire Integrated Care System. Integrated care systems (commonly referred to as ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, to improve the lives of people who live and work in their area. Integral to the smooth running of ICSs are Integrated Care Boards (ICBs), which provide a local focus and help commission and support local services. We are part of the ICBs in our geographical areas.

Provider collaboratives

NHS-led provider collaboratives are a new way of planning and providing the mental health, learning disability and autism services that have previously been commissioned by the NHS England Specialised Commissioning team.

Each NHS-led provider collaborative is formed of a group of providers of specialised mental health, learning disability and autism services (sometimes including the

Patient safety incident response plan

independent sector) who have agreed to work together on specific services to improve the care pathway for their local population by taking responsibility for the budget and pathway. The Collaborative is led by an NHS provider (coordinating provider) who remains accountable to NHS England for the commissioning of high-quality, specialised services. Figure 3 sets out the provider collaboratives we are part of or have a role in coordinating.

Figure 3 Provider collaboratives in South and West Yorkshire

Provider collaborative	Coordinating provider	Date effective
West Yorkshire provider collaborative		
Adult Low and Medium Secure Services	South West Yorkshire Partnership NHS Foundation Trust	1st October 2021
Children and Young People Mental Health (CYPMH) inpatient services (Tier 4)	Leeds and York Partnership NHS Foundation Trust	1st October 2021
Adult Eating Disorder Services	Leeds and York Partnership NHS Foundation Trust	1st October 2020
South Yorkshire and Bassetlaw, Provider Collaboratives		
Children and Young People Mental Health (CYPMH) inpatient services (Tier 4)	Sheffield Children's Hospital	1st October 2022
Adult Eating Disorder Services	Rotherham Doncaster and South Humber NHS Foundation Trust	1st October 2022
Adult Secure Services	South West Yorkshire Partnership NHS Foundation Trust	1st May 2022

Provider alliances

We are committed to the drive to join up care on a local level. We are a leading partner in a number of provider alliances across our areas. Provider alliances bring together partners in local areas who are committed to joining up services across different organisations to create a more seamless patient journey.

These include:

- Barnsley community health and care alliance
- Calderdale cares
- Wakefield integrated care partnership
- Wakefield mental health alliance

We work in a partnership system and aim to always be a good partner. Our commitment to working collaboratively with our partners is reflected in our strategic ambitions.

Patient safety incident response plan

Patient safety

The Patient safety support team works within the nursing, quality and professions directorate to support the Trust's systems and processes for patient safety. This includes:

- Management of the Trust's Datix risk management system
- Administration of patient safety alerts
- Data analysis and performance reporting on patient safety related data to fulfil our internal and external reporting requirements
- Leadership and advice for incident reporting and learning responses
- Patient safety investigation team for conducting patient safety incident investigations (formerly serious incidents)
- Provision of training and guidance to support staff with reporting and reviewing incidents, analysing data using systems analysis techniques and producing reports
- Support our corporate learning processes
- Offering ongoing support and guidance for managers on patient safety related subjects

Patient safety activity spans a wide range of corporate teams, services and governance structures across the Trust.

As a Trust, we developed our first patient safety strategy in 2015 along with an extensive improvement plan. This was reviewed in 2019 through consultation and collaboration with services and patient volunteer/family groups. This was through a range of workshops, meetings and focus groups. At this time, the NHS patient safety strategy was incorporated into our own strategy as we reflected our direction of travel was in line with new developments. We streamlined our improvement plan at this time for focus on a smaller range of subjects and national priority work. Our former approaches fit well with PSIRF principles.

Processes undertaken in the Trust that provide insight into patient safety include:

- Just and learning culture
- Patient safety incident response framework
- Patient safety partners involvement
- Incident reporting and management
- Engaging and involving those affected by patient safety incidents
- Patient safety training
- Patient safety strategy improvement work
- Learning network and our learning approaches
- Clinical risk panel (will be known as Patient Safety Oversight Group)
- Clinical environment safety group
- Supporting patient safety improvement
- Various Trust action groups and committees

Patient safety incident response plan

- Learning from deaths
- Complaints and feedback
- Inquest responses

The operational work for many of these patient safety processes are predominantly owned by our colleagues on the front-line, supported by specialist advisors who offer expert advice and support.

4) Defining our patient safety incident profile

Stakeholder engagement

The following stakeholders have been identified and involved in discussions about our methodology and plan development, content, and commenting on our draft plans.

- West Yorkshire Integrated Care Board
- South Yorkshire Integrated Care Board
- West Yorkshire provider collaborative
- Patient safety strategy group
- PSIRF implementation group
- PSIRF operational group
- Patient safety support team
- Nursing, quality and professions directorate
- Legal team
- Patient representatives of the Trust
- Trust staff
- Healthwatch
- Yorkshire Ambulance Service
- Calderdale and Huddersfield NHS Foundation Trust
- Mid Yorkshire Hospitals Teaching NHS Foundation Trust
- Barnsley Hospitals NHS Foundation Trust
- Care Quality Commission

Data sources

In order to identify our patient safety issues (figure 4), we carried out analysis of qualitative and quantitative data including:

- Patient safety incidents for the period 1/4/2019 – 31/03/2022
- Themes from action plans (serious Incident, service level investigations, significant event analysis, structured judgement reviews)
- Complaints from patients, families, and carers

Patient safety incident response plan

- Claims
- Risk registers
- Strategic risks
- Internal audits
- Freedom to speak up data
- Human resource processes
- Quality improvement and assurance data
- Existing improvement plans

The PSIRF team triangulated the data from these sources in consultation with specialist advisors and the PSIRF implementation group. We considered our existing knowledge by theme against improvement work already in place, to help us identify areas where we wanted to understand more. Colleagues were asked to add other knowledge about current or emerging patient safety risks/issues identified through experience including our clinical risk panel and other forums.

The draft patient safety issues were shared and discussed with our internal PSIRF implementation team, with internal and external stakeholders, before being consolidated into a final list of patient safety priorities and incorporated into this plan. These were agreed at:

- PSIRF implementation group
- Quality and safety committee
- Trust Board

The current local top patient safety issues arising from data analysis are presented in figure 4. It is understood that not every patient safety issue can be included in this version of the plan but may be considered in future versions.

Apparent suicide, whilst identified as a patient safety issue, will be reviewed in line with the learning from deaths national guidance and our policy, with two exceptions. Firstly, where an apparent suicide is found to have been more likely than not to be due to problems in the care we provided, it would meet the criteria for an individual Patient Safety Incident Investigation (PSII) under PSIRF. Secondly, we will conduct a thematic PSII project around suicide prevention.

Data was analysed to care group level to identify any trends specific to one service area. Figure 4 includes detail of where specific areas if relevant.

Patient safety incident response plan

Figure 4 Patient safety issues

Patient safety issue	Criteria	Service area	Improvement plan in place
Self harm	Inpatient – self harm associated with ligatures or swallowing objects Community – overdose of prescribed medication	Mental health & learning disability inpatient and community settings	Improvement plan in place
Inpatient falls	Learning from well managed incidents and/or near misses	All inpatient services	Improvement plan in place
Medication errors	Administration of insulin Medication storage (fridges/clinic rooms)	All services	Improvement plan in place
Violence and aggression against patients	Violence resulting in moderate harm or above Incidents involving use of force resulting in moderate harm or above Incidents where system issue identified	Mental health & learning disability inpatient & community settings	Improvement plan in place
Pressure ulcers	Category 2 resulting in learning not covered in existing improvement work. Category 2 or 3 deteriorating to category 3 or 4 (unrelated to end of life) Clinical documentation including Waterlow risk assessment	Community physical health services	Improvement plan in place
Apparent suicides	Suicide prevention at team level	Mental health & learning disability inpatient & community settings	Improvement plan in place
Risk assessment	Formulation Informed Risk Management (FIRM) clinical risk assessment and associated record keeping and care planning	All services	Improvement plan in place
Physical health/mental health	Deteriorating physical health of mental health patients Issues with medical devices (eg availability/misuse)	Mental health & learning disability inpatient & community settings	Improvement plan in place
Patient absent without leave (AWOL)	Escape and attempted escapes from the fabric of the building	Mental health and Learning disability inpatient settings	To gather knowledge to inform future improvement plan
Transitions in care	Issues with transitions between: inpatient and community teams between community teams	All services	To gather knowledge to inform future improvement plan

Patient safety incident response plan

After the formulation of this table, NHS England have advised that healthcare acquired infection (HCAI) should be included as standard as requiring a local learning response (See figure 7).

While planning supports proactive allocation of patient safety incident response resources, there will always need to be a reactive element in responding to incidents. If a patient safety incident not included in our plan causes an unexpected level of risk or significant systems learning and improvement opportunities, we will always consider undertaking a learning response. These will be agreed by our patient safety oversight group.

In the following sections we will describe the improvement approach and how we will use learning responses to identify new learning for subsequently improving the safety and quality of care our patients receive.

5)   Defining our patient safety improvement profile

As part of the preparation for PSIRF, we have reviewed existing improvement work (described in section 4) related to our identified safety issues and sought areas where improvement work would be beneficial to address known contributory factors. We have incorporated where we have improvement work underway or planned in Figure 4 above. In addition, outputs from our learning responses will be reviewed by our improvement leads.

6)   Our patient safety incident response plan: national requirements

In line with the PSIRF guidance, there are a number of patient safety incident types that must be responded to according to national requirements.

Figure 5 documents how we are expected to respond to the Nationally defined priorities:

Figure 5 National patient safety incident investigations (PSII) or other process

	Event	Approach
a	Deaths thought more likely than not due to problems in care* (Incidents meeting the Learning from Deaths criteria for patient safety incident investigation (PSII))	Locally led patient safety incident investigation (PSII)
b	Deaths of patients detained under the Mental Health Act or where the Mental Capacity Act (2005) applies (where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	Locally led PSII
c	Incidents meeting the Never events criteria	Locally led PSII

Patient safety incident response plan

d	Mental health related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII locally led PSII may be required
e	Maternity and neonatal incidents	Healthcare Safety Investigation Branch (HSIB) criteria. Contribute to any HSIB investigation as required
f	Child deaths	Refer for Child Death Overview Panel review locally led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel
g	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this
h	Safeguarding incidents in which: babies, children or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence adults (over 18 years) are in receipt of care and support needs from their local authority the incident relates to FGM, Prevent, modern slavery, human trafficking or domestic abuse/violence	Case referred to local authority safeguarding lead. Trust must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adult boards *there are discussions underway at national level regarding reviewing low level concerns under PSIRF. We will review in line with national guidance as it is released
i	Incidents in NHS screening programmes Consideration may be related to: • whether individuals, the public or staff would suffer avoidable severe harm or death if the root cause is unresolved • the likelihood of significant damage to the reputation of the organisations involved	Refer to local screening quality assurance service for consideration of locally led learning response See guidance Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)
j	Deaths in custody eg police custody, in prison, etc where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct) to carry out the relevant investigations. See (b) above for deaths under Section of the MHA. The Trust will fully support these investigations where required to do so
k	Domestic homicide	A domestic homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case

Patient safety incident response plan

7)   Our patient safety incident response plan: local focus

Capacity to respond

A review has been undertaken of the current resource and activity associated with existing serious incident investigations, this was assessed against the patient safety incident investigation standards. We have a well-established investigation team within our patient safety support team, and our investigators will lead individual patient safety incident investigations and advise and support care groups with other learning responses. We have adopted learning from pilot organisations and our PSIRF trainer, to start with a small number of PSIIs as we establish our new methodologies and processes in the first year.

In addition, a review has been undertaken to determine the Trust's level of resource for carrying out non-serious incident patient safety related activity. Historically, this included service level investigations, significant event analysis, structured judgement reviews, learning library/SBAR summaries etc. Service level investigations and significant event analysis will cease under PSIRF. Other team focused learning responses will be used in line with this plan (see Appendix A).

PSII selection criteria

Based on the data analysis described in figure 4 and our available resource we have identified the areas below (figure 6) for local patient safety incident investigations (PSII). These are system-based responses to a patient safety incident for learning and improvement. In line with our PSII training, we have identified two types of patient safety incident investigations (PSII) which both include in-depth systems analysis:

Individual PSII – for cases meeting the national priorities for PSII or a small number of locally defined individual patient safety incidents. These will be led by a Patient Safety Incident Investigator with relevant subject matter experts.
Thematic PSII project – systematic safety improvement project (regarding a broader theme or safety concern). These will be led by an Assistant or Associate Director from the nursing quality and professions directorate, supported by a patient safety incident investigator and project team. The scope of each thematic PSII project will be defined by the project lead and team.

All PSIIs will be led by those appropriately trained in line with the PSIRF standards.

Approach to local PSII selection

Individual PSIIs will be selected from relevant incidents by the patient safety support team and information shared with the patient safety oversight group for decision making. We will always attempt to allocate PSII investigations to our investigators so they can bring fresh eyes to a case.

Patient safety incident response plan

Incidents not selected for PSII, may require a local learning response. These will be in line with Appendix B and figure 7. Concerns will be escalated initially through the care group governance structure to the patient safety oversight group.

Timescales for PSIIs

Where an individual PSII is required (as defined in this plan for both local and national priorities), the investigation will start as soon as possible after the patient safety incident is identified and a PSII has been agreed. Each individual PSII will be scoped initially to understand the circumstances and key lines of enquiry. This will enable the lead investigator to discuss the case with the patient and/or their family/carers to agree the timescales for completion. The patient and/or family/carers will be kept informed of any delays that may occur.

NHS England expect that no individual PSII should take longer than six months. A balance will be drawn between conducting a thorough individual PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure findings remain relevant. Where the processes of external bodies delay access to some information for longer than six months, a completed individual PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

Figure 6 Local priorities for PSII for the coming period of one year

Patient Safety issue	Description of areas to identify new learning	Service	PSII criteria
Clinical risk assessment	**Thematic PSII systematic safety improvement project** Clinical risk assessment, specifically formulation informed risk management (FIRM) and related record keeping, care planning and involving patient, family and carers are common contributory factors seen in our data. We will conduct a PSII systematic safety improvement project to analyse the context and underlying factors to aid our learning for improvement	Mental health and learning disabilities	Any further data gathering requirements will be defined in the design of the PSII project
Suicide prevention	**Thematic PSII systematic safety improvement project** Our data analysis showed that apparent suicide of patients was the highest type of serious incident. We aim to reduce the loss of life to suicide and support those affected by suicide or suicidal expressions and actions. We will conduct a PSII systematic safety	All services	Any further data gathering requirements will be defined within the PSII project

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	improvement project to help us to learn from work as done to drive improvement		
Pressure ulcer clinical documentation	**Thematic PSII systematic safety improvement project** Our data analysis from pressure ulcer investigations over time revealed a main theme around clinical documentation. We will conduct a PSII systematic safety improvement project to help us to learn from work as done to drive improvement	All services	Any further data gathering requirements will be defined in the design of the PSII project
Unplanned events	**Individual PSII** Unexpected level of risk and/or potential for learning and improvement not included in our plan	All services	Individual PSII Maximum 2 per year

Selection of incidents for Local Learning Response (LLR)

All patient safety incidents relating to our safety issues (figure 7) will be reviewed by responsible managers with support from those in quality and governance, specialist advisor or patient safety roles, to make sure we:

- Undertake an appropriate level of engagement with everyone affected
- Ensure requirements of duty of candour are fulfilled for notifiable safety incidents wherever required
- Make any other referrals as needed (eg safeguarding)
- Understand what improvement work is underway in the Trust
- Identify if an individual learning response is needed (as described below) (PSIIs will be identified through the Patient Safety Support Team)

It is expected that most incidents will not require an individual learning response except in cases where:

- Initial review identifies opportunity for new learning not covered in the respective improvement plan
- Potential for new insight in relation to a new/emerging area of risk
- Concern about a cluster of incidents
- System issues/failure
- Learning from well managed incidents and/or near misses

A flow chart has been developed to support staff with understanding how to respond to patient safety incidents (see Appendix B), however this will continue to be developed and the latest version will be held on the Trust intranet pages.

Local learning response types

Patient safety incidents that do not require a PSII may benefit from a local learning response to gain insight or address queries from the patient, family, carers or staff.

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Different local learning response methods (Appendix A) can be used, depending on the intended aim and required outcome. The most appropriate learning response method will be selected depending upon the circumstances of the incident/s. Figure 7 gives suggested learning response methods for each patient safety priority.

All patient safety incidents which are identified as notifiable safety incidents must meet the duty of candour requirements.

Incidents that meet the criteria for a PSII but were not selected, may have a local learning response in line with Appendix B.

Local learning responses

Based on the analysis described earlier, figure 7 shows suggested response methods for the list of patient safety issues. It should be noted that not all incidents, including those resulting in harm, will require a learning response.

Patient safety incidents which do not appear separately in this plan, which are cause for concern or relate to a new or emerging theme, will be covered by 'unplanned events' section of figure 7. Specialist advisors and patient safety support team will support this to agree the most appropriate learning response.

Staff will use figure 7 and detail in Appendix B to conduct the appropriate learning response. Where concerns remain, cases will be escalated through the care group governance structure. Advice and support will be provided by the patient safety support team.

Our suggested local learning responses for our patient safety priorities are set out on the next page.

The table below provides suggested local learning response methods. The method will depend upon the incident and circumstances. If the learning response suggested does not feel appropriate, other tools/methods can be considered (see Appendix A). Patient safety support team can provide advice and support.

Figure 7 Suggested Local learning responses to patient safety issues

Most incidents will <u>not</u> require an individual learning response, unless: • Contributory factors identified with opportunity to identify new learning, not covered in our improvement work • Potential for new insight in relation to a new/emerging area of risk • Concern about a cluster of incidents/theme • System issues/failure • Opportunity for system learning from well managed incidents and/or near misses			**Suggested local learning response where improvement work is not already underway (to be agreed locally dependent upon new learning opportunities and circumstances) (See Appendices A and B)**	
Patient Safety issue	**Service**	**Incident criteria**	**Team review**	**Specialist review**
Self harm	Mental health & learning disability Inpatient	Inpatient – self harm associated with ligatures or swallowing objects	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
	Mental health & learning disability - community settings	Community – overdose of prescribed medication	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required

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Medication errors	All Services	Administration errors involving insulin	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
	All community settings	Administration errors involving wrong patient	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
	All inpatient settings	Medication storage issues	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
Violence against patients	Mental health & learning disability inpatient & community settings	Violence resulting in moderate harm or above Incidents involving use of force resulting in moderate harm or above Incidents where system issue identified	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
Pressure ulcers	Community physical health services	Category 2 resulting in learning not covered in existing improvement work. Category 2 or 3 deteriorating to category 3 or 4 (unrelated to end of life)	After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
Physical health deterioration	Mental health & learning disability inpatient settings	Deteriorating physical health of mental health patients Issues with medical devices (eg availability/misuse)	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required

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Transitions in care	All services	Issues with transitions between: inpatient and community teams between community teams	Debrief	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
Patient absent without leave (AWOL)	Mental health & learning disability inpatient settings	Escape and attempted escapes from the fabric of the building	Debrief and/or After Action Review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
Healthcare Acquired Infections (HCAI)	All services	Areas of interest in terms of risk and potential learning and improvement being developed	Debrief	After action review led by Infection Prevention & Control Team Specialist learning review as required
Unplanned events (not covered in this plan)	All services	Unplanned events Emerging risk/new insight Significant patient safety concern	Debrief and/or After Action Review	Specialist learning review as required

Patient safety incident response plan

8)   Areas for further development

At the time of publishing this plan, the following areas remained in development:

Development Area	Anticipated completion date
PSIRF training on engagement and involvement of those affected by patient safety incidents by external trainer.	January 2024
Clinical Risk Panel transition into Patient Safety Oversight Group	May 2024
PSIRF Standards – strengthen some areas of compliance with the standards	October 2024
Develop in-house training package on PSIRF principles, local learning response methods and engagement and involvement	Initial delivery by end of March 2024
Patient Safety Partners recruitment process	December 2023

9)   Approval and review

Approval of our Patient Safety Incident Response Plan
This Patient safety incident response plan has been considered and agreed by relevant representatives from internal and external stakeholder groups before being approved by the Trust Board. The lead within the integrated care board/s has signed off the documents and agreed a transition date with the PSIRF lead (and other board members as required). On the transition date, we will no longer operate under the Serious Incident Framework other than to conclude ongoing cases. This document will be published on the Trust's website.

A living and responsive plan
Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents.

Issues that emerge that are not currently covered by the plan, will be logged for future review and consideration for inclusion in future versions.

We will evaluate our learning response outputs after a minimum of 6 months of use using a recognised tool for this purpose.

Emerging patient safety risks will be considered for escalation through our local care group governance processes and may be escalated to the patient safety oversight group. The resulting discussion and action may include a range of options:

- Ongoing data collection and monitoring.

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- Establish a task and finish group to request further exploration of the concerns and identifying any improvement areas.
- Reviewing findings of task and finish groups to agree next steps and if the patient safety incident response plan will remain unchanged, if additions are required or if further improvement work is needed.

Review date

Our patient safety incident response policy will also evolve over time as we become more familiar with working under PSIRF, and in the spirit of the framework, we will reflect and learn from our experience to make improvements. We will undertake an overall review of the patient safety incident response policy and plan at least every four years to allow time for ongoing improvement work to embed which should then change our patient safety incident profile.

However, we will carry out an interim review of our PSIRF plan around 12-18 months post implementation to reflect on our journey so far and allow us to make any adjustments to our patient safety priorities, improvement work and learning response methods.

As we continue to develop, the related procedure documents will be updated. Updated plans will be published on our website, replacing the previous version.

Patient safety incident response plan

Appendix A – Patient Safety Learning Responses

Where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome.

Learning Response methods	Description	Lead	Approval	Complete by	Duration
Learning Responses to inform improvement Where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome.					
Debrief (immediate incident review)	A team debrief initiated as soon as possible after an incident whilst staff remain on site or as soon as reasonably practicable. Involves all disciplines/grades of staff present. Staff come together quickly to check how everyone is, gather immediate thoughts about what went to plan and what didn't, identify any immediate actions or changes that need to be made to ensure continued safety and support needs are met. Used where incidents are unexpected or unusual, resulting in patient harm. This will be recorded on Datix. Learning can contribute to an after action review at a later date. Consider staff completing a memory capture document to preserve their recollections at this early stage.	Led by the most appropriate person on duty (supported by managers or other colleagues, those in quality and governance or specialist roles as required and/or available)	No approval required	As soon as possible, within 24 hours	Allow around 15 - 45 minutes (dependant on nature of incident)

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Learning Response methods	Description	Lead	Approval	Complete by	Duration
After action review	A reflective facilitated discussion of an incident which gives individuals involved the ability to reflect on and contribute to the understanding about what happened with the aim of learning and improvement. A prompt sheet is available to guide the discussion. A template will be available with prompts and capturing discussions.	Lead to be agreed by the care group quality governance team May involve specialist input as relevant to the incident, if required	Oversight within care group	Within 1 calendar month of the incident	Allow around 60 - 90 minutes approximately
Specialist learning review	Supports teams to learn from multiple incidents or a safety theme (e.g. clusters in one team or a single incident that involved a number of teams) that occurred in the past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. Uses an open discussion to agree the key contributory factors and system gaps that impact on safe patient care. Can utilise a range of systems tools as relevant. A template will be available with prompts and capturing discussions	Led by the most appropriate specialist for the incident type (e.g. specialist advisor, patient safety, quality and governance lead/matron (or equivalent). Team of relevant stakeholders support the review	Oversight within care group for reviews undertaken in line with this plan For reviews commissioned by specialist groups, oversight will be through that group.	Set-up meeting within 1 calendar month. Review of outcomes within 3 months	Set-up initial meeting within 1 calendar month. Allow approximately 60-90 minutes May lead to multiple follow up meetings to review outcomes, as required. Will be dependent upon the nature of the review.

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Learning Response methods	Description	Lead	Approval	Complete by	Duration
Patient Safety Incident Investigation (PSII) (individual PSII or thematic PSII systematic safety improvement project)	An in-depth systems analysis review of specific patient safety incidents which are defined in the Trust's Patient Safety Incident Response Plan. Patient Safety Incident Investigations (PSII) may be: • Individual patient safety incident investigation • Thematic PSII - focussed on systematic safety improvement project (regarding a theme or safety concern) Both investigation methodologies will involve a team approach.	**Individual PSIIs** – lead by patient safety incident investigator **Thematic PSII project** – lead by senior manager from nursing quality and professions directorate, supported by patient safety incident investigator	Chief nurse/Director of quality and professions and chief medical officer (or deputies) on behalf of Trust board	As agreed in patient safety support team	**Individual PSII:** timescales agreed with the patient/family but take no longer than 6 months from the scope being agreed **Thematic PSII project:** timescales agreed with project group chair and are anticipated to have a duration of 6-9 months from the scope being agreed

Learning Responses for improvement based on learning

Where a safety issue or incident type is well understood (eg because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation.

Retrospective thematic analysis	A retrospective thematic analysis of learning identified through our learning response methods for a patient safety priority. The analysis aims to help understand common links, themes or wider issues from a range of methods and data. Outcomes used to identify new system improvement to address key barriers to safety.	Specialist advisors / patient safety support team	Commissioned by specialist groups for the patient safety priority or oversight group	As agreed by specialist group	Dependent upon the nature of the subject/learning responses

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Learning Response methods	Description	Lead	Approval	Complete by	Duration
	Learning Responses for assessing if a response is required Where we cannot easily identify where an incident fits in relation to our plan (ie whether a learning response is required) we would need to perform an assessment. This is to determine whether there were any problems in care that require further exploration and potentially action.				
Manager's 48 hour review	Although not a learning response, our Manager's 48 hour review acts as a first stage case note review for a death under the Learning from Healthcare Deaths policy to help understand the care given and if there were any problems in the care provided. Manager's will review the clinical records to enable the review to be completed within the Datix record. Enables managers to make a safety statement about the care provided.	Completed by the team manager or deputy	Oversight within care group	Within 48 hours of the incident being reported	Dependent upon the nature of the incident
Case note review	Review of care records where the information already provided does not easily identify if there was any problem in care that led to the patient safety incident occurring. It will include a brief timeframe of relevant events dependent upon the incident and care pathway and gap analysis. The output for this review type will determine if a further learning response or action is required. Guidance and a template/prompt sheet will be developed.	Specialist advisor, patient safety investigator or patient safety specialist	Commissioned by specialist groups for the patient safety priority or oversight group	As soon as possible after the incident	2-6 hours

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Learning Response methods	Description	Lead	Approval	Complete by	Duration
Structured Judgement Review (SJR)	Structured judgement review is an assessment tool used where there is a death of a patient, where information already collected does not provide enough information to help determine if there was any problem in care or not that led to the death occurring. It is our second stage case note review under the Learning from Healthcare Deaths policy. This approach will continue under PSIRF. All cases will be allocated to an independent reviewer by the patient safety support team. The outcome of a Structured Judgement review may lead to a PSII or other learning response.	Led by SJR reviewer, independent of the service	Oversight within care group	Completed within 4-5 weeks of allocation	Allow around 7-10 hours

Concerns identified through any learning response method should be escalated through the governance structures as needed

Patient safety incident response plan

Appendix B – PSIRF decision and oversight flowchart

Compassionate engagement with those affected

All patient safety incidents reported on Datix

→ Compassionate engagement Respond to the needs of those affected. Ensure Duty of Candour is upheld if required

→ Incident reviewed on Datix by responsible manager

→ Dependent upon incident – complete Manager's 48 hour review on Datix (based on severity, harm or concern)

Does the Patient Safety Incident meet the PSIRF plan criteria?

- No, PSI not covered by PSIRF plan
- Unsure? Seek advice from Patient safety team
- Yes – Covered by PSIRF plan (including unplanned events)

Has a new/ emerging risk or concern been identified?

If yes, escalate the concern through governance process for potential inclusion in PSIRF plan as 'unplanned events'

Review information collected so far

Are there concerns, risks, questions or contributory factors identified?

No → Ensure feedback to those affected. Update Datix with conclusion ← No

Yes

Is the issue for the incident type included in Trust improvement plan or local improvement work

- Yes – existing improvement work
- Unsure? Seek advice from PSST or improvement lead
- No – not covered by existing improvement work

Care Group - discuss and agree most proportionate learning response method for the incident (as per PSIRF plan) Seek advice from PSST. Early escalation of any potential PSII to PSST.

Care Group – local learning response takes place. If remaining concerns agree further learning response or escalate remaining concerns to Patient Safety Oversight Group. Share areas for improvement identified with PSOG

PSST – review potential PSII for discussion at Patient Safety Oversight Group Further assessment may be required to understand. PSII undertaken by PSST where agreed

Close loop Ensure feedback to those affected. Update Datix with conclusion

Safety actions If improvement work not in place, consider developing safety action, seek advice from PSST

Sharing learning Learning shared through learning library, learning network, learning reports

Patient Safety Oversight Group Receive information from care groups Discuss potential PSIIs Improvement work updates, new safety actions

Learning and improvement Thematic review of learning response outputs, safety actions and improvement work progress to inform PSIRF revisions

Patient safety incident response plan

Staff should refer to the intranet for the latest version of this flowchart

Glossary of terms

After action review	A reflective facilitated discussion used by teams when outcomes of an activity or event, have been particularly successful or unsuccessful. Provides individuals involved in an incident with the ability to reflect on and contribute to the understanding about what happened with the aim of learning and improvement.
Care Quality Commission (CQC)	The Care Quality Commission (CQC) regulates all health and adult social care services in England, including those provided by the NHS, local authorities, private companies or voluntary organisation. It also protects the interests of people detained under the Mental Health Act.
Case note review	Review of care records where the information already provided does not easily identify if there was any problem in care that led to the patient safety incident occurring. It will include a brief timeframe of relevant events dependent upon the incident and care pathway and gap analysis. The output for this review type will determine if a further learning response or action is required.
Debrief (immediate incident review)	A team debrief initiated as soon as possible after an incident whilst staff remain on site or as soon as reasonably practicable. Involves all disciplines/grades of staff present. Staff come together quickly to check how everyone is, gather immediate thoughts about what went to plan and what didn't, identify any immediate actions or changes that need to be made to ensure continued safety and support needs are met. Used where incidents are unexpected or unusual, resulting in patient harm.
Duty of Candour	Care Quality Commission Regulation 20 on Duty of Candour describes how providers should be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things don't go to plan with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things don't go to plan.
Freedom to Speak Up Guardian	Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken.
Healthcare	The preservation of mental and physical health by preventing or treating illness through services offered by the health professions, including those working in social care settings.
Integrated Care Board/System (ICB/ICS)	In broad terms, the aim of integrated care is to join up the health and care services required by individuals, to deliver care that meets their personal needs in an efficient way. Under PSIRF, our ICB/s have oversight responsibilities, summarised below: • ICB will collaborate with us in the development, maintenance and review of patient safety incident response policy and plans.

Patient safety incident response plan

	• Agree our patient safety incident response policy and plan including agreeing a transition date with the Trust. • Oversee and support effectiveness of systems to achieve improvement following patient safety incidents. • Support co-ordination of cross-system learning responses. • Share insights and information across organisations/services to improve safety.
Just Culture / Safety Culture	The Trust aims to work within an open, honest and just culture in which staff can be assured that they will be treated fairly and with openness and honesty when they report incidents or mistakes. We want colleagues to feel confident to speak up when things don't go to plan, rather than fearing blame.
Learning from healthcare deaths	Learning from death in an NHS context refers to the process of examining patient deaths to identify areas where improvements can be made in healthcare practices and patient safety. It involves analysing the circumstances surrounding a death to learn valuable lessons and implement changes that can prevent similar incidents in the future.
Learning From Patient Safety Events (LFPSE)	LFPSE replaced the National Reporting and Learning System (NRLS) in Autumn 2023. Patient safety incidents reported locally are submitted to the national database to aid learning and improvement. It will also replace how we report PSIIs in the future.
Learning Response	Learning responses are different methods of patient safety incident response activity that aim to identify one of the three objectives below: Learning to inform improvement - where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome. Improvement based on learning - where a safety issue or incident type is well understood (eg because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation. Assessment to determine required response – used for issues or incidents where it is not clear whether a learning response is required
Manager's 48 hour review	Although not a learning response, our Manager's 48 hour review acts as a first stage case note review for a death under the Learning from Healthcare Deaths policy to help understand the care given and if there were any problems in the care provided. Manager's will review the clinical records to enable the review to be completed within the Datix record. Enables managers to make a safety statement about the care provided.
Medical Device	Any instrument, apparatus, appliance, software, material or other article (whether used alone or in combination) (including software intended by its manufacturer to be used for diagnostic and/or therapeutic purposes and necessary for its proper application), intended by the manufacturer to be used for: diagnosis, prevention, monitoring, treatment or alleviation of disease; diagnosis, monitoring, alleviation of or compensation for an injury or disability;

Patient safety incident response plan

	investigation, replacement or modification of the anatomy of a physiological process; control of conception and which does not achieve its physical intended action on the human body by pharmacological, immunological or metabolic means, but may be assisted in its function by such means.
Memory capture	A memory capture document is not a statement. Its purpose is as a tool to help staff preserve their memory about an incident that has occurred. It is a protective factor, and allows the widest appreciation of the situation at the time of the incident occurred.
NHS Funded Healthcare	Healthcare that is partially or fully funded by the NHS, regardless of the provider or location.
NHS Patient Safety Strategy	The strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.
Patient Safety	Patient safety is about maximising the things that go right and minimising the things that don't go to plan. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience. (NHS Patient Safety Strategy 2019)
Patient Safety Incident	Any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS funded healthcare.
Patient Safety Incident Investigation	A system-based response to a patient safety incident for learning and improvement. Typically, a PSII includes four phases: planning, information gathering, synthesis, and interpreting and improving
Patient Safety Incident Response Framework	Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for learning and improving patient safety.
Patient Safety Incident Response Plan	Trust specific - In response to the Patient Safety Incident Response Framework (PSIRF). It describes what is being done to prepare for "go live" with PSIRF and what comes next in how we will respond to patient safety priorities.
Patient Safety Partner	Relates to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.
Retrospective thematic analysis	A retrospective thematic analysis of learning identified through our learning response methods for a patient safety priority. The analysis aims to help understand common links, themes or wider issues from a range of methods and data. Outcomes used to identify new system improvement to address key barriers to safety.
Serious Incident Framework	Previous framework to manage reporting and investigating of serious incidents. Replaced by PSIRF.
Specialist Advisor	Trust subject matter expert for a range of patient safety and health and safety subjects
Specialist learning review	A reflective facilitated discussion of an incident which gives individuals involved the ability to reflect on and contribute to the understanding about what happened with the aim of learning and improvement.
Specialist learning review	Supports teams to learn from multiple incidents or a safety theme (e.g. clusters in one team or a single incident that involved a number of teams) that occurred in the past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability.

Patient safety incident response plan

	Uses an open discussion to agree the key contributory factors and system gaps that impact on safe patient care. Can utilise a range of systems tools as relevant.
Structured Judgement Review (SJR)	Structured Judgement Review is an assessment tool used where there is a death of a patient, where information already collected does not provide enough information to help determine if there was any problem in care or not that led to the death occurring. It is our second stage case note review under the [Learning from Healthcare Deaths policy](). This approach will continue under PSIRF. All cases will be allocated to an independent reviewer by the Patient Safety Support Team. The outcome of a Structured Judgement review may lead to a PSII or other learning response.
Systems Based Approach	A system-based approach recognises that patient safety is an emergent property of the healthcare system: that is, safety arises from interactions and not from a single component, such as actions of people. A system-based approach therefore recognises that it is insufficient to look only at one component, such as only the people involved.
Systems Engineering Initiative for Patient Safety (SEIPS)	A framework for understanding outcomes within complex socio-technical systems.

Patient safety incident response plan

South West Yorkshire Partnership
NHS Foundation Trust
NHS

Trust Board 31 October 2023
Agenda item 9.6

Private/Public paper:	Public
Title:	**Workforce Disability Equality Standard (WDES)**
Paper presented by:	Lindsay Jensen Interim Chief People Officer
Paper prepared by:	Iffath Hussain Diversity, Inclusion & Belonging Lead
Mission/values:	The Trust serves a diverse population across a large geographical area and it is important we strive for a workforce that reflects the local population. A diverse workforce is vital to enable all parts of the communities served by the Trust to reach their potential. Equality and Diversity and Inclusion is core to the Trust's values and is an important part of its service and is central to the Workforce Strategy and objectives
Purpose:	This paper presents the 2023 WDES annual summary report and WDES draft action plan for 2023/24

Strategic objectives:	Improve Health	
	Improve Care	✓
	Improve Resources	
	Make this a great place to work	✓

BAF Risk(s):	2.4 - Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience. 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 WDES helps local and national NHS organisations to review their workforce data to enable organisations to produce action plans to close any gaps and improve the experience between disabled and non-disabled staff as valued members of the workforce.
Any background papers / previously considered by:	The 2023 WDES annual summary report and action plan were presented at the People Remuneration Committee on 11th of September 2023 and the Equality, Inclusion and Involvement Committee on 13th September 2023 and EMT on 19th October 2023.

With **all of us** in mind.

Executive summary:	The Trust recognises the importance in delivering culturally sensitive services that meet the needs of the communities we serve, and a diverse workforce is critical to achieving this aim. Also supporting reducing health inequalities. The WDES, which is a requirement for NHS Trusts and has been included in the NHS standard contract, provides a framework which will support the embedding of workforce equality.
	The WDES enables NHS organisations to compare experiences of disabled and non-disabled staff. The main purpose is to help local and national NHS organisations to review their workforce data against the metrics. This review should then enable organisations to produce action plans to close any gaps and improve the experience between disabled and non-disabled staff as valued members of the workforce.
	The WDES equality data was published in May 2023 and is used on a national basis to benchmark and monitor Trust progress against the indicators. Part of the requirement is to publish by 31st October an action plan setting out the actions and improvements to be undertaken across the Trust.
	Attached are:
	• WDES Annual Summary Report 2023
	• WDES Action Plan 2023/2024
	The action plan has been developed to set out actions against the indicators and to demonstrate the expected impact and improvements for disabled people working in the Trust.
Recommendation:	**The Board is asked to SUPPORT and AGREE the contents of the reports for them to be published in accordance with NHS England requirements.**

SWYPFT WDES Annual Summary Report 2023

The WDES is the Workforce Disability Equality Standard that enables NHS organisations to compare experiences of staff with and without reported disabilities. It is mandated in the NHS standard contract and is made up of ten evidence-based metrics. NHS organisations are required to publish the data and develop action plans.

The report and action plan will enable organisations to undertake year on year comparisons, highlight areas of improvement and areas where further work is needed to improve the experiences of staff with a reported disability.

The Trust is required to complete and submit updated WDES data to NHS England and NHS Improvement by May 2023. For ease of reading the data is duplicated below and summarised where appropriate.

The information contained in this report is based on ESR data as of 31st March 2023 and the 2020, 2021 and 2022 staff survey results.

Metric 1 – Workforce representation based on staff in post.							
Non-Clinical Staff	**Total Disabled**	**% Disabled**	**Total Non-Disabled**	**% Non-Disabled**	**Total Unknown**	**% Unknown**	**Total Overall**
Cluster 1 (bands 1-4)	65	7.9%	707	86.3%	47	5.7%	819
Cluster 2 (bands 5-7)	24	8.7%	245	89.1%	6	2.2%	275

Cluster 3 (bands 8a-8b)	4	7.4%	47	87%	3	5.6%	54
Cluster 4 (bands 8c-9 & VSM)	0	0%	22	100%	0	0%	22

Clinical Staff	Total Disabled	% Disabled	Total Non-Disabled	% Non-Disabled	Total Unknown	% Unknown	Total Overall
Cluster 1 (bands 1-4)	122	10.4%	962	82%	89	7.6%	1173
Cluster 2 (bands 5-7)	178	9%	1757	88.6%	47	2.4%	1982
Cluster 3 (bands 8a-8b)	25	9.6%	228	87.7%	7	2.7%	260
Cluster 4 (bands 8c-9 & VSM)	2	5.3%	35	92.1%	1	2.6%	38
Cluster 5 (medical and dental consultants)	8	7.3%	99	90%	3	2.7%	110
Cluster 6 (medical and dental, non-	1	2%	47	95.9%	1	2%	49

consultants career grade)							
Cluster 7 (medical and dental, trainee grades)	1	6.7%	14	93.3%	0	0%	15

Overall, 7.9% of the non-clinical and 9.5% of the clinical workforce (excluding medical and dental staff) have declared a disability through the NHS Electronic Staff Record.

For medical and dental staff, 6.7% of trainee grades, 2% of non-consultant career grade and 7.3% of consultants have declared a disability.

For the total workforce, 9% of staff have declared a disability.

There has been a further reduction in the percentage of staff with an undeclared/unknown status i.e., 4.3% compared to 4.7% in the previous year and 5.1% in 2021.

Metric 2 – Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts based on recruitment data year to 31.03.22.

	Disabled		Non disabled
Number of shortlisted applicants	325 (391 previous year)		3945 (4418 previous year)
Number appointed from shortlisting.	85 (67 previous year)		946 (569 previous year)
Relative likelihood of shortlisting/appointed.	0.26 (0.17 previous year)		0.24 (0.13 previous year)
Relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled*		0.92 (0.75 previous year)	

*A figure below 1:00 indicates that non-disabled applicants are less likely to be appointed from shortlisting compared to disabled applicants.

Based on the recruitment data for the year to 31 March 2023, disabled staff are more likely to be appointed from shortlisting compared to non-disabled staff.

Metric 3 – Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. N.B Metric based on data from a two-year rolling average (2020/21 and 2021/22) – number entering the formal capability process divided by 2.

	Disabled		Non disabled	Unknown
Number of staff in workforce	430		4164	204
Number of staff entering the formal capability process	1		4	1
Likelihood of staff entering the formal capability process	0.002		0.009	0.005
Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff*		2.4		

*A figure above 1:00 indicates that Disabled staff are more likely than non-Disabled staff to enter the formal capability process.

There has been 1 disabled staff entering the formal capability process in the reporting period from a total number of 5 cases. As the number of cases are so small, it is not possible to draw any firm conclusion from the data.

WDES 2020, 2021 & 2022 Staff Survey Data

Metric Indicator	2022						2021			2020				2022 Benchmarking Group average*	
	% Dis-abled	N=	% Non-disabled	N=	Trust	N=	%Dis-abled	%Non-disabled	Trust	%Dis-abled	%Non-disabled	Trust	Change from prev. year	% Dis-abled	% Non-disabled
4a) % experiencing harassment, bullying or abuse from patients, **relatives, or the public** in the last 12 months	34.1	622	26.1	1637			34.8	24.4		36.7	24.0		Improved	32	24.4
4a) % experiencing harassment, bullying or abuse from **managers** in the last 12 months	11.1	620	5.5	1623			11.4	5.9		12.9	8.1		Improved	12.3	7.0
4a) % experiencing harassment, bullying or abuse from **colleagues** in the last 12 months	18.6	619	10.6	1620			15.5	11.0		19.5	11.3		Worsened – however better than average	18.9	12.1

4b) % reporting harassment, bullying or abuse.	60.7	257	63.5	480			59.4	62.7		59.1	61.2		No significant difference – better than average score	60.3	59.8
5) % believing that the Trust provides **equal opportunities** for **career progression** or promotion	55.2	625	63.8	1635			55.7	63.8		54.9	61.2		No significant difference	56.0	61.5
6) % experiencing **pressure from manager** to attend **work when unwell**	18.2	429	13.3	795			20.2	13.6		23.9	16.8		Improved	18.9	12.7
7) % staff satisfaction with extent work is **valued by organisation**	47.0	626	51.8	1640			44.6	51.6		43.3	53.1		Improved	44.0	53.2
8) % of disabled staff saying that **adequate adjustments** have been made	79.2	360	n/a	n/a			77.2	n/a		80.9	n/a		Improved and above average	78.8	n/a

9a) staff engagement score	6.7	629	7.2	1649	7.1	22 78	6.8	7.2	7.1	6.7	7.2	7.1	No significant difference	6.7	7.2

*Combined mental health/learning disability and community benchmark group median.

A higher proportion of disabled staff compared to non-disabled staff state they have experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months. This has improved since the previous year.

A higher proportion of disabled staff compared to non-disabled staff state they have experienced harassment, bullying or abuse from managers in the last 12 months however, this has continued to improve and is the lowest percentage of the last 3 years.

A higher proportion of disabled staff compared to non-disabled staff state they have experienced harassment, bullying or abuse from colleagues in the last 12 months. This had continued to improve consecutively for the past 3 years. However, 2022 survey saw an increase in this figure by 3.1% from 15.5% in 2021 to now 18.6% in 2022. Nevertheless, the Trust result of 18.6% is better than the benchmarking group.

There is lower reporting of harassment, bullying or abuse from disabled staff compared to non-disabled and is not significantly different compared to last year.

A lower proportion of disabled staff compared to non-disabled staff believe that the Trust provides equal opportunities for career progression or promotion. No significant different to 2021 survey however this has been improved since the previous year.

Disabled staff report being more likely, compared to non-disabled staff to experience pressure to attend work despite not feeling well enough to perform their duties however, this has continued to improve compared to previous years.

Disabled staff report less satisfaction that their work is valued by the organisation compared to non-disabled staff however, this has continued to improve compared to previous years.

79.2% of disabled staff report that the Trust had made adequate adjustments to enable them to carry out their work. This has improved since the previous year when 77.2% reported that adequate adjustments had been made.

Disabled staff report a lower NHS staff survey engagement score than non-disabled staff however this is level with average benchmarking score.

Metric 9b – Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard?

Yes. The Trust continues to support the development of a staff disability network and has introduced a staff disability and reasonable adjustments policy.

The Trust held 2 engagement events during a 12-month period, where disabled members of staff were invited to share their opinions and lived experience. Information from this session are shared at Trust board level and all appropriate actions are embedded in relevant forums, ie staff network action plan, WDES, etc.

Members of the staff disability network have again participated in an engagement and listening event with the Trust Board. The staff network chair (or deputy) attends the Equality, Inclusion and Involvement committee and subcommittee to provide updates and discuss matters regarding the staff network. This network is supported additional by the Trust Diversity Inclusion and Belonging Lead.

Metric 10 – Board representation based on ESR data as at 31.03.22.			
	Disabled	**Non disabled**	**Unknown/null**
Total Board members - % by disability	6.67%	80%	13.33%
Voting Board members - % by disability	7.69%	76.92%	15.38%
Non-Voting Board members - % by disability	0%	100%	0%
Executive Board members - % by disability	0%	100%	0%
Non-Executive Board members - % by disability	14.29%	57.14%	28.57%
Overall workforce - % by disability	8.96%	86.79%	4.25%
Difference (Total Board – overall workforce)	-2.29%	-6.79%	9.08%
Difference (Voting membership – overall workforce)	-1.27%	-9.87%	11.13%
Difference (Executive membership – overall workforce)	-8.96%	13.21%	-4.25%

There is 1 board members reporting a disability and 2 reporting as unknown.

NHS Trusts are required to publish the WDES data and associated action plan by 31st October 2023, following Trust Board ratification. An action plan has been produced following discussions with the staff disability network chair and is attached as a separate document.

WDES Actions Undertaken in 2021/22

A summary of the actions taken in 2021/22 are detailed below:

- The Trust has taken action to encourage both staff and service users to share their equality information in our ongoing #Allofyou campaign where we acknowledge that by sharing equality data, individuals will be helping us to offer appropriate support that respects and recognises who they are. This campaign in ongoing.

- The Trust remains committed to Project Search in partnership with Mid Yorkshire Hospitals NHS Trust. The project is a pre-employment programme which helps young people with learning disabilities gain the skills they need to obtain meaningful paid employment. Following a pilot internship, we have offered further placements in our Estates and Facilities department.

- The Trust has continued with a guaranteed interview scheme, and we include a positive statement on our career's portal for prospective applicants which states:

  - The Trust is committed to equality of opportunity for all and will not discriminate on the grounds of any disability or ill health, and that includes mental ill health. We have a positive attitude towards employing staff who have disabilities. Our staff and potential employees are encouraged to be open about their health needs so we can offer the right support. If you are considering applying for a post with the Trust, having a disability including current or past experience of mental health problems will not prevent you being considered from the selection process, providing you fulfil the relevant criteria. We know there's a wealth of talent among people who have a disability, and you can be confident we will support your health needs, not only those that you may have at the moment but also any future mental health needs you may have during your

employment with us as the wellbeing of our staff matters to us. If you would like to discuss this further, in confidence, please contact any member of the recruitment team on 01226 434632 or email recruitment3@swyt.nhs.uk

- Engagement and listening events have continued to be held with the Trust Board which encourages members of the disability staff network to discuss and share their own lived experience.
- 2 engagement event was held over a 12-month period and insight from these events were shared at board level and actions embedded in relevant forums such as disability staff network and WDES action plan.
- We continue to support and embed the staff disability and reasonable adjustments policy which outlines 5 supportive steps to support staff with a disability. Included in this is a disability and wellness planning agreement which will support the process of implementing reasonable adjustments thought open honest and transparent conversation in line with Trust values.
- To support the implementation and embedding of the policy we are developing disability awareness training which we anticipate being rolled out during 2023/24.
- The Trust supports the development of a staff disability network and work is ongoing to embed the network, develop an annual workplan, annual communication plan and increase its membership.
- The Trust has continued to support and develop the peer support worker role.
- Estates and facilities continue to work on accessibility schemes e.g., improving signage, upgrading disabled WC facilities, disabled parking bays etc. as part of an ongoing programme of work.
- Wellbeing conversations form part of the annual appraisal process which provides a vehicle for disability related discussions to take place.
- As a Disability Confident Leader we are committed to supporting our disabled colleagues and we will continue to develop ongoing action plans based on insight gained from a variety aligning with WDES action plans.

Workforce Disability Equality Standard Action plan 2023

This document highlights the actions working towards WDES metrics which have been approved at Trust Board on 31st October 2023.

Each action has a lead, timescales and intended outcome and actions alongside progress tracker.

Progress Key

On Track	
Slippage Likely	
Critical	

Metric	Actions	Update	Intended Outcome	Lead	Timescales	Progress
Percentage of staff in AfC bands or medical and dental subgroups and very senior managers compared to the percentage of staff in the overall workforce.	Touchstone Recruitment Support project.	This project is funded by Health Education England now NHS England and is a pilot partnership project between the Mental Health Learning Disabilities and Autism (MHLDA) Collaborative and Touchstone, focused on. • reducing barriers and increasing awareness of jobs to under-represented groups • increasing diversity in the workforce • supporting Trusts to be local anchor institutions, recruiting locally, and supporting a reduction in health inequalities • engaging with a wider audience • supporting Trusts to have a more inclusive and diverse culture.	Review the annual report from touchstone which will provide an update on the project and present recommendations. These recommendations will be a lined with other project work across the People Directorate in relation to inclusive recruitment to ensure collaboration and learning	Recruitment Group / People Experience team	Ongoing during 23/24	
Percentage of staff in AfC bands or	Project Search	Working in partnership with Mid-Yorkshire Trust and Barnsley Hospital - continue to provide Project Search	Support our inclusive workforce profile.	HR	Q4/Q1 24	

medical and dental subgroups and very senior managers compared to the percentage of staff in the overall workforce. **And** **Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression and promotion**		Internship placements predominately within Facilities and support employment opportunities. Cohort 2023/24 TBC.	Review the success of this project and review if any internships have moved into permanent position. Explore opportunities to expand placements into other services areas across the Trust.		
Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts based on recruitment	Review recruitment process	The Trusts Recruitment Review Group (incorporating workstreams from the Inpatient Recruitment Review Group), including key stakeholders across the Trust to review areas of under-representation and a focus on disability recruitment and address any barriers.	A fair and equitable recruitment process which eliminates barriers for disabled applicants. Following review, map out action plan via collaboration across the Trust with key stakeholders to co-design and co-produce improvement plans to address any barriers in recruitment.	Head of Recruitment & Resourcing	23/24

data year to 31.03.23					
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.		Very small numbers entering the formal capability process, therefore no specific action developed at this time.		n/a	n/a
Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: *Patients/service users, their relatives or other members of the public. *Managers *other colleagues	NHS staff survey analysis	Identify any key patterns and trends which affect disabled staff from survey data and work with disabled staff network and other stakeholders to identifying other sources of insight and use this to develop appropriate action plans.	Improve and reduce the number of B&H cases on staff from SU.	People Directorate Leads/Staff network.	March 24

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: *Patients/service users, their relatives or other members of the public. *Managers *other colleagues	Preventing Harassment and Bullying Framework	New Policy due to be signed off in Q4. An implementation plan is being developed to support the culture change and new ways of working and is also part of the Trust's Great Place to work priority programme.	See a reduction in B&H cases from BME staff from other staff and management. Reduce number of overall B&H cases with the implementation of principles of just and learning culture.	HR & Staff side	End of /Q4	
Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression and promotion	Review the approach to performance and talent development, and how this aligns to our appraisal process and career development frameworks. Consider the current effectiveness and make recommendations to support the Trust's workforce development strategy.	The Trust has continued to develop its Coaching & Mentoring (C&M) Framework. Our Head of People Experience will be conducting a full review of this framework with the Leadership & Management Development Lead. This review will evaluate existing programmes including 360 feedback, peer coaching, executive coaching programmes and medical mentoring, and will also consider new options such as reciprocal mentoring, career planning and development coaching and peer support mentoring. The Trust continues to develop its offer for aspiring and newly appointed managers, and for leaders at all levels seeking to become more effective. This work includes defining the behaviours	Co-produce coaching and mentoring framework Coaching and mentoring framework to include offer for staff from under-represented groups. Support for line managers to promote the Trust's talent management	NF/NB	Q4 23/ Q1 24	

		and capabilities required to lead in a way that is compassionate, inclusive and aligned to our core values and golden threads.				
Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. And **Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work.**	Disability Awareness training and Reasonable Adjustment policy	Roll our disability awareness training for staff and managers linked to the staff disability and reasonable adjustments policy, encouraging the use of supportive disability and wellness planning agreements.	Support and maintain staff wellbeing. Work in collaboration with staff network to map out and lead on communication plan to promote this training and policy.	L&D/People Directorate Lead/Staff Network	Quarter 4 onwards	
Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from	NHS staff survey analysis	The Trust reported figures from the staff survey has reduced from 20.2% in 2021 to 18.2% in 2022. This is now 0.7% better than the average benchmarking group percentage. The Trust is committed in offering a robust OH offer to all staff.	Continue to analyse staff survey results to sustain improvement and develop actions where appropriate.	People Directorate	Ongoing	

their manager to come to work, despite not feeling well enough to perform their duties.					
Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	NHS staff survey analysis	Results from the 2022 staff survey reports figures for staff with a disability above the average benchmark Trust by 3%. The Trust is committed in maintaining and improving its performance	Continue to analyse staff survey results to sustain improvement and develop actions where appropriate.	PD/staff network	Ongoing
Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled Staff Network annual members survey	Co-create annual members survey to capture lived experience of members of the network and map out how this can be circulated to staff recorded on ESR with a disability and/or LTC. This is in line with NHSE recommendation.	Capture voice of disabled workforce on a range of key areas in line with employee lifecycle. Develop action plan to address insight generated from survey results	DIB Lead/ staff network / QAIT	Q3/4
Percentage of disabled staff saying that their employer has made adequate	Accessibility	Continue to identify schemes to improve accessibility and environment as part of the Trust capital plan in conjunction with the staff network.	Eliminate able access barriers for staff	Estates/staff network	Ongoing

adjustments to enable them to carry out their work.					
Staff engagement score and action to facilitate the voices of disabled staff a/b	Disabled Staff Network Annual Communication / Action Plan	Diversity Inclusion and Belonging (DIB) Lead and Disabled Staff Network Steering group to develop an annual communications plan to ensure comms is cascade through the organisation and planned for in a timely manner. Annual action plans will support the network to maintain momentum with key actions led by the voice of disabled staff.	Maintain engagement of disabled workforce and ensure their voice co-creates and co-designs action plans and communication across the Trust	DIB Lead/Staff Network / Comms	23/24

Private/Public paper:	Public
Title:	**Workforce Race Equality Standard (WRES)**
Paper presented by:	Lindsay Jensen Interim Chief People Officer
Paper prepared by:	Iffath Hussain Diversity, Inclusion & Belonging Lead
Mission/values:	The Trust serves a diverse population across a large geographical area and it is important we strive for a workforce that reflects the local population.
	A diverse workforce is vital to enable all parts of the communities served by the Trust to reach their potential.
	Equality and Diversity and Inclusion is core to the Trust's values and is an important part of its service and is central to the Workforce Strategy and objectives.
Purpose:	This paper presents the 2023 WRES annual summary report and action plan 2023/2024

Strategic objectives:	Improve Health	
	Improve Care	✓
	Improve Resources	
	Make this a great place to work	✓

BAF Risk(s):	2.4 - Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience.
	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 WRES helps local and national NHS organisations to review their workforce data to enable them to produce action plans to close any gaps and improve the experience between White and Black and Ethnic minority (BAME) staff as valued members of the workforce.
Any background papers / previously considered by:	The 2023 WRES annual summary report and action plan were presented at the People Remuneration Committee on 11th of September 2023 and the Equality, Inclusion and Involvement Committee on 13th September 2023 and EMT on 19th October 2023.

With **all of us** in mind.

Executive summary:	The Trust recognises the importance in delivering culturally sensitive services that meet the needs of the communities we serve, and a diverse workforce is critical to achieving this aim. Also supporting reducing health inequalities. The WRES, which is a requirement for NHS Trusts, has been included in the NHS standard contract since 2015 and provides a framework which will support the embedding of workforce equality.
	The main purpose of the WRES is to help local and national NHS organisations to review their workforce data against the metrics. This review should then enable organisations to produce action plans to close any gaps and improve the experience between White and Black and Ethnic minority (BAME) staff as valued members of the workforce.
	The WRES equality data was published in May 2023 and is used on a national basis to benchmark and monitor Trust progress against the indicators. Part of the requirement is to publish by 31st October an action plan setting out the actions and improvements to be undertaken across the Trust.
	Attached are:
	• WRES Summary Report 2023
	• WRES Appendix 1 data 2023
	• WRES Action Plan 2023
	The action plan has been developed to set out actions against the indicators and to demonstrate the expected impact and improvements for BAME people working in the Trust.
Recommendation:	**The Board is asked to support and agree the contents of the reports for them to be published in accordance with NHS England requirements.**

Workforce Race Equality Standard
REPORTING TEMPLATE
Template for completion

Name of provider organisation	Date of report; month/year	
South West Yorkshire Partnership NHS Foundation Trust	Month: August	Year: 2023

Name and title of Board Lead for the Workforce Race Equality Standard
Greg Moores, Chief People Officer

Name and contact details of lead manager compiling this report.
Iffath Hussain Diversity, Inclusion Belonging Lead iffath.hussain@swyt.nhs.uk

Names of commissioners this report has been sent to
Wakefield District Health & Care Partnership NHS West Yorkshire and South Yorkshire ICB Barnsley, Kirklees Health & Care Partnership Calderdale District Health & Care Partnership North of England & NHS Improvement West Yorkshire Collaboratives South Yorkshire Commissioning Hub

Names and contact details of co-ordinating commissioner this report has been sent to
Amanda Capper - Head of Contracts - South Yorkshire ICB - Barnsley - Amanda.capper@nhs.net Michael Bennett - Senior Contract Manager – Kirklees and Calderdale, Health & Care Partnership - NHS West Yorkshire ICB Michael.bennett3@nhs.net Ryan Turnbull - Senior Contract Manager – Wakefield District Health & Care Partnership - NHS West Yorkshire ICB - ryan.turnbull@nhs.net Rita Thomas- Head of Mental Health North East and Yorkshire Region, NHS England, and NHS Improvement rita.thomas1@nhs.net Sarah Jane Sam's - West Yorkshire Provider Collaboratives sarahjane.sams1@nhs.net Michelle Fearon - SYB commissioning hub. michelle.fearon1@nhs.net

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

No issues

b. Any matters relating to reliability of comparisons with previous years.

No issues

2. Total numbers of staff

a. Employed within this organisation at the date of the report.

There were 4798 staff employed by South West Yorkshire Partnership NHS FT as of 31st March 2023

b. Proportion of BME staff employed within this organisation at the date of the report.

12.8% BME staff in the workforce as of 31st March 2023

3. Self-reporting

a. The proportion of total staff who have self-reported their ethnicity.

99.74% of staff have self-reported their ethnicity – (0.06% non-clinical / 0.19% clinical)

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity.

The Trust uses ESR employee self-service which staff have been encouraged to use to self-report and check their own data.

c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity.

Trust plans to continuously ask staff to check their personal data stored on ESR on an annual basis.

4. Workforce data

a. What period does the organisation's workforce data refer to?

Years ending 2022/23 compared to 2021/22

5. Workforce Race Equality Indicators

Please note that only high-level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES action plans.

	Indicator	Data for reporting year	Data for previous year	Summary points
	For each of these four workforce indicators, the Standard compares the metrics for White & BME staff.			
1	Percentage of staff in each for the AfC bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Percentage of staff in each of the AfC bands 1-9- or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.	**Please see Appendix 1**	**Please see Appendix 1**	The number of BME staff in the workforce has increased by headcount of 94. (521 in 2022 to 615 in 2023 (including AfC 1-9, VSM and medic staff)) The total percentage BME staff in workforce is now 12.8%. (Total workforce 4797 at 31.3.23)
2.	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.	**1.08**	**1.40**	The data shows that BME applicants are less likely to be appointed from shortlisting than white applicants. This year has shown an improvement.
3.	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	**0.42**	**2.37**	The data shows that BME staff are now significantly less likely to enter a formal disciplinary process than white staff in this reporting year. This is a significant drop from last year's reporting. A cultural and environmental questionnaire is completed by both the individual(s) and the manager. This looks at the individuals' cultural perspective and the culture and behaviours on the ward/service to reduce any cultural or environmental basis. This is completed prior to any decision progressing to either the Resolution or formal disciplinary process.

				The introduction of this positive approach, has impacted on the relative likelihood figure for this reporting year as the numbers of staff going through a formal process has reduced by around2/3. This means that the numbers involved in this year's calculation are now so small that meaningful comparisons are challenging. The disciplinary policy is being reviewed at present and We will continue to monitor and evaluate the new process to ensure this is not having any adverse impact on BME staff.
4	Relative likelihood of White staff accessing non-mandatory training and CPD as compared to BME staff.	0.70	0.86	The data show that BME staff are more likely to access non-mandatory training and CPD than White staff. The data includes medical staff.

	Indicator	Data for reporting year		Data for previous year		Summary points
	<mark>For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff</mark>					
5.	KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	White	27.3	White	27.1	The 2022 staff survey was sent to all staff in the Trust. The response rate was up from 41% in 2021 to 50% (2303 responded) in 2022.

2022 staff survey results indicate that the BME staff who responded were more likely to experience harassment and bullying from service users and carers than white staff. The position is now worse than last year's figures and average benchmark group of 31.5%. |
		BME	37.0	BME	31.1	
6.	KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	16.0	White	15.6	2022 staff survey results indicate that the BME staff who responded were more likely to experience harassment and bullying than white staff. However, this position has improved since last year figures, and we are below the average benchmark group of 22.8%
		BME	18.5	BME	21.5	

7	KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	White	63.0	White	62.1	2022 staff survey indicates that the BME staff who responded indicated they were more negative regarding believing the Trust provides equal opportunities for career progression or promotion than white staff. These figures have got worse compared to last year by 3.8%
		BME	49.8	BME	53.0	
8	Q16b. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Managers, team leader or other colleagues?	White	4.5	White	4.1	2022 staff survey indicates that the BME staff who responded were more likely to experience discrimination at work from their manager, team leader or other colleagues than white staff. This position has improved since last year and we remain below average percentage of other benchmark groups.
		BME	10.5	BME	13.0	

	Board representation indicator. For this indicator, compare the difference for white and BME staff					
9	Percentage difference between the organisations Board membership and its overall workforce disaggregated by: Voting membership of Board Executive membership of Board	+ 10.3% + 12.2%		+ 11.9% +13.8%		The Trust has 3 BME Voting Board members. 2023, 3 x BME 9 x White 2022, 3 x BME, 10 x white. Reporting year White workforce 87% BAME workforce 12.8% Previous year White workforce 88.6% BAME workforce 11.2%

Note 1: All provider organisations to whom the NHS Standard Contract applies are required to conduct staff surveys though those surveys for organisations that are not NHS Trusts may not follow the format of the NHS Staff Survey.

Note 2: Please refer to the Technical Guidance for clarification on the precise means of each indicator.

Report on the WRES indicators, continued

6. Are there any other factors or data which should be taken into consideration in assessing progress? Please bear in mind any such information, action taken and planned may be subject to scrutiny by the Co-ordinating Commissioner or by regulators when inspecting against the "well led domain".

The Trust also publishes a detailed Equality Workforce Monitoring Annual Report on our website, link at No 7 below. Progress regarding the Equality agenda is monitored by the Trust Board at the Equality, Inclusion, and Involvement Committee
The Trust provides secure services across Yorkshire and Humber which has a different population make up compared to that of its local services.

7. If the organisation has a more detailed Plan agreed by its Board for addressing these and related issues you are asked to attach it or provide a link to it. Such a plan would normally elaborate on the steps summarised in section 5 above setting out the next steps with milestones for expected progress against the metrics. It may also identify the links with other work streams agreed at Board level such as EDS2.

The Trust has developed a WRES workforce 4-point action plan, please see link below:
https://www.southwestyorkshire.nhs.uk/about-us-2/performance/workforce-equality/

Workforce Race Equality Standard Action plan 2023

This document highlights the actions working towards WRES metrics which have been approved at Trust Board on 31st October 2023.

Each action has a lead, timescales and intended outcome and actions alongside progress tracker.

Progress Key

On Track	
Slippage Likely	
Critical	

Kay Action Area – Representative Workforce and Recruitment

Metric	Current Actions	Update	Intended Outcome / Actions	Lead	Timescales	Progress
To increase the % of BME staff in each of the AfC bands 1-9 and VSM *(inc Executive Board members)* to reflect the % in the local population.	International nurse recruitment, medical fellowship programme and other staff groups.	The Trust continues to recruit nurses and medical staff from overseas through a planned monthly cohort delivery until March 2024. So far, the Trust has recruited over 80 INR nurses with a further 30 in future cohort delivery. Retention of these nurses is over 95% and some have already been successful in promotion within wards-based roles. Pastoral support offer has been expanded to accommodate our expanding international nurse numbers with a doubling of pastoral roles and a further clinical support role to assist in ongoing pastoral/clinical support on the wards.	Intention was to reduce our inpatient vacancies, and this has been achieved. as a biproduct our BME workforce in clinical areas have increased. The Trust intends to monitor our turnover rates to IN experience to identity areas of improvement and learning.	HR (RB)	Ongoing during 23/24	

To increase the % of BME staff in each of the AfC bands 1-9 and VSM *(inc Executive Board members)* to reflect the % in the local population.	Touchstone Recruitment Support project.	This project is funded by the former Health Education England now NHS England and is a pilot partnership project between the Mental Health Learning Disabilities and Autism (MHLDA) Collaborative and Touchstone, focused on, • reducing barriers and increasing awareness of jobs to under-represented groups • increasing diversity in the workforce • supporting Trusts to be local anchor institutions, recruiting locally, and supporting a reduction in health inequalities • engaging with a wider audience • supporting Trusts to have a more inclusive and diverse culture.	Review the annual report from touchstone which will provide an update on the project and present recommendations. These recommendations will be aligned with other project work across the People Directorate (PD) in relation to inclusive recruitment to ensure collaboration and learning.	Recruitment Group / People Experience (PX) team	Ongoing during 23/24	
To increase the % of BME staff in each of the AfC bands 1-9 and VSM *(inc Executive Board members)* to reflect the % in the local population.	Sustainability/Anchor organisations	In July 2022 the Trust agreed a social value and sustainability strategy including commitments to engage with local anchor networks to increase opportunities for local recruitment in deprived areas to reduce inequalities with a focus on areas with high numbers of people from different ethnic backgrounds This work will be supported by the Trust having adjusted our maths and English qualification requirement to entry level 3.	Increase applications from BME candidates. Review and evaluate the impact to see if more candidates have applied	PD (LJ & RB)	3-year project up to 2025	
To increase the % of BME staff in each of the AfC bands 1-9 and VSM *(inc*	Recruiting from the Trust bank staff into the substantive workforce	The Trust is continuing to actively encourage bank staff to consider moving into vacant posts in the substantive workforce following an informal interview rather than a full application process.	Collaboration between People Experience and Recruitment team to review current process and outcome.	PD (C. Hill) / PX team.	Ongoing during 23/24	

Executive Board members) **to reflect the % in the local population.**			Following review, map out improvement plan, which is drawn up with the principals of co-create, co-produce and co-design. This therefore will include engagement plans with bank staff.			
To increase the % of BME staff in each of the AfC bands 1-9 and VSM *(inc Executive Board members)* **to reflect the % in the local population.**	Review if there are key areas where there is under representation, e.g., corporate services bands 5 to 7 and key clinical jobs.	The Trusts Recruitment Review Group including key stakeholders across the Trust to review areas of under-representation of BME staff across the Trust in all areas e.g., corporate/clinical.	Gain an understanding of workforce profile by race and map out if this is representative of the community. Identify areas of improvement and draw up an action plan to address this.	Recruitment Group & RB	Q4 23/24	
To ensure that the relative likelihood of BME staff being appointed from shortlisting across all posts is the same as that of white staff	Review recruitment process. Look at including BME representative on all key appointments include 8a and above.	The Trust ensures BME representation on senior level recruitment (8a and above) through both interview panel representation and/or stakeholder group events as part of the interview process. We are widening the representation of BME availability staff and will be delivering staff interview training. As a Trust we encourage all interview panels involve BME representation regardless of band/role being appointed.	We will define our approach in representative panels in the recruitment process. Review our current pool of representatives and drawn up plans to increase this. Ensure recruitment training is completed by all representative and newly recruitment representatives. Collate feedback from candidates and recruitment panel as part	Recruitment Group & RB	Ongoing during 23/24	

			of an evaluation process to capture leaning and identify potential arears of improvement.			

Kay Action Area– Representative Leadership at all Levels

Metric	Actions	Update	Intended Outcome	Lead	Timescales	Progress
To ensure that the relative likelihood of BME staff accessing non-mandatory training and CPD is the same as that of white staff.	Full review to understand why colleagues do or do not access learning, to find out how learning is accessed and the barriers to doing this, and what learning resources are available and their relevance, quality and impact.	An extensive review of our leadership and management development resources for all colleagues is being conducted by our Leadership & Management Development Lead. This will consider the views of key stakeholders including Diversity Inclusion and Belonging Lead, OD and L&D Leads as well as insights generated from Inclusive Leadership Culture Programme (ILCP), Appreciative Inquiry workshops, staff survey and focus groups	Appropriately tailored communications and learning resources to support BME staff development. Priority places for colleagues from under-represented groups where programmes are fully or over-subscribed. Support for line managers to increase focus on development and access to learning resources of BME workforce.	PD/NF/NB	During Q4 23/ Q1 24	
To increase the numbers of BME staff believing the Trust provides equal opportunities for career	Inclusive Leadership Culture Programme	An external provider is working alongside the People Directorate to facilitate a collaborative discovery and action planning exercise focussing on inclusive leadership and culture. We aim to understand current state and identify opportunities for	Following completion of phase 2 the recommendation report will identify best practice approach to measure progress on the trust	PD/OD	Q3 with recommenda tions in Q4 23/24	

progression or promotion.		improvement which will help strengthen and grow inclusive leadership and culture. The programme is currently in phase one, discovery and output.	journey towards inclusive culture. Recommendations will help shape and inform the Trust on its leadership and training offers for staff		
To increase the numbers of BME staff believing the Trust provides equal opportunities for career progression or promotion.	Review the approach to performance and talent development, and how this aligns to our appraisal process and career development frameworks. Consider the current effectiveness and make recommendations to support the Trust's Great Place to Work strategy.	The Trust has continued to develop its Coaching & Mentoring (C&M) Framework. Our Head of People Experience is now the lead of coaching and mentoring and will be conducting a full review of this framework with the Leadership & Management Development Lead. This review will evaluate existing programmes including 360 feedback, peer coaching, executive coaching programmes and medical mentoring, and will also consider new options such as reciprocal mentoring, career planning and development coaching and peer support mentoring. The Trust continues to develop its offer for aspiring and newly appointed managers, and for leaders at all levels seeking to become more effective. This work includes defining the behaviours and capabilities required to lead in a way that is compassionate, inclusive and aligned to our core values and golden threads.	Co-produce coaching and mentoring framework for BME staff. Coaching and mentoring framework to include offer for staff from under-represented groups. Support for line managers to promote the Trust's talent management of BME workforce.	NF/NB	Q4 23/ Q1 24
To ensure that the relative likelihood of BME staff accessing non-mandatory	Flair project	This project will look at harnessing Trust data to drive racial equality by using 4 key metrics: awareness, inclusion, behaviours, and diversity. The Trust is considering	Recommendations following survey results are being mapped out against existing Trust processes and identify areas of improvement and	DP/HR	Ongoing till 2025

training and CPD is the same as that of white staff. **And** **To increase the numbers of BME staff believing the Trust provides equal opportunities for career progression or promotion.**		expanding the project to include other protected characteristic groups. Flair survey was first conducted in April 2023 with a commitment to undertake a further 2 surveys up to 2025. The results are being reviewed and an infographic is being produced to share the key finding, actions and ongoing recommendations with staff. The survey results will also be key information to use as part of our ongoing development of our EDI / belonging and inclusion strategy work which will strengthen the trust GPTW strategy	developing these actions with stakeholders across the Trust. Mapping work on round two of flair survey in 2024.			
	Enhanced Equality, Diversity Inclusion and health inequalities training delivery.	Development of Enhanced E D I and Health Inequalities Training delivery due to commence in September 2023 with a roll out plan for all Line Managers	All line managers to have completed Enhanced ED&I training by Q3 2024.	ZM	Ongoing	
To have a Trust Board whose BME voting membership reflects its overall BME workforce	Clear board succession plans	Continue to engage in the Non-Executive Gateway Programme	Ensure when any recruitment takes place that we advertise as wide as possible to attract diverse candidates			

Kay Action Area – Bullying and Harassment (including All of You Race Forward)

Metric	Actions	Update	Intended Outcome	Lead	Timescales	Progress
To reduce the numbers of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	ALL of You Race Forward network focusing on embedding a zero-tolerance approach regarding harassment and bullying from service users, carers and visitors. Reciprocal mentoring is also offered to network members.	Group led by Chief Nurse, Quality and Professions, with more clinical involvement/engagement and data to understand all the issues. The Network has a focus lens on B&H cases on staff from SU and discuss ways to map out workstreams to address and reduce these. As a result, task and finish groups are created to lead on actions and a monthly work program is created to track progress. Reciprocal mentoring is offered to all groups members to ensure all voices are heard.	To work toward a zero-tolerance approach to B&H. Benchmark and learn from other Trust systems and process to zero tolerance approach. Whilst the focus of All of You Race Forward network is to reduce B&H cases on staff from SU and carers, it's expected that this will have a ripple effect in reducing the number of cases of B&H on BME staff from other staff and managers.	CN/CPO	Ongoing	
To reduce the numbers of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Appointment of Equity Guardians to support staff throughout the Trust who are experiencing racial bullying and harassment from service users and carers.	The Trust continues to work on embedding Equity Guardians Trust wide. Currently we are mapping our Equity Guardian Champion roles. This role will help to support senior Equity Guardians and widening access of all staff across all Care Groups and services. People Experience team will review a development plan to support EG to thrive in their role.	Support staff who are victim of B&H and support managers in the management of cases in line with policies and procedures. Draw up a comms plans to market the EG offer across the Trust. Review interventions by EG to identify any hot spots and areas and trends to map out improvements where needed and a line this intel with other stakeholders	PD/IH	Q3/Q4 23 / Q1 24	

Metric	Actions	Update	Intended Outcome	Lead	Timescales	Progress
		such as race forward group.				
To reduce the numbers of BME staff experiencing harassment, bullying or abuse from staff in the last 12 and To reduce the numbers of BME staff who have personally experienced discrimination at work from manager/ team leader or other colleagues in the last 12 months.	Preventing Harassment and Bullying Framework to include communications programme on racially motivated B&H.	New Policy due to be signed off in Q3. An implementation plan is being developed to support the culture change and new ways of working and is also part of the Trust's Great Place to work priority programme. The revised policy includes an enhancement which introduces bystanders training and restorative practice.	See a reduction in B&H cases from BME staff from other staff and management. Reduce number of overall B&H cases with the implementation of just and learning principles.	PD & Staff side (DT)	Q3/Q4	

Kay Action Area –Formal Disciplinary

Metric	Actions	Update	Intended Outcome	Lead	Timescales	Progress

To ensure that the relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation is the same as that of white staff	To continue to monitor numbers of cases by BME groups	Numbers and information by ethnic and other protected characteristics reported to Operational Management Group on a regular basis	To identify any potential bias	DT/JM	Ongoing	

Collaborative Committee	
Date	3 October 2023
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)

Key items to raise at Trust Board	Alert
	• The Committee discussed the appropriate governance routes for papers on options re commissioning for the Phase II FCAMHS Collaborative and the business case for SY Community Forensic Team. Further meetings agreed to discuss the role of the Committee.
	
	Advise
	• December Committee meeting to receive paper evaluating current performance of Collaboratives against objectives set in original business cases.
	• Trust confirmed as co-ordinating provider for Maternal Mental Health Services from April 2024
	• Whilst there has been progress, further work is needed to harmonise performance reporting across the two Phase1 collaboratives; this will also need to address the integration of Phase II. In addition, Committee members have asked for further consideration to be given to comparative report across WY and SY collaboratives.
	• Furthermore, there are opportunities for further analysis of ethnicity data.
	• NB Performance reporting received currently covers:
	   o Bed occupancy
	   o Referrals
	   o Admissions
	   o Out of area
	   o Discharge rates/delayed discharge
	   o Length of stay
	
	Assure
	• The ORR risk to the Trust from the role of Co-ordinating/Lead Provider was reviewed independently at Committee following a committee workplan update. Mitigating actions are in place/underway but a further review of the Trust's appetite for this risk should be carried out at Board level.
	• The Committee continues to receive reporting across the following areas from both collaboratives.
	   o Finance – forecast for year at end of period 3 shows surplus position for WY Adult Secure but small deficit for SY Adult Secure.
	   o WY also has investment fund available for 23/24 which can't be carried forward so further work needed to make best use of that fund.
	   o Contracting – work on track to complete work for 22/23 and 23/24 by December but latter year still dependent on NHSE

	• Quality – specifics covered Length of Stay/Discharge/Out of Area beds/8 weekly reviews for all service users/SY SPA team • Risk – timing of actions to mitigate detailed risks to be looked at further. • Reporting received covering performance of the Trust where we are a partner in collaboratives rather than the lead. Committee confirmed that the financial risks associated with these are included in the overall Trust forecast.
Approved Minutes of previous meeting/s for receiving	Minutes presented to the private board due to being commercial in confidence.

Audit Committee	
Date	10 October 2023
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)

Key items to raise at Trust Board	Alert
	• The Committee received an Internal Audit Report with Limited Assurance on Accessible Information Standards. Issues related to inconsistent application of the framework of governance, risk management and controls – an update re progress re delivery of agreed recommendations will be brought back to a future Audit Committee meeting.
	• Internal Audit's regular report indicated that there has been some slippage in the timely availability of Trust staff/information to support internal audit activity and the timely delivery of audit recommendations. It is recognised that there is significant pressure on staff at present but providing input to audit activity is needed to support this important assurance process.
	• The standard report triangulating risks across the BAF/ORR/IPR was presented. As at previous meetings, this lists those risks that are on the ORR but do not feature in the BAF or IPR (generally as they are operation in nature). There are currently 6 out of 35 risks that fall into this category, which is an increase on previous periods. It is recommended that the Board review these risks on an annual basis to confirm that they are comfortable that the risks should not feature on the BAF and/or IPR.
	
	Advise
	• A new report on Procurement activity was presented by the Head of Procurement. The Committee has requested that the Head of Procurement provides an assessment of the Trust's procurement function for presentation at a future meeting.
	• The Committee approved changes to the annual internal audit plan to reflect current pressures in HR team.
	• Final external audit certificate of completion received for 22/23.
	
	Assure
	• Positive assurance received from regular reporting of
	   o Internal Audit and Counter Fraud activity by 360 Assurance
	   o Treasury Management
	• Papers were received covering
	   o Comprehensive review of systems development activity
	   o The annual National Cost Collection exercise – NB authority to sign off delegated to Director of Finance

	o Declaration of "partial compliance" against revised NHSE Core Standards for EPRR, NB this is consistent with last year despite more stringent standards. Work is ongoing to assess the cost/benefit of seeking to achieve substantial compliance.
Approved Minutes of previous meeting/s for receiving	11 July 2023

Quality and Safety Committee	
Date	17 October 2023
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	Alert • The committee was made aware that there is an issue regarding inequity of access for ADHD (attention deficit hyperactivity disorder) for people with a learning disability, this is in relation to accessing an assessment. Further work is being undertaken to understand this and will be reported back to the committee. • The committee was advised that forensics are reviewing their discharge reporting process and there is an expectation that the number will increase (currently zero). • Risk 1530: The committee was made aware that related to this risk a review into demand has shown that the data does not correlate with what we are hearing from staff in terms of increasing demand. This work is ongoing and will report back to the committee. • The committee shared their concerns about the findings of the RRPI (Reducing Restrictive Practice Interventions) Annual Survey in terms of the trust being an outlier and subsequent discussion on how we record at SWYPFT. Specific concerns were raised around the use of prone restraint. This risk is being escalated to the Trust board and an update has been requested from the Director of Nursing and Professions and the Medical Director for the next meeting on 31st October. Advise • The committee heard from the Long Covid service and noted it was therapy-led. The service is keen to raise the awareness so people can access it and get support. • The committee agreed to support the move away from the Mental Health Inpatient Service User survey with the condition that we develop our alternatives and continue to do better in hearing from those who use our services and acting on their feedback. • The committee heard that the trust is investing in bespoke safety pods as an alternative to prone restraint and NEDs asked if they could visit and see these to understand more about their use and effectiveness. • The committee was advised that the Barnsley Speech and Language Therapy Service have won a national award 'Giving Voice' for their 'Hey, it's ok to stammer campaign'. • The committee heard about the work being undertaken to prevent falls across the community service attending Barnsley market with other partners to share information and guidance. • The committee received the update on the Clinical and Strategic Approach to Learning Disability Improvement. Assure

	- The committee received the Older People Service Inpatient Transformation business case. The committee was assured about the stakeholder engagement process to date and the process around the comprehensive Quality Impact Assessment. However, the committee asked for clarification when it comes to the Board around consultation process and the difference in engagement and feedback. - The committee received the Deep Dive report into Pressure Ulcers and was assured by the analysis and work being undertaken by the team to report and prevent. The committee were assured by the data provided that reporting at the early stages is increasing and having an impact on reducing the prevalence of pressure ulcers in category 3 and 4. - The committee received the Quality strategy update and were assured of the progress and noted the risks to delivery. - Risk 1650 is being reviewed in line with trust process following an incident whereby a person gained access to the roof from Melton Suite PICU. The committee has oversight of this risk and will monitor this review and the risk. - Out of Areas beds usage has seen an ongoing reduction (at the meeting we were advised it was down to 2 people). - PSIRF (Patient Safety Incident Response Framework) was recommended for approval at Trust Board.
Approved Minutes of previous meeting/s for receiving	24 July 2023 and 12 September 2023

Finance, Investment & Performance Committee	
Date	23 October 2023
Presented by	David Webster, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	Alert - Capital availability sits on the risk register and has increased from possible to likely due to constraints across the system. - Agency spend continues adverse to budget. Advise - Cost Improvement Programmes are beginning to be explored for future years across this quarter via engagement with all suitable teams. - Agency spend increased month on month, and further understanding why will be brought (alongside review of out of area spend) in November's committee. - Forecast was reviewed, including possible risks and opportunities to deliver year end position. - Differing wait times across local areas was discussed, and noted that due to differing commissioning and journeys, we had limited ability to balance this out. Assure - Capital remains behind plan but expected to close this gap by the end of the year. - Slight deficit in the month, adverse to plan, expected to recover this by the end of the year.

Approved Minutes of previous meeting/s for receiving	17 July 2023 and 18 September 2023

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

Minutes of the Audit Committee held on 11ᵗʰ July 2023
(Virtual meeting, via Microsoft Teams)

Present:	Mike Ford (MF) Mandy Rayner (MR) David Webster (DW)	Non-Executive Director (Chair of the Committee) Non-Executive Director (Deputy Chair of the Committee) Non-Executive Director
Apologies	Lianne Richards (LH) Nick Phillips (NP)	Client Manager, 360 Assurance Deputy Director, Estates & Facilities
In attendance:	Rob Adamson (RA) Imran Ahmed (IA) Elaine Dower (ED) Charles Elliott (CE) Carmaine Gibson-Holmes (CGH) Caroline Jamieson (CJa) Lindsay Jensen (LJ) Estelle Myers (EM) Leanne Hawkes (LR) Adrian Snarr (AS) Julie Williams (JW) Nicola Wright (NW) Jane Wilson (JWi)	Deputy Director of Finance Head of Procurement 360 Assurance Governor (observing) Deputy Director of Nursing Quality & Professions (item 15, observing) Senior Manager, Deloitte Deputy Chief People Officer (item 15) FTSU Guardian (observing) Deputy Director, 360 Assurance Director of Finance and Resources Deputy Director of Corporate Governance Partner, Deloitte Note taker

AC/23/64 Welcome, introduction, and apologies (agenda item 1)
The Chair of the Committee, Mike Ford (MF) welcomed everyone to the meeting. Apologies were noted as above, and the meeting was deemed to be quorate and could proceed.

MF 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.

AC/23/65 Declaration of interests (agenda item 2)
There were no further declarations over and above those made in the annual return to Trust Board or subsequently.

AC/23/66 Minutes from the meeting held on 26 June 2023 (agenda item 3)
It was RESOLVED to APPROVE the minutes from the Audit Committee meeting held on 26ᵗʰ June 2023

AC/22/67 Matters arising and action log from the meeting held on the 11 April 2023 & 26ᵗʰ June 2023 (item 4)

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

AC/23/68 Actions delegated to Audit Committee from Trust Board (item 5)
MF confirmed there were no actions delegated from the Trust Board to Audit Committee.

AC/23/69 Consideration of items from the Organisational Risk Register allocated to the Audit Committee (agenda item 6)
AS presented the update stating the paper covers all the risks aligned to the Audit Committee, and that currently there were no proposals to change any of the risk rating scores.

Key headlines:-

Risks above 15
Risk 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.
AS confirmed there is a Cyber paper on today's agenda and the committee will be aware from our many discussions here, it is a difficult area to reduce the risk rating, due to the continual inventive ways people try to facilitate cyber-attacks. We balance this with the fact that whilst we do not want to be complacent, we do feel we are in a strong place compared to NHS peers.

Risks below 15
Risk 1159 - Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.
AS confirmed there was no change, we have looked at some of the control measures, particularly where the Trusts smoke free policy has been updated and is now in the process of implementation.

Risk 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.
AS confirmed that although not much has changed, work is being carried out in the background around processes to capture positive consent, there is always a risk of an IG breach to the trust should we release something where we do not have the right consent in place. Julie Williams (JW) and her team are working on this area so we can assure ourselves we have the correct consent in place when we develop digital solutions. AS explained that part of the challenge is that some of the digital solutions build in assumed consent, and we have slight differences with partner organisations or other bits of the NHS. One of the things we have been working through is a process where our clinical information flows through to primary care records, and the GP record, and we are clear we have the necessary markers in place where consent has been obtained or not.

Risk 1217 - Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.
AS confirmed that Salma Yasmeen (SY), Director of Strategy (DoS)had taken the opportunity to review all the actions prior to leaving the Trust, these have all been updated and there is no change to the risk status.
MF remarked the only comment he had was around the expected date for completion of our actions is March 2024. He commented that you could argue that if we have not completed these actions by then does it not increase the risk that we will not have capacity to deliver this year's objectives.
AS responded that it does and that is a good point, he agreed to take this away as an action to discuss with the newly appointed DoS. AS stated that he was confident it will get picked up elsewhere, but he will check the dates on the risk register entry to see whether there should be quarterly touch points to see how progress is going around that capacity challenge.

MF commented that although this is not particularly discussed in detail at this committee, more generally he does have concern around capacity, as we continue to take on new initiatives. He stated as this risk is assigned to this committee is there something else we should be doing or looking at, and he suggested AS take a look at this in light of the actions.

MR remarked that some of that risk would be picked up at Board. MF replied that he thinks it would, but because it is an ongoing challenge and is assigned to this committee, should we be doing something in more detail. He appreciated that EMT are looking at this, but if there is no other committee looking at it, where do non-executives receive assurance around work being

carried out to manage capacity.

MF commented that in the light of ongoing changes at senior level with SY leaving the Trust, maybe this committee should be looking at this in more detail and was happy for AS to pick this up with EMT.

ACTION: Adrian Snarr

<u>Risk 1545</u> <u>Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic or as a result of the public inquiry.</u>

AS stated that although this risk is assigned to the Chief Medical Officer, AS is director lead for EPRR and JW is fundamental to making sure that we are capturing all the information we need to support the Covid enquiry, so we do not think this risk has changed.

MF commented for everyone's benefit this is legal challenge to the Trust around covid, as opposed to a clinical risk. He explained for those observing the committee today the individual risks from the Trust risk register are assigned to committees and it is the Audit Committees role to oversee the processes around risk and to understand whether they are fundamentally operating effectively. It also has responsibility for an individual number of risks which AS has just taken the committee through.

AS confirmed that a tracked changes version of the risk register is attached for the committee so that they can see clearly what has changed between reviews.

MR commented that whilst she appreciated there would be an update on cyber later in the meeting, she was aware of a cyber-attack at Barts Healthcare a couple of weeks ago and there had been a ransom demand on a phishing email. She stated the Trust were very strong technically around cyber, and she is aware there is a lot of work going on around staff awareness, but this is not as obvious as the great technical work we are doing.

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

AC/23/63   Triangulation of risk, performance, and governance (agenda item 7)

JW presented the update stating that the purpose of this report is to triangulate the information from the Organisational Risk Register (ORR), the Integrated Performance Report (IPR) and the risk management system that we have, including the Board Assurance Framework (BAF) which looks at the risks to us delivering our strategic objectives, to ensure that we are covered in terms of the level of risk that we have, and whether that is reflected in the key performance indicators that we are monitoring through the Integrated Performance Report.

JW stated that the triangulation process ensures the risks that are highlighted are escalated appropriately, and part of her role is to look from ward to board and board down to ward to check that risks that have been identified at an operational level, where necessary are getting raised into the organisational risk register, and this is done through discussions with the senior service directors and the chief operating officer. She stated this document supports the fact that we can evidence that we are managing the risks and the committee are asked to receive the report as part of the evidence of assurance on the operation of risk processes within the trust.

MF remarked this is a really good report and the only comment he would add is that when Mark Brooks (MB), CEO observed at the previous meeting he referenced the fact that there were lots of other committees overseeing individual risks, which resulted in lots of crossing referencing between committees.

MF thanked JW for the update.

It was RESOLVED to NOTE the updates on the Triangulation of risk, performance, and governance.

AC/23/64 Declaration of Interest Annual Update (agenda item 8)

JW presented the update stating the NHS spends a significant amount of public money every year and it is vital therefore that it is done in the best interests of the population it serves. The declaration of interests is one of the trust and national policies we have to adhere to. This is designed to ensure that executive directors and senior decision makers who hold a budget of a significant amount, medical consultants are now included from last year.

JW confirmed that she was pleased to report that of the 413 that are key decision makers in the trust all declared their interest or zero interest back as part of this report. She confirmed that 382 were nil returns, all of the ones that did declare an interest have been reviewed and reported where necessary.

JW stated that the Committee are asked to note the processes in place and be assured that the Trust is meeting the requirements of NHS England and there is no current risk to the Trust from declared staff conflicts. JW also asked for the committee to recognise the work of FE Hornby.

MF stated this is a significant improvement on recent years and it is great work from the team to get us to 100% in time for the annual report process. Particular thanks to be passed on to Fe Hornby, who has managed the process this year and has done an excellent job.

MF remarked that the success of this process will be one of the things he will declare to the board. He asked of the 31 items that have been declared are there any issues with those outside interests. JW replied that these have all been reviewed and are acceptable.

DW commented that it always flags alarm bells in his mind when personal sensitive information is being stored in excel. JW confirmed that the information is stored on a secure drive with access limited to herself and only one other individual who has been undertaking the exercise.

It was RESOLVED to NOTE the updates on the Declaration of Interest Annual update.

AC/23/65 SFI & Scheme of delegation Update (agenda item 9)

RA presented the update stating that the standing financial instructions and scheme of delegation are the rules and list of principles that helps protect the trust and individuals who work for the trust. He confirmed these were reviewed and agreed at the January 2023 Audit Committee. Changes incorporated included the move to provider collaboratives. Increases were made to financial hierarchy limits to reflect the move to purchase order. He stated all of these have been listed in the financial ledger and this is what the system is following and there have been no issues flagged.

RA confirmed spot checks continue to take place which seem appropriate, this will come back to the committee for periodic review in 12 months' time.

MF thanked RA for the update.

It was RESOLVED to NOTE the Scheme of Delegation update.

AC/23/66 External Audit Progress Update (agenda item 10)

Nicola Wright (NW) presented the update, she said it would be brief as the last meeting was not that long ago and they brought the financial statements report to that meeting. She confirmed Deloitte signed the opinion and that it was modified as discussed at the last meeting. It was submitted to the National Audit Office (NAO) on 5th July, which was the deadline.

NW confirmed the final steps are completion of the auditor's annual report, this work is largely complete, and it now needs to be written up and sent to the trust. There is also the audit of the charity which is a small component, and NW did not foresee any issues in getting this finalised.

MF asked if the value for money work was still to be finished. NW replied that this goes into the auditor's report, so most of this has been completed in order to issue the main opinion, it is now a case of finalising the documentation and getting the report written.

MF asked if this report went to Members Council. NW replied yes this is a public report and it will go to governors and be made available on the Trust website.

JW confirmed it will go as a public document as part of the pack to the annual members meeting in September.

MF thanked NW for the update.

AC/23/67   Procurement Report (agenda item 11)

Imran Ahmed (IA), newly appointed Head of Procurement, introduced himself to the committee members. IA stated at the outset he has taken the same approach that Tony Cooper had taken in the past in that the document still has 7 sections within the report.

IA confirmed the previous quarter had been fairly quiet compared to Q4 of the last financial year. The number of single tender waivers in the last quarter are below what they were in the last financial year.

MF commented that this is what we would expect as in Q4 there tends to be a lot of activity being pushed through before year end, he said he would be interested to see if the activity is lower than Q1 in the previous year.

AS remarked that IA and himself have only discussed this briefly but when they have looked at some of the single tender quotations, the rationale is not particularly strong and therefore we want to try and get that number down further. He stated one of the things that IA wants to focus on, is having a much better pipeline of activity for the Procurement team, rather than a lot of reactive requests. AS commented that it will help that IA has a lot of experience in this field, he is also going to work hard with the estates team to try and get a more even pipeline which will help the flow of the volume of work through the Procurement team, and also reduce the number of single tender actions, thereby demonstrating a strong value for money.

IA confirmed he has already started working with Nick Phillips, and looking at the long-term programme for estates, and measures are being put in place to ensure compliant contracts are in situ, rather than relying on single tender waivers.

IA confirmed the Q1 data from the previous year is included within the report.

DW remarked that in relation to quotation of waivers, one of the things he had spotted was that the inclusive leadership and culture programme, was sole provider and bespoke to SWYPFT. DW commented there are lots of companies out there who do these kind of things so he would appreciate a progress update at a future meeting around this. IA confirmed that he had spoken with AS about this and the fact that at the time of writing this report this had happened, and now that the new measures are in place, when we receive future requests for single tender waivers there is a lot more due diligence in place.

MF remarked that with IA now joining the trust, and with AS still being relatively new in post there is an opportunity to refresh this reporting. MF stated he felt the committee would benefit from a fresh pair of eyes, the experience of IA and where he has worked previously, and also the kind of challenges and improvements he would like to make as the new Head of Procurement.

MF remarked that he realised the next meeting will roll round quickly, and he understands if they need longer, he felt sure that DW as Chair of FIP and MR with her experience would be happy to work with IA if he wanted to share some ideas.

ACTION: Imran Ahmed/Adrian Snarr

MF remarked that as a committee we do not feel there is a significant risk here, but we would value some fresh input from IA.

MR asked if this report went to FIP as it states in the background that it is part of regular

reporting. AS replied that what would go to FIP is high value procurement and the business threshold has been set between the board and FIP.

MF stated the focus of this committee needs to remain on the risk management and governance of procurement.

MF thanked IA for the update. He remarked that one of the things he likes to do on this committee is to tap into our external expertise, and if Deloitte or 360 Assurance can help us in terms of what good practice they have seen in terms of procurement risk management and procurement governance elsewhere, it would be helpful for IA to make this connection.

It was RESOLVED to NOTE the Procurement update.

AC/23/68   Treasury Management Update (agenda item 12)

RA presented the update stating that he would firstly provide the highlights from the paper, and then the committee can have a discussion around whether or not they need to see samples of investment. He confirmed that all funds remain within the Government Banking Service (GBS). As of 30th June 2023, there were no funds invested, either with the National Loan Fund or with external organisations. Investment with the National Loan Fund is being explored to maximise the financial return. Interest rates continue to be monitored. These have increased for 13 consecutive times and are now at the highest rate since 2008. Current interest rates, with effect from 22nd June 2023 are 5%.

RA confirmed the trust are forecasting interest receivable this year of £3.6m, which considering it has been pretty much zero for the last three years, is quite a significant financial benefit. RA stated there is a lot of work going on in the background to ensure that we are maximising cash in the bank in order to get the most interest received as possible.

RA commented that previous discussions at the committee have been around at what point do we make a decision to invest some of the money currently in our main government banking service bank account to what would probably be the national loan fund to get higher rates.

He remarked that from his perspective he would be nervous about going too soon when all of the market intelligence shows that rates will continue to rise. He stated we are trying to gauge where the peak will be, so that we do not invest and get a lower rate than if we had just left it in the government banking service in the first place.

AS stated that it is worth clarifying that when we talk about investment away from government banking service we have got a very prudent approach, which would be to put it into the national loans fund, which is still part of treasury. He stated we are still some distance off making consideration about commercial opportunities.

AS asked RA if he could explain the technical bit about the 3.5% PDC to the committee in a way that everyone can understand.

RA explained that the national loan fund still counts the same as the government backing service, in that we can still deduct this from our PDC payment that we make, which is basically 3.5% of our net assets for the year. If we invested that money outside of those two accounts we would not get that sort of discount factor, so we would be looking for a rate in a private banking firm that was 3.5% more than we were getting which again will be around 10% by the time we are finished, and we do not think it is going to get to that stage.

RA remarked that our treasury investment strategy is very prudent, it is extremely low risk, so we are currently only looking at the national loan fund at the moment.

MF asked what the difference between the national loan fund and the government banking service was. RA replied that apart from a slightly differential rate, and it being locked in for a period of time there is not a lot of difference. He stated the benefit the national loan fund offers is it locks that rate in, so if we think rates have peaked and they are going to reduce, we can effectively lock in at that top point and secure all the benefits that come with that.

MF commented that it does not feel like this is a significant opportunity. RA replied that it can be, and the monies we are talking about could be £20-40m invested for six months, so there might

be a difference of £60k which is certainly an extra amount of money for the trust.

MF asked if the national loan fund was below the government banking service at the moment. RA replied yes and it always is, the point is to try and lock it when it is at the peak to protect ourselves against any reductions, the question is do we think it is going to reduce.

MF stated that it does not feel that now is the right time to make a move.

MF asked if this was discussed at FIP.

AS replied that it is to some extent, and for clarity we were unsure if it was a proposition to the Audit Committee or to FIP, and as it was not obviously clear we have tried to discuss it in both.

MF commented that from his perspective the principle that we are applying, he is happy that the Audit Committee oversees that, and gives an opinion and assurance to the board that the strategy and the policy are being applied appropriately, and the policy is a suitable balance between risk and reward. He stated that he would expect EMT to make the final decision and if needed FIP to be involved on an offline basis if it there was an urgent decision required.

DW remarked that for him the Audit Committees role is to agree the risk appetite. He asked RA if the trust work with any economists, as a lot of banks can give you access to economists for free essentially. AS replied that as far as he is aware we have not done historically.

AS stated there is quite an important contextual point in all of this, and when foundation trusts were created and wrote their investment strategies, the whole premise of a foundation trust was that you operated in surplus, built cash reserves to reinvest in capital, so your cash investment strategy was aligned to your capital investment strategy. He stated now, because of the CEDEL limits that we have discussed at board and elsewhere, that cash is in effect locked into the bank account and we cannot really do anything with it, other than get some interest from it. The whole investment decisions are much more simplified because we would have been having a conversation saying do we want to lock in £40m for six months, or do we want to leave it available for capital investment, and we cannot do that anymore, so it now much more of a binary decision than it used to be.

MF stated that it does not feel like we need to do any more detailed scenarios on this at the present time.

RA replied that from his perspective we will keep an eye on it and try and make a decision. He said the bit he is pushing with the team is maximising the cash in the bank in the first place.

MF commented that what the trust does with the extra interest that it is earning over and above the original plan is something that EMT will discuss and will be covered by FIP as opposed to this committee. AS replied yes and this is in our efficiency programme which we do present to FIP.

MF thanked RA for a really helpful update.

It was RESOLVED to NOTE the Treasury Management update.

AC/23/69   Losses & Special Payments Report Update (agenda item 13)

MF commented that this item has an asterisk against it on the agenda which means it is only covered if anybody has a specific question, otherwise it is taken as red. MF remarked that after setting that system up he now has a question in that how the trust is responsible for a theft of property from a stolen car. RA replied that it is because the lost goods were lower than the insurance excess, so it was cheaper to pay for what was stolen than claim through the insurance. MF asked if it was a member of staff or a service users' car. RA confirmed it was a staff members car with Trust property in it.

It was RESOLVED to NOTE the Losses & Special Payments update.

AC/23/70   Update on National Cost Collections, Deadlines and Process (agenda item 14)

RA presented the update stating he has intentionally not prepared a paper as they were waiting for the national meeting to take place that was scheduled yesterday, which was hopefully going to announce what the plan was for the national cost collection exercise for 2022/23, and this meeting was cancelled. He stated as things currently stand we do not really know what the plan is for this year's collection, guidance has been issued, but no deadlines have been issued so we are just waiting for feedback nationally on what the next steps are.

RA remarked that before we make a submission the committee have a role in terms of approving both the process undertaken and the submission itself, so we will need to work out the timescales for that, as it is he was not entirely sure when the window will open, but it is unlikely to be the original suggestion of September.

MF asked AS if he could provide the committee members and people observing with a quick update around what this process entails.

AS explained that for this particular national cost collection we go through a costing exercise which is called reference costing, and members will recall that the trust is moving from service line reporting whereby we do this costing at service level to patient level costing, so we do it an individual patient level and we have been on this transition for nearly a year now, partly because it is the right thing to do, but partly because that was the national ask, that all organisations move to patient level costing.

AS stated it is quite hard to figure out what is going on at a national level at the minute because costing is becoming increasingly high profile, in terms of the benefits it can offer across systems.

AS stated that he had attended an event last week where four of the presentations were on different initiatives that people are taking on costing. Nationally, there just seems to be a lot of ambiguity as to what the centre wants to do with the costing information. RA is feeding back that we have not got clarity from NHS England what the process is for that national cost collection, but we continue as a trust to develop our costing system, so we are ready to respond to that, and also to use it. He stated there does seem to be a bit of a disconnect going on.

MF asked if there was a likelihood that we would need to deal with something offline before the next meeting. RA replied that he thought it was more likely to be post-Christmas, which makes it slightly less meaningful when it is nearly a year out of date before you run the process. He explained we have only just received some output for 2021/22 that we think is reliable, which we need to report on and there are a lot of exclusions in this, so the outputs are not great, so it becomes slightly less meaningful.

MF asked that RA keep the committee up to date on what the next steps will be.

It was RESOLVED to NOTE the National Costing Collections update.

AC/23/71   Internal audit progress Update (agenda item 15)

Leanne Hawkes (LH) presented the update stating this is the first progress update for 2023/24 and it provides an update on the delivery of the plan across this year.

LH confirmed that since the last meeting 4 reports and 4 terms of reference have been issued. There stated there are a few highlights which she would like to update the committee on first of all as 360 Assurance will be looking for committee approval for some slight changes to the plan.

LH confirmed that they are just concluding the work on the waiting list management and that this should be coming through to the next Audit Committee. There has been a scoping meeting for the policy framework audit, and they are just waiting to hear back from the trust, the terms of reference should be ready to bring to the next meeting.

LH advised the trust has requested that 360 Assurance defer the Q2 data quality audit until Q3/Q4 so they are looking for committees' approval today to delay that piece of work, the trust have also requested that 360 Assurance bring forward the financials systems work into Q2 so that they can keep the flow of work going throughout the year, and we want to check the committee are happy with that.

LH remarked that so 360 Assurance can manage their delivery in year they are requesting a

change to one of the clinical quality pieces of work. They are requesting that the observation and seclusion work, which was scheduled for Q2, be moved forward to Q3.

LH stated the trust have requested that the absence management audit be deferred to Q3, this was originally a Q1 audit. 360 Assurance have suggested that the work on corporate governance be brought forward into Q2. She confirmed the Head of Internal Audit Opinion terms of reference were attached to the progress report.

LH stated that this is everything in terms of the adjustments to plan. In terms of other key messages, on follow up, the first follow up rate is 80%, which is a good position to start the year in, and the trust are currently hitting the target to get a significant assurance at year end, 360 Assurance work closely with JW to ensure we are on track with this.

LH asked if the committee would like to ask any questions before she moved on to the appendices where the detailed reports are.

MR stated it is good to see the absence management has moved to Q3 now on the back of the conversation that had taken place previously, and she is happy the trust is where they need to be at this early stage.

MF stated he was happy with the changes as long as trust management are happy with these. He remarked one thing he would like to question was the trust has proposed 360 Assurance bring forward the governance review and have requested they focus on governance arrangements at care group level. MF commented that as we have already just completed a report on care group risk management, he wondered why we were going to do another review at care group level, as these feel quite similar.

JW stated these are in fact quite different, and there is a framework that has been tested with other trusts around looking at governance throughout care group or divisional structures. The rationale for looking at our care group structures is that we moved from business delivery units to care groups about 12 months ago now, and this checks and balances that all the governance arrangements are in place post those restructures, it is much wider than looking at risk management, it is looking at overall governance.

MF confirmed the committee were happy to agree the changes to plan.

MF commented that in the matters arising there was a query around KPIs, and these have now improved, apart from the one area around having staff being available, and 360 Assurance have given us the reasons for this one KPI being below target. LH replied yes and the explanation is in there.

E Rostering Internal Audit

LH stated this is a limited assurance report, where 360 Assurance picked up some weaknesses. She stated there is some context in the summary of the report that Lyndsay Jensen (LJ) will want to touch on in terms of this is a fairly new arrangement in a roll out process and the trust know there is a lot of work to be done, and they have asked us to look at this for this reason.

LH stated that 360 have identified some issues and all the recommendations have been agreed in the report, they did pick up on a high-risk issue, and again this has been agreed and there are recommendations in place, which will be tracked down to conclusion.

LJ confirmed that the trust did ask for this audit to be carried out because we knew we had some gaps and weaknesses across our e-rostering process. In terms of the outcome, there were few surprises, and Greg Moores (GM), Chief People Officer had recognised that there probably was a lack of governance around the process. We rolled out e-rostering a number of years ago and took a decision at that time that we would only look at inpatient services, and upon reflection of this decision, we now wonder why we did not actually roll it out much sooner across the trust.

LJ remarked as a result of this audit we are now in good position whilst rolling out the rest of the project to understand what we need to do in terms of making sure we have the right policies, the right approach, and right governance around this, and what came out of the report was really

helpful and actually confirmed what our own thoughts were, and we totally agreed with all the actions.

LJ stated that that this is not just something that can be managed and monitored through the people directorate, this involves people in services, managers who actually create and manage those rosters. She stated there is definitely a link in with the safer staffing work that takes place as well as looking at what the overall staffing is and the staffing review. She explained the e rostering does some of this and we have the governance around this, but there is also something around us looking to see if we have the the right staffing in the right places, and this is another way to give us some check and challenge around that. LJ stated she thinks it will be really helpful when we look at setting up those groups and she will obviously make sure the right people are in the room to have that conversation.

LJ stated Richard Butterfield, Head of Recruitment and Resourcing, is the lead on this and has recently taken over the management of the e-rostering team and they have received agreement from PRC and Executive Management Team (EMT) in support of the rollout of e-rostering across the trust, there is a plan in place for this, and this will be built into the governance meetings for check and challenge, along with regular reports that ensure our services and managers know where they are in terms of performance around e-rostering.

LJ stated it is really important for us that we have an effective and efficient e-rostering service as it really helps us with the deployment of staff and will help us understand both the safer staffing needs but also what is happening around some of our bank and agency staff, as this is a really useful system and will help us understand where some of the challenges and pressures are.

LH remarked that overall, they totally agreed with what came out of the audit and have put some actions in place and they are looking at October to deliver some of these and are committed to moving forward on some of this.

AS stated that at board we have an agency oversight group to look at our expenditure levels on agency and usage. Our two biggest spend areas are registered and unregistered staff, predominantly on inpatient units, so having an effective e-rostering system is what we will use to give us assurance that we are effectively filling the rotas on all the wards, which will help with the agency oversight. It will also help with any external scrutiny as the audit makes reference to the expected standards from NHS England when you are deploying an e-rostering system, so this all fits together in terms of providing assurance through to the board once we start looking at some of those key workforce metrics as they align to finance metrics through the IPR.

MR remarked she is fully aware we need to get these controls in place, and the fact that it will pay dividends if we do, she said she is also acutely aware of the pressures the people directorate are under. She stated she is really looking for some assurance that do we have the capacity to make some of this happen and if not, does LJ and AS need to get together to make sure this process does not slow down because of the current pressures.

LJ thanked MR for raising this, she stated this has been looked at, and this is something that herself and AS need to look at in line with the agency scrutiny group.

AS stated that MR is correct but not all of the pressure on e-rostering is within the people directorate, some is within the operations team. He stated there was a lot of debate before this audit was signed off because some of the management tools are utilised within various ops teams, but they were not utilising them consistently for oversight across the whole organisation. He explained the journey that people need to go on is differential, in terms of how they are using the e-rostering system now, as some people are using it quite effectively, whilst others have a way to go. He felt the people resource's role was to apply that consistent methodology across the e-rostering model for the trust.

MF commented that when he was reading this he was trying to understand whether the risks that are being reported are around the implementation of the new system, and if so what the impact of that was, and have we increased the risk of not having the right staff in the right places through

a less than perfect implementation, or is it a question of we have not exposed ourselves to more risk it is just that we have not fully grasped the opportunity of closing the risk of that.

AS replied that he thinks we increase the risk of not effectively deploying our workforce, rather than risk not filling rota gaps, he said the rota gaps would get filled but they might get filled with the most expensive resource.

MF stated this sounds more of a financial risk and agency spend limit risk than a clinical risk. AS replied not necessarily, and what the rostering system will highlight very clearly is the percentage of banking and agency staff on a shift for example, so that is a quality and safety measure also.

LJ stated just to add to this if you have an efficient rostering system what you are also doing is looking at good management practise, in terms of making sure that annual leave is spread across the year, so you do not end up with gaps where you have a lot of people off and then you are having to cover with bank and agency. It helps us just look and that whole efficient way of managing and deploying staff fairly across the system. She stated we have got a lot of managers who have really grasped it, and then others not so much, and one of the comments was that sometimes people are writing it down on a bit of paper and then putting it into e-rostering, so there is something around practice and us understanding the benefits of the system. She remarked that for her we are using the e-rostering system to a degree which is another risk as we are not maximising its potential and what it can do for us, and this is what came out of the framework, it gave us a good practise guide and we are not doing that good practice guide in a way that we should be doing.

MF remarked that the hope is that the successful and timely implementation of the audit recommendations will help us maximise the opportunity that the system provides.

MF thanked LJ for the update, stating this was a positive way to conclude this.

Risk assessment and care planning internal audit
Elaine Dower (ED), 360 Assurance, presented the opening remarks. She confirmed that 360 Assurance looked at three main areas, first of which was risk assessments, in terms of their existence, their timeliness and completeness. Secondly, they looked at care plans, in terms of their existence and their alignment to the risk assessments and the risks identified in those assessments, and thirdly they looked at the translation of those care plans into observable practise and the things that were happening for that patient in practise, through some site visits.

ED confirmed that following review of 42 risk assessments across 15 services, 62% were not completed within 24 hours as per the policy currently, and then only 57% of community records actually had all the required elements of that risk assessment again as per policy. A medium risk was raised in respect of risk assessments.

ED commented that in terms of care plans, of the 42 patients that they sampled, 35 had a care plan, or more than one care plan, the 7 that did not were all in the community services that they looked at. 60% of care plans reflected all the risks from the risk assessments that 360 Assurance had looked at and 40% reflected some risks.

ED stated that in three cases they could not evidence a care plan review since 2021, so it had been at least two years since those care plans had been reviewed. There were also a few instances where 14 out of the 35 where the care plan identified risks that had not been captured in the risk assessments.

ED stated in terms of care and practise they tested 18 patients, six teams visited on site, and what they were looking for was whether we could see things that were written as needing to be done for that patient to meet their needs in the care plan, and whether they could see those were being followed through and evidenced in day-to-day practise. Only 33% of those care plans that we looked at could we observe that all the elements we tested were actually being delivered in day-to-day practise. This resulted in three medium risks, one for risk assessments, one for care plans, and one for translation of care plans into practise.

ED remarked that Carmain Gibson-Holmes (CGH)will now provide some context around this.

MF commented that risk assessments and care planning are two areas on the IPR which the

board has been very concerned about for a number of months and we have been assured that there are process improvement works in progress, and we have seen some improvement in the stats we are measuring, for example in the care plans a specific stat is that service users will be provided with a copy of their specific care plan.

MF asked CGH how does this report feed back into the context of that board level concern about these areas.

CGH replied that it is all linked together, so the improvement work is part of one of the trust priorities around care planning and risk assessment and we know is featured in the 2019 CQC report, and multiple efforts have been made to try and make the improvements that are required, but they have not got underneath the overarching problem.

CGH stated since she has been in post she has been delivering a care plan risk assessment improvement group (CPRAIG) and that is where they have seen some improvements to the IPR reporting. What they have been required to do is look at the quality of what we are doing.

CGH remarked this audit has come at the right time to really triangulate that what we have understood from the CPRAIG to date, with all the intelligence we have gathered, with all the observations we had made, with all the intelligence from the local care groups, actually alongside this audit, tells us that we are looking at the right mechanisms now to make the improvements that are required.

CGH explained that they created some driver diagrams, and she is reassured to say that the 360 audit tells us what we already knew, which is positive because nothing new has come up that is alarming or concerning. It does demonstrate what we felt, in that there was some inconsistency ad some variation in the practise, and we have got some pockets of really good practise and we need to transfer that across the whole of our systems, and across all of our care groups.

CGH confirmed that the CPRAIG are now moving into action, and they have already done some quick wins around how we can improve the data and have seen the benefit of that. They are now moving into the real quality and getting underneath the challenges that have been there for a long time, but that are much more challenging to address, and need a whole systems approach to getting it right.

CGH confirmed there are working groups which will be addressing this over the coming months with a view to seeing some further improvements by September, which is the date they have put on for the actions, some of these may require a little longer to see them embedded consistently in practise, but she is sure we will see some positive change by that time. She stated that we do report our progress through the Operational Management Group (OMG) Extended Management Team (EMT) and through Clinical Governance & Clinical Safety Committee (CG&CSC).

MF asked will this report also go to CG&CSC. CGH replied that it is on this month's agenda, and she will be cross referencing how the actions from the CPRAIG and these actions are intertwined to ensure we are covering them together.

MF stated that he has a concern that when he first read it, and maybe after listening to some of this that the improvements we have seen in the reporting of the IPR has been in a numerical sense, as opposed to a qualitative sense, and is that a fair comment?

CGH replied that they are measuring something different, and in the IPR they are looking at whether the care plan has been co-produced, and that is the measure they are taking through the IPR. Part of the work they are doing is looking at what are the right measures, what do we need to be telling board to assure them that we are delivering care plans effectively, and that we are including the risk assessment into our care planning and through into action, in terms of our care delivery, alongside that patient outcome, so actually how do we know that we are making the difference that we intend to make by doing a care plan and risk assessment. She explained that part of the work they will do will perhaps review what we report on in the IPR.

MF commented that he would hate to think that we as a board in a couple of months' time receive an IPR that says 100% of service users have been issued with their care plan to time, and then we find out that actually we only managed to get to 100% because we gave them a

pretty low-quality inappropriate care plan. He asked CGH if she could assure him that this would not be the case.

CGH replied absolutely, and they keep the focus on that conversation through OMG monthly, through CG&CSC every fortnight, and then through the CPRAIG. She stated the whole driver for this is about patient experience, staff experience and being outcomes driven, of course the reporting evidence is how well we do that, but it is key that reporting is not the driver for this.

MF stated that this would be part of his assurance report to the board, which is in a couple of weeks, and he was unsure whether or not CG&CSC will have met before this. He remarked that it might be worth JW thinking about adding a 5-minute specific item on this at the board, as he felt there could be a few queries around this, and he will need to explain it carefully with Darryl Thompson, the Director of Quality and Professions support.

JW agreed with MF in that she was going to suggest this is a AAA discussion for himself and Natalie McMillan, Non-executive director, who is chair of CG&CSC, and she will ensure there is enough time on the agenda for this.

JW stated she also wanted to confirm that CGH is part of the group where they are looking at reviewing the IPR, in terms of what we measure, and how we measure it, particularly for the areas such as care plans and risk assessments to make sure that we are not just counting widgets, but we are looking at the quality of the care we are delivering.

MF asked MR and DW if they had any comments.

MR replied she probably has, but it might be worth her having a conversation with CGH separately as she did not think there was enough time to explore this at today's meeting. She stated as we know this has been a longstanding issue, the care plans are built into SystmOne, and this is not always easy for users to navigate, therefore she wondered if there is some mileage in reviewing the way our workforce uses SystmOne. Is the data structured in a way that they can actually input it easily because they are under pressure, and she wonders if there is another angle to this to complement all the work they are trying to do to try and get that improvement further on.

CGH replied that systems have been key to this and that has been part of the driver for how we have improved the IPR, we have made some quick win changes to the systems and that is part of our longer-term programme. She confirmed she would book an hours meeting in with MR to discuss this further, also if anyone else wants to join she is more than happy to open that up.

ACTION: Carmain Gibson-Holmes/Mandy Rayner

MF remarked that for future meetings where we have had a couple of limited reports, will there be a separate section in their general report on implementation of these actions, or will it be part of the normal follow up to recommendations.

LH replied that it will be part of the normal follow up, and if these actions are not being followed up 360 Assurance will be flagging them, so the trust will find out about them by exception.

MF commented that it is whether or not we need to invite LJ or CGH to a future committee to update us on progress. LH replied this has been done previously and a short paper has been brought back to say where they are with things. MF commented that he would consider this.

ACTION: Mike Ford

JW requested that Mike Garnham, Health Intelligence Analyst join the discussion with MR & CGH from a systems point of view.

JW commented that we have brought people back to present updates previously, once they have implemented the actions, and as part of that report you provide the evidence for the

implementation of the actions, as well as it being signed off by 360 Assurance. JW remarked that MF may want a progress update before this, she suggested they discuss offline.

MF remarked the alternative is that presumably PRC will pick up on e-rostering, and the CC&CSC will pick up on the care planning and risk assessment, so it may be excessive to bring LJ and CGH back here when they have already done a very similar update to other committees, he said we will pick this up offline.

AC/23/72   Counter fraud progress update, including Counter fraud annual report and benchmarking information (agenda item 16)

Claire Croft (CC) presented the update, she commented that due to time constraints would MF like her to cover action point 2349 around the work plan first of all. MF replied that he would.
CC stated that this workplan is risk based, and it is designed to prioritise highest risk areas and target counter fraud activity at the trust. It is an ongoing process, and it is flexible, and they respond to new and emerging risks whenever they occur.
CC explained that the trust and herself continually review risks and act upon them to ensure that they are prioritising the most significant threats. It is also important to note that trust officers have responsibility for specific risk actions and JW has brought the counter fraud risk register to this meeting, so there are specific actions on the fraud risk register which are subject to ongoing review, which feed into the work that they do.
CC stated they have included in the work plan for this year work to address the trusts highest risks, and they have got the absence management review which they are doing in conjunction with internal audit. There is also a working whilst sick review which they are utilising national fraud data to do this, so they are looking at anyone who might have worked for another NHS or government organisation whilst working for the Trust. In terms of other proactive detection work they have already undertaken work on substantive versus bank shifts to identify anybody who has worked on the bank whilst sick from the trust.
CC remarked she was happy to answer any other questions.

MF remarked that for people observing or attending the committee for the first time that the challenge we raised at the committee in April was whether there was the right balance between the process work within the counter fraud plan, as opposed to proactive work. MF commented that from what CC has just described in terms of some of the exercises 360 Assurance are carrying out, it does give him greater assurance that the plan is doing that kind of work on our behalf.

AS remarked this is a tricky one, and some proactive work is about communication of the counter fraud function, and if that is successful you get referrals which then become reactive investigations. His personal view is that you want more in the proactive than in the reactive investigations, but a measure of a successful counter fraud function might be lots of ongoing investigations.
AS stated he is taking this as a positive that we have a modest number of referrals starting to come through from the proactive work that CC and the team are doing.
CC stated in terms of the plan 360 Assurance split it out into certain areas for different projects that they need to do, and the reactive time is the allotted time that they are given for investigations. CC explained if there is an influx of investigations then that number will raise and that is something she would discuss with AS in their meetings, as to whether they need more time putting into the plan, in addition to what they have already been given to prioritise those investigations. CC confirmed that 360 Assurance would not look to take it away from the proactive plan but would look for the trust to be resourcing more for the reactive work that is being taken.

MF remarked that in all the previous updates he felt there had been a lot of focus on the functional standard requirements exercise and the risk work, and he is happy that the paper this quarter is genuinely starting to show more proactive work. He liked the referral comparison piece,

which benchmarked the activity within the trust against other trusts of a similar nature and he was happy that this action can be now closed.

CC remarked that she would now provide some key messages from the report. 360 Assurance have submitted the counter fraud functional standard which the trust is required to do annually, the trust was rated green across all components. Three new referrals were received throughout this reporting period and 360 Assurance are taking action on those, as necessary .

CC asked MF if he wanted to give a brief update on the benchmarking report.
MF replied that the only question he has is around the number of mental health and community referrals per fraud type, the dominating number was around NHS employees' timesheets absence, and also expenses. MF remarked that he had not being conscious during his time here of anything arising around expenses and did CC think that in most other trusts it is predominantly timesheets and absence and shifts rather than falsely claiming expenses.
CC replied yes and they do not get many referrals for falsely claiming expenses. She stated something she has suggested to the trust and is actually on the fraud risk register tracker is that they should look at doing some exception reporting, just to look at the highest spend for expenses, perhaps car mileage or something like that, just to do an audit on them.
MF stated he would welcome that even though it may not possibly be a high-risk area. CC replied that given the current economic climate this is an area that could be exposed to weakness.

MF commented that most generally the number of referrals by provider we have been traditionally quite low, so it is interesting to see some of the proactive work maybe leading to a slight increase.
CC replied that during Covid, referrals dropped off, and for many trusts they had close to zero for two years and they are seeing a bit of a rise now in referrals, which she thinks is probably why they are seeing those coming through.
CC explained she is working with the trust to try and increase referrals wherever they can, and she is targeting specific areas for training where they know we have had issues. They will continue to with us this to try and identify areas throughout the year on which they can focus.

JW remarked that she just wanted to pick up on Risk 1794 on the risk register around expenses. She stated there were some additional actions to be undertaken on this risk by September by Lindsay Jensen, who is the risk owner, in terms of production of exception reports to look at the highest claims. JW stated the trust do not have an expenses policy and CC has kindly shared an example policy with us which they are going to review.
JW remarked it is just worth noting that all of our expenses are reviewed by a manager who has to sign a declaration of their approval on the expenses system, so we are going to look at the wording that is on that in terms of whether it is explicit or not around fraud.
MF questioned the fact that the trust does not have an expenses policy.
JJ replied that we do not have a specific expenses policy, we have HR policies that discuss about expenses, but we do not have a specific policy.
AS remarked that he was not aware the trust did not have an expenses policy, but they do have controls embedded within the e expenses system that determines what you can and cannot claim for.

CC stated the only other thing she wanted to mention was the committee are also in receipt of the annual report which summarises the work carried out throughout the year and has previously been reported to the committee in the form of regular progress reports.

MF asked if the piece of work that is being done on expenses will come back to a future committee. CC replied that this is work that the trust is looking to undertake in terms of looking at high spend in expenses so she would think this would come from the trust.
JW confirmed this would form part of the risk update report that comes to the committee.

CC remarked that if there is anything significant that comes out of that report that she needs to review then this will be discussed with AS and reported back to the committee.

MF thanked CC for the update.

Counter fraud risk register

JW presented the update, stating this is the full fraud risk register which is being developed in conjunction with CC. Members of the committee are provided with a full tracked changes version so that they can see the reviews that have been undertaken by the risk leads.

JW stated the proposal is to bring this to the committee bi annually, so that is in April and October, given the length of time some of the required actions take. JW asked MF if he was happy with this proposal or do the committee still want to see this at each meeting.

MF responded that he was happy to receive this twice yearly. He commented that for his own benefit in the tracked changes version of the register, there are more risks in there than in the executive summary and is that right.

JJ replied yes it is and they had just pulled some of the key ones through to the executive summary.

MF remarked that his only other question was that there is a cyber related risk in there, which is risk 1796, and do we need a separate risk. JW replied that these risks are not necessarily at a level that they would feature on the ORR, but they are cross referenced where relevant.

MR commented that on the Cyber risk under controls there is the Phishing exercise that is listed in that cyber which would almost dovetail into this.

MF remarked that for the specific purpose of this committee this is a useful register.

The committee agreed they were happy to receive this report bi annually.

It was RESOLVED to NOTE the Counter fraud progress and Counter fraud risk register update.

AC/23/73   Health and Safety Annual Report (agenda item 17)

AS presented the update stating that the report covers four key workstream areas; health and safety, fire, security, and emergency planning.

AS explained that in terms of context, this is a look back to 2022/23 so the workload and work plans of these teams have been heavily influenced by Covid measures still, particular health and safety and emergency planning, but still to some degree fire and security. AS stated that the individual work areas have different focuses and different priorities. Health and safety, this is non clinical health and safety, an audit is conducted during the period November to January, and we ask operational teams to feedback on health and safety compliance. Historically compliance levels have been good in terms of people completing the questionnaire, and the compliance levels indicate that health and safety team quality assure.

AS remarked there is a statement in there that is probably not intended to be quite as threatening as it sounds which is if you do not fill in the questionnaire you will get a visit from the health and safety team. He explained this is because they have not completed the assurance questionnaires, so we have nothing to base it on, the health and safety team do actually go out and directly interact with those teams and either help them complete it or help them if they have some compliance challenges so that we have very good coverage in terms of compliance levels.

AS confirmed this team are not the lead for ligature audits but they support operational colleagues with ligature audits, and obviously it sits within this directorate, so any ligature audits that follow through to an estate's requirement is picked up directly through Nick Phillips, Deputy Director of Estates and Facilities, management team meetings.

AS explained for the fire team, we have had some estates work underway, we have got some fire panels that are end of life that have been replaced, and we are increasing our fire misting systems in some of our secure services. He stated the predominant area where the fire team get their assurance from is around training, and again, notwithstanding the challenges we have had through Covid with statutory mandatory training, and particularly as one element of fire training is

face to face, we have hit the required levels of statutory mandatory training across the organisation, and we are seeing an increased number of people booking on face to face fire training courses, and we are at this point able to facilitate all those people that want or need face to face training.

AS stated that security has being a bit of a challenge over the past year, it is a hard to recruit to area, not just in terms of the leadership that is referred to in this report, but actually keeping some of our security personnel in the trust is quite a challenge, and there is quite a high level of turnover.
He explained we have a hybrid between directly employed staff and then external contracts that provide services for us. Notwithstanding a lot of stuff that is in the media around relationships between the police and mental health services, our security team have good relationships with local police forces, they predominantly focus on incidents in our inpatient units where either staff members or other patients are assaulted.
AS explained we have policy here where we encourage that to be pursued with the police if a member of staff is assaulted in the workplace, it is not always that straightforward for all sorts of reasons, but that security team are on hand to support individual members of staff to pursue.
AS stated that we did highlight some challenges around CCTV, either the sighting of, or the quality of, and it has been reported into this committee before that we have an improvement programme to replace and resight some existing CCTV. I believe we have had some challenges on Fieldhead with drug drops, and we have found out they were in areas not covered by CCTV, so we have been enhancing these areas, so we have better coverage across the Fieldhead site.

AS stated that EPRR has been talked about many times at this committee, along with the challenges that they face or have faced through Covid, and so the expectations on the emergency planning team increase continually. We have been through Covid, but we are now into various rounds of industrial action, which they are required to respond to, and we have just had issued the core standards which came out in June, which will be our look back on assurance, and there will be a more rigorous confirm and challenge process in place for EPRR.
AS explained that we know we have got some challenges around decamp facilities, if our buildings become unavailable, and again we have discussed this at Board and other committees. By and large we have got good coverage of emergency planning, it is a small team, it is very stretched, we are seeing some back backlog worklog issues in that team because of industrial action largely, but again we can demonstrate a good level of compliance.

AS confirmed that there is also a fairly comprehensive action plan attached with four appendices, one for each area that talks about the key actions they are working through for each area.

MF commented that he thinks if a service did not engage in a mandatory survey they should expect to receive a full audit from Health and Safety, and you would hope that might be an incentive for them to complete it in future.
MF remarked this is a very comprehensive report.

MR asked do we need timelines on the action plan. AS replied that he thinks it is assessed in quarters and members will see that some have these have been completed in Q1, but he agreed that maybe we do need to be a bit more specific than quarterly timelines.

ACTION: Adrian Snarr

MF commented that where he had worked previously, which was non-NHS, the health and safety report would include numbers of incidents, he presumed they are all within our other reporting systems.
AS replied that they are, but if members think that would be beneficial, he can feed that back, as this report is supposed to bring a lot of activity together in one place for annual review, and if it has been reported somewhere else separately, that does not preclude us from putting it in the

annual report.

MF commented there is no reference in here to RIDDOR, so this might be something we do look at going forward. AS agreed to take this away as an action when thinking about future annual reports.

ACTION: Adrian Snarr

AS replied that this is a fair point as RIDDOR is in the IPR every month so we could pull the figure out and put it in for the annual figure.

DW stated the action on here was because we did have stats last year, and his question was because we had some areas that had lots, whilst some had not so much, and he had asked if we could get comparable figures.

AS stated that he did not think they were in the appendices, and he will leave this action open and pick it up with Nick Phillips to bring this back.

MF stated that one of the other actions was around security incidents, and there should have been more detail around the incidents in the report. he felt these actions had not been met for this year's report and he asked if AS could refer these back to NP.

ACTION: Adrian Snarr

MF stated that within the ligature point in this report, the only comment is that Health & Safety are involved in ligature audits, so again we are not seeing any context to this, he felt just being told they are involved does not seem a sufficient update. AS agreed to check this with NP.

AS asked CGH if the number of ligature incidents go to CG&CSC. CGH replied that they do an annual report on our incident reporting so it could be cross referenced from that.

MR commented that some go to private board, before they go to public board, so we do see the number of incidents through that committee and then also board committee.

MF stated this came from an action delegated to the Audit Committee from the Trust Board.

MR remarked is it not the job of this committee to remedy any work issues around making the place safe.

AS replied we have the estates risk on here and maybe we need a better read across it, and agreed to pick this up with CGH, DT & NP outside the meeting.

MF agreed that he would refer to last year's report and the minutes that came out of this. He suggested the three of them get together to think about what they might want to do in terms of bringing a separate report to a future committee.

ACTION: Mike Ford/Adrian Snarr/Nick Phillips

JW remarked that a piece of working she is currently looking at is looking at how we triangulate between reports, so on a subject such as ligatures, that might have different reasons for reporting, so on one area we might be looking at clinical outcomes, on another we might be looking at preventative works, so it is around how the people who are writing the reports triangulate and reference with other reports on the same subject area. JW confirmed she is currently writing a piece of guidance for people who write reports.

MF stated he was more concerned that there is a gap between committees, and something does not get picked up by either, as opposed to more than one committee receiving reporting on the same area.

JW replied that is also the way we are also looking at it, to see where there might be a potential gap.

MF remarked that this is a report that demonstrates a significant amount of work and a lot of progress.

It was RESOLVED to NOTE the Health & Safety Annual Report update.

AC/23/74   Cyber Progress report, to include penetration test update Cyber

Progress report, to include penetration test update (agenda item 18)

PF presented the update stating this is the 6 monthly update. He stated there is a lot of detail in the report and he primarily wants to call out the main points of update that have changed and have been reflected in the last 6 months.

Key headlines:-

- Preparing for the introduction of windows 11. This does not go out of support until 2025. There has been a lot of preparation work going on with Daisy, our IT provider, and some of our key system asset owners across the Trust where we have been testing Windows 11 against the existing applications in a safe and controlled manner.

- Testing our automated upgrade process. When we change from Windows 10 to 11 we want to ensure that that automated process works effectively, so this has been really tested robustly,. Any new build computers moving forward will be issued out with Windows 11 by default, so we will have a mixed economy for a period of time, but there will be no major impact to the end users.

- We have also applied some cosmetic change has taken place to the Windows 11 environment to minimise impact on staff, this is really where the Start and Shutdown buttons are located on screen so that they stay in the same place as they do now on Windows 10. The menu/toolbar location for these buttons' changes in Windows 11 but we have applied that local amendment.

- Regarding Microsoft licensing, there has been a lot of work going on nationally with NHS England renegotiating the new NHS wide licensing agreement, which is now coming to conclusion, and it is going through the final stages of Treasury approval around the overall financials. The commercial model has been released and we have been starting to raise orders based on this for our own Trust licensing agreement, so whilst the costs have significantly increased across the NHS, across the board it works out roughly somewhere in the region of 45% discount from the retail Microsoft prices and this is reportedly the best deal globally.

- For password security, the Trust has got very robust and strong security password controls in place,

- A business case has been developed which will be considered by EMT towards the back end of quarter 2 this financial year, which aims to bring in some additional proactive countermeasures that will aim to reduce down the organisations risk rating for cyber, which is highest rated risk on the register, noting significant associated recurrent revenue consequences.

- Standards and controls, in the last 6 months there has been a lot of activity, the penetration test was completed in January 2023 and the report was provided for the April 2023 meeting for information, and it has been incorporated in the report today. There has been a significant amount of activity completed for this penetration testing work, and the report that was provided by the independent penetration testers was extremely positive, and the remediations were done within 14 days for the final report. There were no high or critical risks raised, with only a handful of medium and low risks highlighted, with most of these having been addressed now, and for any remaining ones, plans are in place to address those during the financial year.

- The Trust continues to consistently respond to the high severity care certs issued by NHS England, and we acknowledge all within stipulated timelines.

- Standards and accreditation, the key thing to note is that we have also been successful in getting the reaccreditation for cyber essentials plus which was completed in quarter 4, last financial year.

- Lots of work still going on around the communications for staff to maintain awareness around cyber. In December we also conducted a workforce cyber evaluation survey, this was mainly to gauge understanding of staff's awareness of cyber security, and the responses helping to inform and influence how will shape the communications focused on

cyber into 2023/24. All these types of communications and activities for staff, whilst they benefit the work environment, they also equally benefit the awareness for home life as well, so it is double edged.

- In March 2023, NHS England also published the national cyber security strategy through to 2030, and it recognises the important role that individual organisations play, but also understands and highlights the need for a more collaborative approach at system and place level. In terms of the Trusts controls measures and safeguards, we align very well against the direction of travel with that strategy. In support of this, we are contributing and proactively engaged on ICS level cyber forums and activities as well.

PF commented that it is always a constantly evolving complex and technical subject area, but the Trust remains in a good place.

MF thanked PF for the update stating it was as comprehensive as ever.

MR remarked this is more of a shout out for her, around the work that we are doing, and the reaccreditation gives us all assurance that we are making the right investments at the right time. Our biggest problem is not the technology because we are in a great place it is more the people and it is good that we have got the workforce evaluation survey now, so we can start to look at where our gaps are and really hone in on the staff awareness. She stated that penetration testing, cyber essentials plus, the data collection for the data security & protection toolkit are all measures that the Trust completes and gets good scores on, on a regular basis so that is what gives her assurance.

JW requested those people who are attending the meeting for the first time, also those observing, that the detail discussed in this committee on this matter is not shared outside of this committee for security reasons.

DW remarked that he mainly wanted to echo everything that MR had said in that it is always great to hear everything we are doing and also the point around the biggest risk is always going to be the people. He stated he has come across some software recently for his own company, and he is happy to make any introductions and share some contacts if they are useful. He said essentially this is a proactive one that can intercept before phishing comes across.
PF replied that he is always happy to take any points of contact, the enhancements that he mentioned around the business case cover some of those proactive elements off, but he is always happy to explore avenues.

ACTION: David Webster

AS commented that it is a bit of a difficult one as we have a high level of assurance, and therefore is it a priority spend area, but then if you fail to maintain your investment your risks increase. He felt we got the balance right. Discussions had taken place at EMT around further investment in cyber regarding the business case mentioned earlier, AS stated that PF is more than able to get the message over to EMT around what the risk and benefits are on this when we are making those investment decisions so that is positive.

MF remarked that we have almost accepted that we are going to be in this slight catch twenty-two position, and we are doing everything we can, we are assured as a committee that we are in a strong position, but the likelihood of the consequence of something happening is still too high for that risk to be reduced.

MF remarked on the incident that happened recently with a number of organisations losing a lot of payroll data, referencing the BBC and Boots and this was not an individual issue, or someone making a mistake. This was a behind the scenes hack, and we need to be mindful that it is not always about people, there are some pretty nasty organisations out there trying to do some bad actions.

MF stated we are all grateful for the work that is being done to keep us all protected.

AS remarked that part of the challenge is organisations are understandably reluctant to participate in open and transparent lessons learned. In relation to the Advanced cyber security incident in the NHS, we are still waiting for some feedback as to what the system weaknesses were, but for obvious reasons Advanced do not want to tell anybody so it is difficult to get that open dialogue going.

PF gave the committee assurance that our password policy is strong and the results that come out of the penetration testing substantiate this.

MR commented that there is software that will now pick up if there is either a weakness in your password or something is happening that is making it vulnerable, and you will receive a notification to tell you that. She said one of the things we have to continue to try to eliminate is people writing their passwords down on bits of paper.

PF stated that he would like to add one final point, with the cyber essentials plus accreditation, this also helps with the data security protection toolkit submission, so it covers off a lot of the evidence which is a further benefit to the organisation.

MF asked LH & NW how the update that PF provides on a regular basis stacks up against other organisations that they provide work for, and could they give us some further reassurance in that respect.
LH replied it is quite a detailed update compared to what a lot of audit committees receive, there is a lot of information in there that does not typically come through audit committee.
NW stated that some audit committees do not get this sort of an update, so to see it as a separate item and a paper, is a lot more fulsome than other organisations receive.

MF remarked he was looking for a qualitative judgement as well as a quantitative one, as a committee we feel very assured by what PF presents, do they feel it is reasonable based on what they hear at these meetings, and Trusts they see elsewhere.
LH replied it seems sensible, but obviously they are not reviewing what PF has done against others, so it is difficult for them to give a qualitative answer on that basis. She stated that what some other organisations do is probably have an IT type group which they take the more detailed information through, which is why NW and herself do not see that level of detail coming through.

It was RESOLVED to NOTE the Cyber progress report update.

AC/23/75   Oversight of Covid 19 Public Enquiry (agenda item 19)
JW presented the update, stating the Audit Committee is responsible for the oversight of the trust's performance against the Covid 19 inquiry requirements, and she is happy to take the paper as red.
JW remarked that for those people who are attending or observing for the first time, the inquiry commenced last year, and four modules have already begun. Resilience and preparedness, which is mainly a government module. Core UK decision making and political governance, which she is sure people will have seen items in the press on this particular one. Module 3 which is the main one the trust will be involved in is around the impact of the pandemic on healthcare. We are not a core participant in module three of the inquiry, but we will be supporting our other providers and system leaders in terms of requests from the inquiry, and these have already begun.
Three new investigations have been announced, and Module 4 has opened, we will not be a core participant, but we will be involved in this one because we were a vaccination hub for Mid Yorkshire hospitals, so that is the vaccine, therapeutics, and antiviral treatment module. The scope for Module 4 was published on the 5th of June.
JW explained that Module 5 will examine government procurement across the UK, again we will not be a core participant, but we will be involved from a point of view of been at the receiving end

of that procurement programme in terms of PPE, and it also crosses over with vaccinations.
JW stated that Module 6 is the core participant hearing and will open up on the 12th of December and close again in in January, the trust is not expected to be involved in that one at all.
JW explained that as an organisation we have a Covid inquiry lead which is herself, we have an executive lead which is Dr Shuba Thiyagesh, who is our Chief Medical Officer (CMO). JW stated it is key that the CMO is our lead because of the involvement in terms of vaccinations, care, and treatment.
JW confirmed that the trust has fully completed the required stages of readiness for the Covid 19 enquiry, and we now have in place a dry store and safe haven of hard copies of all data that may be required by the inquiry, and this is against the list that was provided of everything that must be put in a stock notice. The trust is ready, and we have started to receive minor inquiries, in terms of who the lead is in terms of requesting some information from the system leaders in our area.
JW stated she will provide a further update at the meeting in January 2024 or by exception, should anything need to come to the Audit committee by exception.
MF confirmed that he was the non-executive director lead on this, and he just wanted to confirm there are no specific actions for us at the moment. JW replied there are no specific actions currently.
MF asked JW if she could explain what she meant when she said we will be involved in a module. JW replied that we may get questions, she gave an example of us providing community nursing in Barnsley so we may get asked questions by the local authority who will be a core participant to provide information on district nursing visits into care home during the pandemic, as part of their response to the inquiry. We may then get further questions from the inquiry on the request for statements, but currently it is all unknown.
MF asked if any information requests will come through the committee for approval. JW replied no, and that information requests will be managed against the Covid inquiry framework and monitored by EMT.
MF remarked that we expect module 3 hearings to begin in autumn, and in the executive summary it says 2023, and in the detailed paper it says 2024. JW apologised stating it is 2024, there will be preliminary hearings this year, but the full hearings will not place until next year. She confirmed they are still waiting for the detailed timeline to come through.

It was RESOLVED to NOTE the Covid 19 public enquire progress report update.

AC/23/75   Any other business (agenda item 21)
Place 2022 scores
AS provided the update, stating that in the ordinary run of business the trust organises it, but it is led by volunteers, or governors or non-executive directors. He explained we have had to change that process slightly through the Covid years, but we are reverting back to a volunteer led process. The trust scores consistently high and has scored high again this year, the only areas where we score lower than the national average are in some of our wards that are in PFI hospitals, and the challenge there is, we are a tenant of Calderdale and Huddersfield Foundation Trust (CHFT) but CHFT have it in the PFI, so it is harder to get maintenance done and changes made on those sort of sites and that feeds through the scores.
AS explained that for the vast majority of our owned estate we score in excess, with some areas significantly in excess of national averages.

MF remarked that he thought that this was a positive paper and an impressive set of results considering the stress and challenges that everyone is facing.
MF commented that he will raise this as part of his assurance paper to the board and pass on the committees thanks to the teams through Carole Harris. AS confirmed it is Karen Hinch, Head of facilities services who is organising it, and there are a lot of volunteers that feed into that process.
MF remarked this is the first time as a committee we have seen this paper. AS replied this is an estates report and because estates have move into his portfolio it now comes to this committee.

AC/23/76 Annual work programme (agenda item 22)

MF stated that we just need to make sure that the counter fraud risk register is reflected accurately in here.

<u>ACTION: Julie Williams</u>

MF remarked that we should have received a risk management framework procedure update this quarter and will this come in October.
JW replied that this should have been removed from the work programme completely as it was approved at the April committee meeting.

<u>ACTION: Julie Williams</u>

MF thanked everyone for attending the meeting and in respect of people observing not having an agenda, he felt that whilst we will not ever issue full papers to everyone who is attending, it might be useful going forward if we issued an agenda.

MF remarked that himself and AS will continue for 5 minutes to complete the details for the AAA report for board. For those attending/observing the meeting for the first time he provided a brief outline of what the report entailed.

**Minutes of Clinical Governance and Clinical Safety Committee meeting
held on Tuesday 24 July 2023
Microsoft Teams meeting**

Present:	Nat McMillan (NM)	Non-Executive Director (Chair of the Committee)
	Darryl Thompson (DT)	Chief Nurse / Director of Quality and Professions (Lead Director)
	Kate Quail (KQ)	Non-Executive Director
	Carol Harris (CH)	Chief Operating Officer
Apologies:	Dr Subha Thiyagesh (STh)	Chief Medical Officer
	Marie Burnham (MB)	Chair of the Trust
In attendance:	Carmain Gibson-Holmes (CGH)	Deputy Director of Nursing, Quality and Professions
	Sarah Harrison (SLH)	PA to Chief Nurse / Director of Quality & Professions (author)
	Julie Williams (JW)	Assistant Director of Corporate Governance & Risk
	Yvonne French (YF)	Assistant Director of Legal Services
	Naomi Sutcliffe (NS)	Serious Incident. Investigator, Suicide Prevention Project Support (item 16)
	Dr Kieran Rele (KR)	Consultant Psychiatrist (deputising for Dr S Thiyagesh)

CG/23/146   Welcome, introduction and apologies (agenda item 1)
The Chair, Nat McMillan (NM) welcomed everyone to the meeting and apologies were noted as above.

It was noted that due notice had been given to those entitled to receive it and that, with quoracy, the meeting could proceed.

NM outlined the Microsoft Teams meeting protocols and etiquette.

CG/23/147   Declarations of interest (agenda item 2)
The Committee noted that there were no further declarations over and above those already made.

The Clinical Governance & Clinical Safety Committee NOTED the declaration.

CG/23/148   Minutes from previous Clinical Governance and Clinical Safety Committee meeting held 13 June 2023 (agenda item 3)
The minutes were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the Clinical Governance and Clinical Safety Committee meeting held on 13 June 2023 as a true and accurate record.

With **all of us** in mind.

CG/23/149   Matters arising from previous Clinical Governance and Clinical Safety Committee meeting held 13 June 2023 and action log (agenda item 4)

NM informed the Committee that she will raise the proposed name change to Quality and Safety Committee at Trust Board tomorrow.

NM also noted that the Committee had the powers to approve the IPC BAF at the May meeting, and that it did not need to go to Board.

The action log was reviewed and updated as follows:

- ➤ CG/23/145 Quality Regulatory & Oversight Paper
  NM confirmed that she had raised the issues in relation to appraisals in the Finance Investment & Performance Committee (FIP) however had not been able to raise in the People and Remuneration Committee as they had yet to meet.

  NM informed that she had also discussed agency issues in the FIP meeting and her concerns in waiting for September and the concerns regarding appraisals, and will mention this in Trust Board.

- ➤ CG/23/135 Patient Experience / Customer Services Annual Report
  NM and Kate Quail (KQ) to forward comments to Carmain Gibson-Holmes (CGH).

- ➤ CG/23/90 Clinical and Strategic Approach to Learning Disabilities.
  NM reiterated the need for a focus on learning disabilities would like formal reporting into this Committee and an agreement for how often. Darryl Thompson (DT) will explore with Emma Cox and CGH and the suggestion was quarterly.

- ➤ CG/23/58 Patient Safety Strategy Update.
  NM confirmed that this will be taken to the Non Executive Director meeting tomorrow. Complete.

- ➤ CG/23/61   Care Group Quality & Safety Report
  Carol Harris (CH) informed the Committee that demand, and our understanding of demand has been reflected on in this month's Trio report and propose that this action is covered routinely as part of future Trio reports. NM was happy with this. NM did ask what this might look like, and CH noted that the rise in demand was not showing in the figures that have been reported by staff and is awaiting further detail around this. This will be taken to the executive management committee (EMT) in September and will therefore be included from October onwards.

- ➤ CG/22/111 Annual reports
  RPPI Annual Report – DT informed the Committee that all the requests from EMT and Trust Board will be incorporated into the annual report which will be brought to the Committee in September.

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates for 16 May 2023.

CG/23/149   Review of Committee related risks including focus on Covid 19 related risks for Committee – update following Board discussion (agenda item 5)

DT noted that the paper highlighted all the risks that have been reviewed that are aligned with this Committee.

DT informed the Committee of a new risk that will be owned by Carol Harris in relation to people who have been the subject of delayed transfer of care. This relates to people who are clinically ready to be discharged from our care but there is nowhere for them to move on to. This could relate to housing, placement or support post discharge. DT informed that there were an increase in the number of people who are clinically ready for discharge and was concerned how this will impact on patient flow. There are robust actions in place and e risk will be takenth for approval at Trust Board.

NM noted the quality impact of the risk which would align to this Committee and felt comfortable with the suggestion.

CH added that the executive Trio have had discussions about how this links to the bed management risk, however this does not relate to finance and capacity it relates to people being kept for too long in inpatient care.

The Committee were happy to confirm and note the new risk which will now be aligned to this Committee.

NM stated that she felt that risk was increasing at the moment and noted the challenging risks that the Trust was contending with.

RISK ID 1151 – Julie Williams (JW) noted that this risk had been reviewed prior to Greg Moore's absence and Lindsay Jensen had also since reviewed.

RISK ID 1568 Seclusion Rooms. CH noted that this was reviewed in the Operational Management Group (OMG) and there is a programme of works in place which will reduce the risk as the work continues.

RISK ID 1078 - Young people will suffer serious harm as a result of waiting for treatment.
NM noted the score of eight against this risk and felt that this seemed quite low given that this is something discussed frequently. However, noted that this is "serious harm" but wondered about the risk of moderate harm in incidents.

CH advised that all the controls that are put in place are there to try and minimise all harm, including moderate harm, and to quantify moderate harm could be a challenge.

DT agreed with CH around the challenge of measurability and that the controls and actions are there to prevent all harm.

JW informed the Committee that she has recently been on a national risk management call where the longer-term impact of issues are being seen in risk registers and informed that discussion needs to take place now and suggested a discussion at OMG.

KQ noted that if all harm was included then the likelihood rises considerably. CH agreed with this.

CH advised that the Committee should focus on the score of eight for harm to children from waiting and this could be reflected in the comments and asked the teams to monitor the incidents.
Action: CH

CG/23/150   Staff / Team Story (agenda item 6)
There was no story available for the Committee this month. This time is to be used for additional discussion about the apparent suicide report.

CG/23/151 Chief Nurse - Update Paper (update on verbal items) inc update of topical & legal risks, Issues from IPR, COVID-19, escalations, QIA/EIA reviews / escalations, QIA / Quality Account (agenda item 7)

DT highlighted the key points:

- ➢ DT noted the backlog of complaints and informed the team had made good progress and the backlog was now at 10.
- ➢ The CQC report from the recent inspection of forensic and mental health in-patient services has not yet arrived.
- ➢ The Patents Know Best App is being launched and the Trust is also seeking to be involved in supporting the development of a broader NHS App.
- ➢ DT confirmed the appointment of Tracey Smith as the new Chief Psychological Professions Officer.
- ➢ DT suggested to remove the IPR, COVID-19 and QIA around COVID-19 sections from this report going forward. Any aspects of the IPR are now covered in the Care Group Quality and Safety Report. With regards to COVID-19, given that nationally and locally this is now considered to be business as usual, any issues would be escalated via the usual infection prevention and control reports.
- ➢ DT confirmed that QIA's will be signed off by DT and Subha Thiyagesh.
- ➢ The link to the Quality Account for 2022/23 is available on the Trust website, as required.

NM noted that Mark Brooks CEO queried in Trust Board the backlog of complaints and how we define 'backlog'. DT confirmed that the backlog refers to people who have yet to be allocated to a complaints advisor.

KQ noted the large number of complaints in June and DT informed that the team will be looking into this.
Action: DT

It was RESOLVED to RECEIVE the update.

CG/23/152 Quality Monitoring Arrangements (agenda item 8)

DT included at item 7.

CG/23/153 Quality & regulatory & Oversight Paper (agenda item 9)

CGH gave a brief update to the Committee and took the paper as read.

CGH advised that the two Care Groups inspected following the CQC visit had taken the following actions: -

Forensic inpatients:
- ➢ Ligature environment audit: All wards have a brightly coloured folder which contains the ligature audit and a summary of specific ligature risks for that ward. There are a range of other connected improvements being worked through in the quality improvement (QI) plan to ensure all staff have awareness.
- ➢ Fridge temperatures: a quality improvement (QI) plan is underway led by the Deputy Chief Pharmacist. Oversight is being provided by clinical governance group. Guidance has been re-issued which explains about re-setting of fridges to allow compliance and accuracy with monitoring fridge temperatures.

- Emergency equipment and clinic checks: The Care Group have strengthened the governance and oversight around ward audit checks through revising the process, full re-fresh of check required, review of who is responsible and Tendable is being looked at to to support audit and assurance checks within the Forensic Care Group.
- Activity: An initial meeting has been arranged with occupational therapy (OT) colleagues to look at how we record activity programmes more effectively. A meeting is being arranged with ward managers to look at ward-led activity.
- Patient call alarms: Contact made with the nursing, quality and professions directorate to develop a Trust-wide protocol.
- Security Checks: A QI process has begun which is in the scoping and benchmarking phase looking at a plan-do-study-act (PDSA) cycle for improvement. This is monitored through the Care Group governance and improvement programme.

Acute inpatient / Psychiatric Intensive Care Units:
- Appraisal rates: Continued with the plan to increase appraisal rates with significant improvement across all areas. The figures are reported weekly via operational management group (OMG) with a trajectory for all outstanding appraisals to be completed by the end of July 2023.
- Ligature audits: In line with Trust action, all ligature audits are now stored in brightly coloured folders in ward offices and have built on existing practice to display the highest scoring ligature points using photos as a visual guide in the folders.
- Ward activities: Activities within the inpatient areas continue to increase through the introduction of creative practitioners.
- Use of non-designated beds: Reporting around use of admissions to non-designated beds is now being recorded through the new patient flow dashboard.

The CQC report from the visits is expected towards the end of July 2023.
Feedback from recent quality monitoring visits (QMVs) is as follows:

QMV Waterton Ward
On 9 May 2023, a MV took place on Waterton Ward at the medium secure unit in Newton Lodge. This was a re-visit to follow-up on some concerns that were identified from a previous QMV in November 2022. The visit saw an improvement plan that was helping to improve standards on the ward, and this was evident within the changes observed.

Routine CQC Enquiries
14 new enquiries were received in May 2023 and 17 new enquiries in June 2023

The following reports on CQC MHA visits have been returned since the previous paper in May 2023. These are the following:
- Newhaven – visit date 5 April 2023
- Clark Ward – visit date 13 April 2023
- Ward 19 female – visit date 18 April 2023
- Stanley Ward – visit date 9 May 2023
- Lyndhurst Ward – visit date 8 June 2023

NM queried the ligature audits on the wards and how we would know that they are compliant.

DT advised that this was through the oversight of the Lead Matrons who have been working closely with the Ward Managers to provide assurance and consistency of the summary paper

at the beginning of the folders, however a formal audit of the folders' presence has not been undertaken. NM noted that this potentially felt like a gap.

CGH advised that this was discussed at the last clinical environment safety group meeting where they asked for assurances that the audits were in place. The nursing directorate are also undertaking checks when completing their usual work within the wards. The checks are also part of the QMVs.

NM noted that as part of the QMVs that non-executive directors (NEDs) were essential, and governors are optional and noted that there was a struggle to get the dates in the diaries for them to undertake the visits as sufficient notice has not been given. NM will discuss in the NED meeting tomorrow to firm up the process.

It was RESOLVED to RECEIVE Quality & Regulatory Oversight Paper

CG/23/154   Patient Safety Strategy Update (agenda item 10)
CGH gave a brief update to the Committee and noted the following:-

Patient Safety training
➢ An update of progress with level 1 patient safety training.
➢ Level 3 training has been approved and booked with the provider.
➢ The above training supports transition to working under the Patient Safety Incident Response Framework,
Learn from Patient Safety Events (LFPSE)
➢ There is a delay with Datix in relation to developing the right software.
➢ It has been agreed nationally, September will be used for updating the system and also standing down National Reporting and Learning System (NRLS).
Patient Safety Incident Response Framework
➢ A number of workstreams are underway to support implementation planning ahead of transitioning in Autumn 2023.
➢ The culmination of the preparatory work will be a policy and a plan which will require approval from Trust Board.
Patient Safety Partners
➢ Plans to explore the options of putting out Expression of Interest to the Trust volunteers
Patient Safety Strategy Group update
➢ Patient Safety Group meeting took place on the 6 June 2023

The Committee thanked CGH for the update and noted the paper.

It was RESOLVED to RECEIVE the Patient Safety Strategy Update.

CG/23/155   Patient Experience Update (agenda item 11)
CGH gave a brief update to the Committee and noted the following:-

➢ 2023 Community Mental Health Service User Survey preparation is underway.
➢ Service Line Patient Experience Surveys are under way.
   o Physical health services have adapted their commissioner surveys to include the five key questions (safe, effective, caring, response, well-led) and these go live in July 2023
   o Surveys which are specific to child and adolescent mental health services (CAMHS) and attention deficit hyperactivity disorder (ADHD) services are being developed in their respective project groups.

- Meetings are being arranged with both community health teams and learning disabilities teams to develop their own service specific surveys.
- Both mental health and forensic inpatients surveys are now live
- Other survey developments will include a carers survey, later in 2023/24
- Once the surveys are set up, quarterly data will be collected, analysed and shared. This is expected in autumn 2023.

➤ Text Messaging
  - The new friends and family test (FFT) text message has now been fully implemented across mental health community teams, CAMHS, ADHD, learning disabilities and some physical health services.

➤ Patient Experience Dashboard
  Conversations are underway to develop a patient experience dashboard for both patient experience surveys and friends and family test feedback.

➤ Wakefield District Health & Care Partnership Experience of Care Network
  - Themes from recent meetings have been around waiting lists and waiting times and maintaining contact with services users. Information was shared around text messaging used in CAMHS to support people on waiting lists.

➤ Patient Experience Improvement Framework
  Currently awaiting NHS England to publish this framework.

➤ Patient Experience Group
  - There is now good attendance from Care Groups and the agenda continues to develop, with feedback gathered from group members.

NM will provide comments to CGH offline regarding the formatting of the report.

Committee received and noted thee update.

It was RESOLVED to NOTE the report.

CG/23/156   Care Group Quality & Safety Report (agenda item 12)
CH noted that there was more detail including in the report around demand.

Review of demand
There is a perception that demand is rising across all areas. However, this was not always supported just by referral numbers data, as this doesn't include the level of need or the acuity of each person being referred. Work is taking place to further understand this to support the right next steps.

Appraisals
Significant improvements to performance in acute and older people's inpatient wards have been made. Issues with reporting performance have been mitigated temporarily with a local record and work is underway to assimilate this with the overall Trust report.

Industrial action

The British Medical Association (BMA) announced further strike action between 13 to 18 July for junior doctors and 20 to 22 July and 24 and 25 August for consultants. At the time of reporting, the actions to manage the junior doctors' strike are in place with no escalated concerns.

The BMA are supporting 'Christmas Day' cover for the consultants' strike which means that they will support the services to provide the same cover that would be available on Christmas Day. Plans are being finalised to confirm the arrangements.

The Horizon Centre
Progress on the Horizon action plan continues to be monitored through the operational and executive management teams, supported by nursing, quality and professions colleagues.

Patient flow – new live dashboard
Patient flow continues to be pressured and out of area placements are above trajectory.

There is a keen focus on ensuring the best patient flow through the services and the team are really excited to have launched a new patient flow dashboard that provides real time information.

Quality of care in inpatient mental health wards
The chief nurse, chief operating officer and a matron attended the regional event in Leeds where senior representatives from Trusts from across the Northeast, Yorkshire and Humber shared good practice in relation to inpatient care. The Chief Nurse and the matron presented some of the Trust's work around reducing restrictive practice.

Neighbourhood nursing service
The operational management team received an update on the actions to address capacity within the Barnsley neighbourhood nursing services. Positive progress on recruitment has been noted and resources from other teams have been mobilised in order to increase capacity until new staff are inducted.

Water at Fieldhead site
Inpatients in Fieldhead hospital were impacted by a major water leak in the local area on 13 July 2023. Bottled drinking water was provided, as wards were asked to restrict water use to emergencies only for the day, which meant service users were asked not to use the baths or showers. Business continuity measures were implemented and on 14 July restrictions were lifted.

Visit to Barnsley Consultant Psychiatrists
Based on an idea from the consultants, work is taking place to determine how weekend clinics can be best implemented in order to reduce a reliance on locums and improve the quality and experience for service users.

Poplars Fundraiser
Peter, who attended Board to tell his wife, Julie's story raised £3000 for Poplars. The ward plan to use the money to improve the care and experience for others.

Single point of access (SPA) triage process
Following the learning from the death of a service user who had been referred but was not seen, which prompted a Regulation 28 Report from the coroner in Sheffield, a quality improvement approach is being used to develop and implement a triage checklist. This will be reported through the clinical governance group with a review planned in 6 months' time.

Discussion about monitoring of action plans

Further work is underway to strengthen the governance, monitoring and assurance of the vast range of action plans across each of the care groups.

NM reflected that it was nice to have a balance of news included in this report and acknowledged the helpful explanation of SPA.

The Committee noted the improvement in the appraisal rates however acknowledges that they should be reported through the people and remuneration committee (PRC). DT agreed and noted the assurance received should the CQC raise a concern and PRC will oversee appraisals from a business point of view.

It was RESOLVED to NOTE the report.

CG/23/157   RRPI Annual Report (DEFFERED) (agenda item 13)
Deferred to September Committee meeting.

CG/23/158   D&T Annual Report (agenda item 14)
Dr Kiran Rele took the report as read and advised that the electronic prescribing and medicines administration (EPMA) had been going well and as next steps will be rolling this out in the community.

The actions for the next year are also included in the report.

The Committee received and noted the report and approved the actions for the next year.

It was RESOLVED to NOTE the report.

CG/23/159   Sexual Safety Report (agenda item 15)
CGH gave a brief update to the Committee and noted that the paper provided data which indicated the Trust continues to report sexual safety incidents within normal variation rates. Ongoing analysis of the data indicates that there continues to be a positive reporting culture across all Care Groups, with specific hotspots involving a small number of service users when presenting with episodes of mental ill-health. Additionally, assurance has been provided through the completion of the Safeguarding Adult Review action plan and the facilitation of a sexual safety presentation at the Kirklees Safeguarding Health Alliance group in June 2023.

Since the last report there have been no reported red or amber incidents. Between April and the end of June 2023 there have been a total of 63 incidents reported. The highest proportion of incidents relate to service user against staff member. The majority of these incidents involve service users whose mental health is impacting on their behaviour and includes sexual disinhibition.

Within the time frame of this report there have been three allegations relating to inappropriate sexual behaviour from a staff member to a service user. All cases were reviewed, support offered to the service user and also to the staff member. Oversight of incidents to continue to be monitored through the Trust's weekly Clinical Risk Panel and the quarterly Safeguarding Strategic Subgroup.

The Trust will participate in the sexual safety of the NHS staff and patients workstreams as identified in the letter received into the Trust in June 2023.

NM noted the good report in terms of assurance, evidence and data.

NM did raise a query around criteria of reporting which was at the bottom of page three of the report and asked CGH to clarify. CGH noted that the table at the bottom of the page was specifically in reference to the freedom of information requests and will endeavour to make that clear in future reports.

NM noted that a lot of assurance was given through this report and good to see the progress around sexual safety.

It was RESOLVED to RECEIVE the report.

CG/23/160   Apparent Suicide Report (agenda item 16)
Naomi Sutcliffe returned today to discuss the report in more detail and gave a further update to the Committee. The report had previously been reviewed in Committee in May 2023.

The report included analysis of data for the 46 apparent suicides reported within the Trust during the year 2021/22 and a summary of the findings of the 2022 National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) report covering the period 1 January 2009 to 31 December 2019.

The main findings of the 2021/22 apparent suicide report were:

- 46 apparent suicides reported during 2021/22, compared with 44 in 2020/21 and 45 in 2019/20.

Overall, the rate of deaths by apparent suicide over the last three years has decreased.

The largest number of deaths in 2021/22 occurred within the 45-54 years age range with 13 deaths, eight of which were male. This is an increase on 2020/21 where there were six.
Deaths of those under 25 has seen a decrease with four, compared to eight in 2021/22.
There has been a decrease in deaths in the age group 25-34 in 2021/22 with four, compared to eight in 2020/21.

There has been an increase in deaths in the age group 65 to 74 years in 2021/22 with five, compared to two in 2020/21.

KQ noted the national confidential inquiry had a self-assessment for trusts and that the Trust does use that and would like to understand how we benchmark against that framework. NS noted that the Trust did undertake this a few years ago, however it would be useful to do this again. NS advised that a lot of work has been undertaken in the background looking at aims and ambitions and this strategy highlights that.

KQ also noted the last sentence on the front sheet which stated "In 63% of cases the last contact with services was within 7 days prior to death. The national figure is 46%" which was a large discrepancy between our figure and the national figure and would like to know why this was.

NS noted the good point raised and advised that it was a difficult question to address as every case was individual and we would need to review all the cases to give a definitive answer. NS will discuss a drill down with Emma Cox (associate director of nursing, quality and professions).
Action: Naomi Sutcliffe

DT noted a discussion at Board where it was discussed how Kirklees appeared to be an outlier in the number of serious incidents. He noted the data on page 15 and 16 of the report that flagged the expectations through population and also the rate of suicides per 1000 GP

referrals, and how this data would not support the view that Kirklees is an outlier. NS advised that on looking at the number of suicides per population within each of the areas it would only be telling part of the story and what needs to be done in the context of this report is bring the actual number of individual referrals as this can give a different percentage rating.

DT also advised of a planned meeting with Kirklees public health colleagues in relation to the above.

NM acknowledged the detail included in the report and was surprised about the "location of death" and the risks that are still involved even when patients are in acute, community or inpatient care.

NM acknowledged that the Committee would continue to see the work and impact of that work through the regular updates that are scheduled.

It was RESOLVED to RECEIVE and NOTE the report.

CG/23/161 Medical Devices Report (agenda item 17)
CGH gave an update of key highlights: -

This paper relates to the current risk and a breakdown of medical devices which require servicing. There are a total of 850 devices that have not been serviced and 67% that are now in date, this is an improvement from the last report figures. There are 22 devices that have a blank service history. Due to the physical health nature of the service provision, Barnsley has the largest number of devices with 1,699 medical devices on the contract, and there has been improvement with 37% of these devices remain unserviced.

NM acknowledged that the report covers all the data and the targets set.

KQ stated that she underestimated the huge task of this and queried who would oversee this work and also whether this would be included on the risk register.

DT informed this paper had not been to this Committee before and the Clinical Governance Group led a deep dive into this which in turn was escalated to EMT. As regards to ownership DT informed that it was between the nursing directorate and estates. There are plans to substantively recruit a medical devices officer and a decision will be made as to where this post would best sit. DT noted the amount of work that needs to be done and advised that this was on the organisational risk register.

DT informed the Committee that further updates will be taken to EMT and will be back to this Committee when available.

The Committee received the highlight report and will continue to receive updates to monitor the progress.
DT confirmed that this risk was on the organisational risk register (number 1757) and is aligned to this Committee.

It was RESOLVED to RECEIVE the report.

CG/23/162 Physical Health Strategy Report (agenda item 18)
CGH gave a brief update to the Committee.

Key highlights from the strategy include:

- ➤ The strategy has been developed to support the physical health agenda across the Trust and will continue to evolve and develop with oversight and leadership from the medical directorate and the nursing, quality and professions directorate.
- ➤ It focuses on the Trust's ambition of improving the physical health of people within our mental health and learning disabilities services.
- ➤ It sets out achievements made during the life of the previous strategy and celebrates successes and developments in supporting physical health.
- ➤ It outlines the strategic aims and sets out how these will be delivered.
- ➤ It highlights the detail of the Trust's commitments:
    - o People will be supported and encouraged to receive the physical health care that they need, including screening.
    - o People will be supported to achieve the best possible physical health status, in addition to providing excellent mental health and learning disability care and support.
    - o People will have equitable and inclusive access to health and well-being activities and initiatives.
    - o People will have the opportunity to influence the organisation's improvement in physical health care.
    - o Collaborative and partnership working will support and enable physical health opportunities to be embedded, improving the health of people in our services, improving decision making, activities, strategies and policies.
    - o The Trust will ensure that our health professionals are confident in their knowledge and skills to support service users in achieving their best possible physical health outcomes.
    - o Everyone will identify any serious or untoward incidents and ensure that improvement plans are developed, actioned and monitored in order to improve patient safety for physical health.
- ➤ It also sets out how success and delivery of the strategy will be monitored.

There was acknowledgment that there was more work to do to strengthen our physical health offer and the support required to do this.

The physical health strategy will continue to evolve and reflect any changes in the operational environment, care delivery and national performance and improvements plans.

DT informed the Committee that ordinarily this paper would have gone to EMT in the first instance however it will be going in two weeks and will be return here in September.

KQ advised on the need to differentiate between serious mental illness and learning disabilities within the report and also the need to be clear what our role is in terms of our care and our impact.

it was RESOLVED to RECEIVE and NOTE the report.

CG/23/163   Tees Esk and Wear Valley (TEWV) Report (agenda item 19)
CGH gave an update to the Committee and noted that the paper was to provide the oversight and assurance for our Trust.

Niche Health and Social Care Consulting (Niche) were commissioned by NHS England in November 2019 to undertake an independent investigation into the governance at West Lane Hospital (WLH), Middlesbrough between 2017 up to the hospital closure in 2019. The report was published in March 2023. WLH delivered Tier 4 child and adolescent mental health services (CAMHS) inpatient services. The review incorporated the care and treatment findings for three young people.

A number of findings were made which are detailed within the full report. A total of 12 recommendations were made to TEWV. .

Some work has been undertaken in this Trust to compare the report with the learning from the East Kent and Ockenden reviews which have been discussed at Committee previously.   The team will be looking to pull all the learning from the national reports together into one report.

NM noted that this was a really helpful report in terms of navigation and whether this would come back to this Committee with any further detail or updates. CGH noted that updates will be included in the Quality and Regulatory Oversight paper which comes to the Committee regularly.

DT informed that the current plan is for this paper to go to the next public Trust Board meeting and did the Committee feel that this format would be helpful for Board or an abridged version. NM felt that an abridged version would be better suited NM would advise Trust Board that further discussions could take place in the private session given the confidential and sensitive nature of the report.

The Committee was happy with this approach.

It was RESOLVED to RECEIVE and NOTE the report.

CG/23/164   Reports from Formal Sub-Committees (agenda item 20)
CG/23/1164a Drug & Therapeutic TAG (agenda item 20.1)
The report was taken as read.

CG/23/164b Infection, Prevention and Control (agenda item 20.2)
The report was taken as read.

CG/23/164c Joint Safeguarding (agenda item 20.3)
The report was taken as read.

CG/23/164d Reducing Restrictive Physical Interventions (agenda item 20.4)
There was no update for this item.

CG/23/164e Improving Clinical Information Governance Group (agenda item 20.5)
The updated was received and noted.

CG/23/164f Clinical Governance Group (agenda item 20.6)
The report was taken as read.

CG/23/164g Clinical Ethics Advisory Group (agenda item 20.7)
There was no update for this item.

CG/23/164h QUIT (agenda item 20.8)
The report was taken as read.

<u>CG/23/138i Safer Staffing (agenda item 20.9)</u>
There was no update for this item.

<u>CG/23/164j Physical Health (agenda item 20.10)</u>
There was no update for this item.

CG/23/165 Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 21)

NM will share the AAA update with CGCSC members should anyone wants to comment before it goes to Board however NM will provide a verbal update to Board as follows:

➢ **Alert**
New risk to be aligned to the Committee – Delayed transfers of care.
Review of demand and work underway.
Medical Devices Report.

➢ **Advise**
RPPI Annual Report - deferred to September.
Unallocated complaints.
Appraisal rates improving.
Industrial action.
Draft Physical Health Strategy.

➢ **Assure**
QMV's
Waterton visit.
Apparent Suicide Report.
Patient Experience Update.
Patient Safety Strategy.
Drugs & Therapeutics Annual Report.
TEWV Report.

CG/23/166 Risk Register review (agenda item 22)
There were no further updates for this item.

CG/23/167 Work Programme (agenda item 23)
The updated Work Programme was noted.

CG/23/168 Date of next meeting (agenda item 24)
The next meeting will be held on 12 September 2023. Both MS Teams and face to face.

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Minutes of Quality & Safety Committee meeting
9.00 Tuesday 12 September 2023
Hybrid

Present:	Darryl Thompson (DT) Kate Quail (KQ) Dr Subha Thiyagesh (STh) Marie Burnham (MB)	Chief Nurse / Director of Quality and Professions (Lead Director) Non-Executive Director Chief Medical Officer Chair of the Trust (from 9 – 10.10 am)
Apologies:	Nat McMillan (NM) Carol Harris (CH)	Non-Executive Director (Chair of the Committee) Chief Operating Officer
In attendance:	Carmain Gibson-Holmes (CGH) Sarah Harrison (SLH) Julie Williams (JW) Yvonne French (YF) Chris Lennox (CL) Janet Watson	Deputy Director of Nursing, Quality and Professions PA to Chief Nurse / Director of Quality & Professions (author) Assistant Director of Corporate Governance & Risk Assistant Director of Legal Services Director of Services, Adults and Older Peoples (deputising for Carol Harris) Live Well Wakefield (item 6)

QS/23/171 Welcome, introduction and apologies (agenda item 1)

This was a blended face to face/ Microsoft Teams meeting. Natalie McMillan (NM) was unavoidably detained and so couldn't chair the meeting. Therefore, the chair of the meeting until 10.10am was Marie Burnham (MB), with Kate Quail (KQ) taking on the role of chair from then until the end of the meeting. As Darryl Thompson (DT) was present in the room, DT co-ordinated the hybrid meeting on behalf of the chairs. Everyone was welcomed to the meeting and apologies were noted as above.

It was noted that due notice had been given to those entitled to receive it and that, with quoracy, the meeting could proceed. Marie Burnham (MB) advised that she had to leave the meeting at 10am therefore the meeting would not be quorate after that time. Therefore, the order of contents of the meeting were prioritised to ensure decisions could be made when quorate.

DT outlined the meeting protocols and etiquette.

DT and MB suggested that future meetings of the Committee would be better on Microsoft Teams due to the length of the meeting and the distance that people have to travel from.

QS/23/172 Declarations of interest (agenda item 2)

The Committee noted that there were no further declarations over and above those already made.

With **all of us** in mind.

The Quality & Safety Committee NOTED the declaration.

QS/23/173   Minutes from previous Quality and Safety Committee meeting held 24 July 2023 (agenda item 3)
The minutes were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the Quality & Safety Committee meeting held on 24 July 2023 as a true and accurate record.

QS/23/174   Matters arising from previous Quality & Safety Committee meeting held 24 July 2023 and action log (agenda item 4)
The action log was reviewed and updated as follows:

> ➢ CG/23/160 Apparent Suicide Report.
> DT will discuss the drill down of the figures with Emma Cox and Naomi Sutcliffe outside of the Committee. Complete.
> ➢ CG/23/151 Chief Nurse update paper. DT confirmed with KQ that the large number of complaints that were referred to in the Chief Nurse Report for June of this year were shown to be not unusually high on further exploration – Complete.
> ➢ CG/23/124 Review of Committee related risks.
> Medical devices. DT confirmed that a paper had been brought to the Committee. Complete.
> ➢ CG/23/135 Patient Experience Annual Report. On the agenda today. Complete.
> ➢ CG/23/84 Patient Safety Strategy. MB confirmed that this was now complete.

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates for 16 May 2023.

QS/23/175   Committee related risks were reviewed in accordance with the terms of reference. Including:

DT advised that there were no decisions or changes in the risks that would need approving.

DT did note that:

RISK ID 1568 Access to a seclusion room was under constant review and that estates are being extremely responsive with the situation.

RISK ID 1368 Access to a CAMHS bed. Ongoing conversations at Place level are taking place. DT highlighted that in Place conversations it is reaffirmed that it was not always in relation to a Tier 4 bed, and sometimes in relation to a specialist placement for the child or young person.

Medical devices. A blue light alert has been issued for colleagues which highlights both the clinical and professional risks.

RISK ID 1078. Relating to the conversation as to whether young people suffer 'harm' or 'serious harm' from waiting for a service. DT confirmed that the Trio have discussed and agreed that the actions and controls would be the same irrespective of any level of harm, and so it was suggested that no changes to the risk descriptor are made.

KQ queried the number of risk owners for RISK ID 275 and RISK ID 1820 as it appeared to be most of the directors and would like to know who has total ownership. DT advised that in terms of accountability it would be the executive Trio, with reporting to this Committee.

KQ and MB felt that the risk ownership needs to be more explicit for accountability. JW will look into this on behalf of the Committee. Julie confirmed that regular meetings are held with the executive Trio and other named directors in relation to the ORR.

Action: Julie Williams

It was RESOLVED to RECEIVE the update.

QS/23/176   Staff / Team Story (agenda item 6)
Janet Watson from the Live Well Wakefield Team came to the meeting to discuss her team's achievements, including a nomination for the Live Well Wakefield service for a Trust Excellence Award. The team promotes social prescribing and supportive management services. The programme is accredited and consists of three avenues, a general programme for any long-term conditions, a programme for people post cancer and a programme for people with mental health conditions. There are also four small workshops available for people who are unable to attend a longer programme and are focused on wellbeing. The sessions run for six weeks (one session a week)

DT noted the positive work that that has been achieved by the service.

MB thought that the presentation and the success the team has had was fantastic. MB asked how the service links to the recovery college. Janet confirmed that they work in partnership to run wellbeing as well as clinical sessions and that she goes in to deliver the workshops.

MB also queried how referrals are made. Janet confirmed that self-referral was the first option and they can also be found on line at www.livewellwakefield.nhs.uk, together with all their other contact details. A health professional can also refer a person to the service.

Kate Quail (KQ) acknowledged the brilliant presentation, hearing what the service achieves and hearing the personal experience of Janet was invaluable. KQ also asked who would be commissioning the service. Janet informed that it was between SWYPFT/public health and Nova Wakefield [the support agency for Voluntary, Community, and Social Enterprise (VCSE) organisations in Wakefield District].

KQ queried what was the biggest challenge the service was facing and if there was anything the Committee could assist with. Janet advised that the self-management arm of the service had lost several staff and that investment would need to continue as the staff that remain are stretched.

Janet also mentioned that further volunteers would be beneficial for the service but noted that the mandatory training required doesn't always feel necessary for their roles and has an impact on recruitment and retention. MB agreed with this and will discuss with DT and Subha Thiyagesh (SThi) outside of the meeting.
Action: Marie Burnham.

Subha Thiyagesh (SThi) thought the discussion with Janet was insightful and the lived experience was also invaluable to the post, and asked whether Janet felt that she was getting enough help. Janet advised that having more capacity would help in being able to get out more to talk to people and teams, to enable more referrals and get the service more widely known.

Chris Lennox (CL) noted the successful bid for the service in 2017. CL also highlighted the existence of the Wakefield Mental Health Alliance where there are opportunities each year to present for funding for new or existing services. CL advised that the next round will be starting in October. MB thought that was an excellent opportunity and idea.

Julie Williams (JW) asked about the diversity of the people who use the services provided. Janet noted that there were some gaps, for example people who did not have English as their first language, therefore Janet had provided some sessions where an interpreter would assist, for example.

QS/23/177   Chief Nurse - Update Paper (update on verbal items) inc update of topical & legal risks, escalations, QIA/EIA reviews / Quality Account (agenda item 7)

Paper had been circulated to all members. The agenda item was deferred but relevant aspects will be included in the report submitted to the next committee meeting.

QS/23/178   Quality Account Production Update (agenda item 8)

Included at item 7, therefore deferred to the next meeting.

QS/23/179   Quality Monitoring Visit Annual Report (agenda item 9)

DT noted that the quality monitoring activity is noted in the quality and regulatory oversight update paper which was brought to every meeting therefore the Committee do not now have to wait for the annual report for an update.

CGH gave a brief update to the Committee.

The quality monitoring visit (QMV) programme is a well-established internal governance framework within the Trust and has been running for many years. The QMV programme has been traditionally closely aligned with the Care Quality Commission (CQC) inspection regulatory process. This continues and as the CQC start to embed the single assessment framework, QMV's will adapt to ensure they are aligned with this.

Building on the post-pandemic QMV programme which was completed in 2021/22, the plan for 2022/23 was developed based on learning and successes following the annual review. This included adopting a flexible approach, allowing visits to be undertaken at short notice if there were immediate or urgent concerns.

During 2022/23 (August to March) ten visits were completed. These visits covered a wide range of services across inpatient settings and community services.

Learning from QMVs

Below is a summary of themes identified.

A number of positive themes were identified during the visits, and these included:

- Staff commitment and good levels of care
- Recording of incidents
- Service users reporting feeling safe on the wards
- Positive safeguarding practices

Some areas for improvement were also identified and these included:

- Lack of service user and carer involvement in care planning
- Lack of discharge planning
- Management of risk

- ➢ Physical health monitoring (learning disabilities)

Specific service concerns were escalated immediately.
Trust wide themes of these included:
- ➢ Supervision rates
- ➢ Appraisal rates
- ➢ Service user and carer involvement in care planning
- ➢ Mandatory training compliance

Monitoring and oversight
Action plans are developed by services following a QMV and these actions are incorporated into the service and Care Group improvement plans. Oversight is provided by the quality and governance arrangements in each individual Care Group.

Next steps
The Trust are looking at a quality surveillance programme to oversee and monitor service performance and quality outcomes. This work has started and will continue during 2023/24.

There are 18 QMVs planned for 2023-24, of which five of these have been completed at the time of writing.

DT confirmed that this report would be presented to Member's Council.

KQ queried how assurance was obtained that action plans and changes are being implemented. DT noted that action plans were held at a local level, wards and care groups, centrally within the Quality Improvement and Assurance Team, with any escalations to the Clinical Governance Group and on to the executive management team and committee as necessary..

KQ thanked the group for the helpful comments.

DT will add a paragraph into the report to reflect the assurance processes .
Action: DT

SThi stated that some bite sized learning could be shared at local levels to provide feedback.

It was RESOLVED to RECEIVE the Quality Monitoring Annual Report

QS/23/180   Quality and Regulatory Oversight Paper (agenda item 10)
Paper had been circulated to all members. The agenda item was deferred but relevant aspects will be included in the report submitted to the next committee meeting.

QS/23/181   Care Quality Commission Inpatient and Community Surveys update (agenda item 11)
Paper had been circulated to all members, but the agenda item was deferred to be included in the next committee meeting.

QS/23/182   Quality Strategy update (agenda item 12)
Paper had been circulated to all members, but the agenda item was deferred to be included in the next committee meeting.

QS/23/183   Care Plans and Risk Assessment Improvement Plan (agenda item 13)

CGH gave a brief update to the Committee and outlined the progress to date of the Care Plan and Risk Assessment Improvement Group in the completion, coproduction and recording of care plans and risk assessments.

- The care planning and risk assessment improvement group has been meeting regularly, utilising the three primary drivers to define a key topic for discussion. The outcomes of the meetings are presented within the paper.
- Improvements have been noted in the performance reported through the Integrated Performance Report, with the next step to ensure continued improvement and sustainability whilst developing future reporting metrics.
- Progress to date has been meaningful and there is continued positive engagement in the improvement work both formally and informally.
- The recent 360 Assurance audit found limited assurance with regards to aspects of the quality and the processes around clinical risk assessment. A summary of the findings were included, alongside the approach to improving the assurance.

This work will continue to take a staged approach; the scope of which includes:

- Identify and test improvements to person-centred care planning.
- Identify and test improvements to person-centred risk assessments.
- Develop and test a metric that accurately reflects coproduction of care planning.
- Develop and test a metric that accurately reflects risk assessments; and
- Embed record keeping as a key part of this work to ensure provision of readily accessible data that supports assurance and improvement against standards.

CGH will circulate the plan on a page document after the meeting.
Action: CGH

It was RESOLVED to RECEIVE and NOTE the report.

QS/23/184   Care Group Quality & Safety Report (agenda item 14)

Paper had been circulated to all members. The agenda item was deferred but relevant aspects will be included in the report submitted to the next committee meeting.

QS/23/185   RRPI Annual Report (agenda item 15)

Paper had been circulated to all members, but the agenda item was deferred to be included in the next committee meeting.

QS/23/186   Trust-Wide Incident Management Report Q1 (agenda item 16)

CGH gave a brief update to the Committee.
Incident Management Trust-wide report
- The number of incidents reported in Q1 2023/2024 was 3,733.
- Reporting rates remain within normal variation.
- 96% of all incidents reported resulted in no harm or low harm to patients and staff or were external to the Trust's care.

Learning from incidents

Learning from incidents has been incorporated into the report. This is a new section; previously this was provided annually and has been changed to enable provision of more current information in each quarterly report.

Serious Incidents
- There were four serious incidents reported in Q1 2023/2024.
- Serious incidents account for 0.11% of all incidents.
- We have continued to strengthen our initial review process to ensure we are using our resources to investigate the right incidents, as this will be the approach in the future under Patient Safety Incident Response Framework (PSIRF).
- During Q1 2023/24 there were no 'Never Events'.

Learning from Healthcare Deaths
- 92 deaths were reported in Q1 2023.
- 70 of the 92 deaths were in scope for mortality review.
- There are no areas of special cause variation that require further exploration.

The Committee were happy to recommend the report for approval at Trust Board.

It was RESOLVED to RECEIVE and APPROVE the report.

QS/23/187   Internal Audit Report – 360 Risk Assessment and Care Planning (agenda item 17)
CGH gave a brief update to the Committee and advised that the Audit Committee have already seen this document and that it provides limited assurance.

The Trust's internal auditors, 360 Assurance were invited to carry out a review in respect of risk assessments and care planning.   The effectiveness of controls in place were examined in accordance with the Public Sector Internal Audit Standards.

The Trust recognises that clinical risk is 'an inevitable consequence of people making decisions about their own lives and that positive risk management, as part of a carefully constructed plan, will help manage those risks more effectively.'

The Trust's Clinical Risk Assessment, Management and Training Policy identifies that it is expected that all service users will have a clinical risk assessment undertaken and that this informs the care planning process. The care plans should identify specific interventions based on an individual's support needs, taking into account safety and risk issues.

One of the Trust's priorities for 2023/24 is 'safe and responsive care', and 'risk assessment and care planning' is identified as one of the priority work areas for achieving this.

The auditors concluded that, in the areas examined, the risk management activities and controls are not suitably designed, or were not operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed during the period under review. Therefore, a limited assurance rating was applied.

The context of the gaps in assurance were as follows:
- There did not appear to be sufficient evidence that risk assessments were completed to the minimum standard of Formulation Informed Risk Management (FIRM), or in a timely manner.
- Care plans do not accurately reflect all relevant service user related risks.
- There did not appear to be sufficient evidence that all planned care, documented within a service user's care plan, could be observed in practice.

The recommendations and the improvement actions required are now part of the broader care plan and risk assessment improvement workstream. Of note, the audit reviewed the data prior to the recent reported improvement in performance. Engaging with these recommendations will also ensure a focus on the quality and application of clinical risk assessment, as well as the performance.

KQ noted that the Trust had asked for this audit as we had identified the issues and put in place actions to give further assurance.

JW noted that in the Audit Committee there had been a focus in the Integrated Performance Report on getting the numbers of people with a care plan and risk assessment improved and the next steps are of ensuring the quality, which is where the gaps are.

SThi queried as to whether the right controls, policies and procedures are being put in place and that staff fully understand the documentation.

CGH confirmed that through the Care Plan and Risk Assessment Improvement Group part of what is being considered is how to measure to ensure things are working effectively, and it was noted that the FIRM audit tool was not capturing everything effectively and this is being currently reviewed.

It was RESOLVED to RECEIVE the report.

QS/23/188   Patient Led Assessment of the Care Environment (PLACE) Report (agenda item 18)
Now addresses by Audit Committee.

QS/23/189   Safeguarding Annual Report (agenda item 19)
CGH gave a brief update to the Committee and noted the following.

The report provided high level assurance under four headings:
Assurance
> ➢ Mandatory training data (all levels are reported above the mandatory training target 80%)
> ➢ Datix information (the highest reported for safeguarding adults is around neglect and for safeguarding children this is child protection)
> ➢ Advice calls (the safeguarding team have responded to an increase of 166% of advice calls within the past five years)

Quality
> ➢ Updates to policies and procedures (both the adult and children's policies and relevant procedures have been updated in light of changes to legislation and local and national learning)
> ➢ Compliance with the NHS Domestic Abuse contract
> ➢ Compliance with the mandatory reporting of Female Genital Mutilation
> ➢ Multi-agency working (involvement in inspections and audits)
> ➢ Compliance with the Commissioner Safeguarding and Mental Capacity Act Standards

Alert
> ➢ Briefing papers and Situations, Background, Analysis and Recommendations (SBAR)

- Learning (presentation to external safeguarding challenge events, internal trust learning form and to specific teams)
- Compliance with the sexual safety collaborative benchmark
- External reviews (involvement in Safeguarding Adult Reviews, Domestic Homicide Reviews, Mental Health Homicide Reviews, Safeguarding Children Practice reviews and Lessons Leant Reviews)
- Multi-agency workstreams (safeguarding youths and gangs, routine enquiry, Prevent and pregnant person's guidance)

Advice
- Persons in Position of Trust and Boundaries (identified Trust lead, process, and training)
- Violence against women and girls (signatory to the Statement of Intent, 'Violence Against Women and Girls Independent Advisor Group in South and West Yorkshire).

DT noted that the paper provides a sense of how well connected the Trust is across the safeguarding agenda in all of our Places.

The Committee thought that the report was well written and were happy to approve for Trust Board and also submission to NHS England.

It was RESOLVED to RECEIVE and APPROVE the report.

QS/23/190   Medical Appraisal / Revalidation Report (agenda item 20)
SThi advised that this was the annual report along with annual organisational audit and will be submitted to NHS England (NHSE) after approval here and at Trust Board. SThi reported that there were no significant changes that need to be highlighted, however some post COVID-19 and industrial action impact was noted.

- 98% of the doctors that were due to have their appraisal have successfully completed the appraisal process during 2022/23, which is a further increase on last year.
- 19 revalidation recommendations were made between 1st April 2022 and 31st March 2023.
- There are no long-standing post-COVID-19 implications to the medical appraisal and revalidation process.
- It has been agreed that a training video will be recorded for the Associate Medical Director to use during induction to appraisal meetings for new starters within the Trust. This will complement the already robust sessions that take place periodically.
- The number of appraisers and appraiser trainers will continue to be monitored to ensure there is sufficient availability for appraisals to continue to take place within the timescales in order to meet compliance, and all appraisers are asked to encourage new doctors into the appraiser roles, if there are qualities and interest highlighted in a doctor's appraisal.
- The Trust is in the process of finalising a response to the GMC document *Fair to Refer*, which relates to the fair and equitable response to doctors facing complaints and/or referrals to the GMC, and is waiting for input from our People Directorate colleagues.
- The Trust has nominated three to four doctors to attend the next Case Investigator training, which was scheduled to take place in June 2023, to complement the existing Case Investigator.
- The Trust is in the process of developing a MWRES (Medical Workforce Race Equality Standard) Lead job description being developed with the assistance of the People Directorate and the Equality, Diversity and Inclusion team.

DT noted that this is a comprehensive report with a lot to be proud of. DT queried some data on page five of the report regarding complete and incomplete appraisals. SThi advised that not all the doctors received an appraisal within that year as some of the doctors leave before the end of the year and so would not require an appraisal within the time frame.

The Committee was asked to:

➢ receive this report noting that it will be shared with NHSE.
➢ recognise that the resource implications of medical revalidation are likely to continue to increase year on year.
➢ approve the NHSE Designated Body Annual Board Report Statement of Compliance, attached as Annex D of the report confirming that the Trust, as a Designated Body, was compliant with the regulations.

The Committee recommended approval of the report to Trust Board, stipulating that it first needed the approval of MB, who had left the meeting at 10.10am.

It was RESOLVED to RECEIVE and APPROVE the report (pending MB review)

QS/23/191   Physical Health Strategy Report (agenda item 21)
This item will be circulated to the members of the Committee for comments.

QS/23/192   Pressure Ulcer Deep Dive Report (agenda item 22)
Paper had been circulated to all members, but the agenda item was deferred to be included in the next committee meeting.

QS/23/193   Patient Experience Annual Report (agenda item 23)
CGH gave a brief update to the Committee and noted the following.

In response to previous Committee and Board feedback to include experience from beyond just the customer services team, more detail had been included with regards to data from other sources.

Performance in response to closure of a complaint within 6 months of receipt has deteriorated over 2022/23, with a range of factors impacting on this situation. The improvement approach currently underway to address this is referred to in the report.

A backlog of complaints awaiting allocation to a complaints case handler has reduced from a peak of 61 in autumn 2022, to 40 at the end of 2022/23, with further and sustained reduction since.

The Trust received eight requests for information from the Parliamentary and Health Service Ombudsman (PHSO) in 2022/23 with five of these cases having been brought by two complainants. Four of these cases have been closed by the PHSO with no further action or recommendations.

A full review of this annual report is planned for February 2024 to ensure that the experience of patients and carers is further reflected in it for 2023/24. This will be held and developed through the Patient Experience Group

A proposal for the new report will be shared with Quality and Safety Committee in March 2024.

CGH also noted the increase in compliments received into the Trust.

Work by the team is also underway in terms of protected characteristics to enable people to feel able to voice any concerns that they may have.

DT advised that the team were working hard with the performance team on the statistical process control (SPC) charts, to show trends over time.

MB confirmed that she was happy with the report and that it had progressed really well and was happy to approve for Trust Board. MB would however like to the message about staffing shortages to be an internal issue and therefore a slight amendment would be needed for public board.

The Committee were happy to approve the paper for Board with an updated reflection in relation to staffing.

KQ agreed with MB and felt it needed to be broken down further by protected characteristics and Care Group. DT suggested that perhaps this level of detail didn't need to be in the annual report, but that the annual report could describe where in our governance processes this information is reviewed and acted on. KQ was happy to support going to Board.

It was RESOLVED to RECEIVE and approve the report for Trust Board

QS/23/194   Reports from Formal Sub-Committees (agenda item 24)
QS/23/1194a Drug & Therapeutic TAG (agenda item 20.1)
There was no update for this item.

QS/23/194b Infection, Prevention and Control (agenda item 24.2)
There was no update for this item.

CQS/23/194c Joint Safeguarding (agenda item 24.3)
There was no update for this item.

QS/23/194d Reducing Restrictive Physical Interventions (agenda item 24.4)
There was no update for this item.

QS/23/194e Improving Clinical Information Governance Group (agenda item 24.5)
There was no update for this item.

QS/23/194f Clinical Governance Group (agenda item 24.6)
Paper had been circulated to all members. The agenda item was deferred but relevant aspects will be included in the report submitted to the next committee meeting.

QS/23/194g Clinical Ethics Advisory Group (agenda item 24.7)
There was no update for this item.

QS/23/194h QUIT (agenda item 24.8)
There was no update for this item

QS/23/194i Safer Staffing (agenda item 24.9)
There was no update for this item.

CG/23/194j Physical Health (agenda item 24.10)
There was no update for this item.

QS/23/195   Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 25)

DT will share the AAA update with Q&S members should anyone wants to comment before it goes to Board:

➢ **Alert**
• Internal Audit Report – 360 Risk Assessment and Care Planning. Committee considered the auditors' findings of 'limited assurance'. The context of the gaps in assurance were that there did not appear to be sufficient evidence that risk assessments were completed to the minimum standard of Formulation Informed Risk Management (FIRM), or in a timely manner. Care plans did not accurately reflect all relevant service user related risks, and there did not appear to be sufficient evidence that all planned care, documented within a service user's care plan, could be observed in practice. The Trust's response to this is now embedded in the care plan and risk assessment improvement workstream.

➢ **Advise**
• The committee received an inspiring presentation from Janet Watson from the Live Well Wakefield service. Janet described the accredited programme delivered by her and the team to promote wellbeing with regards to long-term conditions, people recovering from cancer and a programme for people experiencing mental health problems.
• An update on the Care Plans and risk Assessment Improvement Plan was received.

➢ **Assure**
• The Patient Experience Annual Report was recommended for approval at Board.
• The Incident Management Q1 report was recommended for approval at Board. Reporting rates remain within normal variation and 96% of all incidents reported resulted in no harm or low harm to patients and staff or were external to the Trust's care.
• The safeguarding annual report was approved by the committee.
• The Quality Monitoring Annual Report was received.
• The Medical Appraisal / Revalidation annual report was circulated to MBu outside of the meeting, to then be able to recommend for approval at Board.

QS/23/196   Risk Register review (agenda item 26)
There were no further updates for this item.

QS/23/197   Work Programme (agenda item 27)
There were no further updates for this item

QS/23/198   Date of next meeting (agenda item 28)
The next meeting will be held on 17 October 2023 (MS)

**Minutes of the Finance, Investment & Performance Committee
held on 18 September 2023
(Virtual meeting, via Microsoft Teams)**

Present:	David Webster Kate Quail	Non-Executive Director (Chair of the Committee) Non-Executive Director
Apologies	Natalie McMillan Carol Harris	Non-Executive Director (Deputy Chair of the Committee) Chief Operating Officer
In attendance:	Adrian Snarr Rob Adamson Chris Lennox Nick Phillips Julie Williams Jane Wilson	Director of Finance, Estates & Resources Deputy Director of Finance Director of Services, Adults and Older People Mental Health Deputy Director, Estates & Facilities Deputy Director of Corporate Governance Note taker

FIP/23/48   Welcome, introduction, and apologies (agenda item 1)
The Chair of the Committee, David Webster (DW) welcomed everyone to the meeting.
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/23/49   Declaration of interests (agenda item 2)
There were no further declarations of interests to declare.

FIP/23/50   Minutes from the meeting held on 17th July 2023 (agenda item 3)
It was RESOLVED to APPROVE the minutes from the Finance, Investment & Performance Committee meeting held on 17th July 2023

FIP/23/51   Items delegated from Trust Board held on 25 July 2023 (agenda item 4)
DW commented that items were raised around agency and the continuing challenge and negative trend. The biggest concern for Mark Brooks, Chief Executive was Out of Area (OOA) usage, and it was agreed that a review would take place here, following this feedback would be provided to the Board.

Chris Lennox discussed the Care Closer to Home and Reduction of Agency Usage presentation which had been shared with the committee in advance of the meeting.

Key highlights covered were:
- Reducing OOA placements: agreed trajectory for improvement
- Care Closer to Home priority programme: how we will improve
- Key Impacts and risks of reducing OOA placements including potential impacts on agency usage.
- Impacts and risks of reducing OOA placements: inpatient quality perspective.
- Reducing agency usage
- Impacts and risks of agency usage reduction – inpatient perspective.

- Way forward and mitigations

KQ remarked that this is a system problem, and it feels like the partnership working with our colleagues and also learning from peers feels like the right approach. She commented that when we got the consultants it did have an impact and the numbers rose again and is this due through demand, complexity, and acuity or is it because we did not implement everything they said or is it a bit of everything.

CL replied that she did not think we could attribute the success last time entirely to the Specialist Support Group (SSG) people who came in, however it was undoubtedly helpful for us to have those ideas and to have that focus on improvement in the organisation and at Place. She felt that what happened in between was the Covid years, and the Trust held it down for a considerable period of time. Covid did have a huge impact and the acuity of people coming out of Covid had a huge impact in terms of the levels of challenge we have seen. Also, there has been pressure in community teams which was not seen in previous years to the same extent, so the staffing challenges, the turnover, the vacancy rates, the levels of challenge that they are having to cope with in terms of supporting their service users, and their ability to keep people in the community has not been as strong as it used to be 4 or 5 years ago and that is another focus for us.

DW stated this looks like a really solid plan and we are moving in the right direction. He suggested bringing a further update back to the November meeting.

ACTION: Chris Lennox

FIP/23/52   Matters arising and action log from the meeting held on the 17th July 2023 (item 5)

It was agreed that the following actions could be closed:-
23/35, 23/36, 23/38, 23/41, 23/42, 23/09, 23/21, 23/29, 23/30, 23/31,147.

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

FIP/23/53   Consideration of items from the Organisational Risk Register allocated to the FIP Committee (agenda item 6)
AS presented the review of committee related risks stating there were no real changes since the September update.

Risk 1114 Capital
AS confirmed this risk is prevalent across the NHS, it is getting increased air time because of the reinforced autoclaved aerated concrete (RAAC) issues that were publicised across schools. Although we are not directly impacted by this, as a system we are because Airedale Trust was RAAC. There will be a capital update later on the agenda, also a significant agenda item on the older people's plan which is going to be a significant part of our capital plans for the next couple of years. AS did not feel there was a need to change the risk at this point in time.

Risk 1585 - Revenue
AS stated there is quite a lot on the agenda today that talks about our in-year position, our forward look, and also our forecast and some of the risks and mitigations that we have in place. He said there is nothing that warrants the risk changing the risk, but there are levels of volatility in the business environment we operate at the minute, so we just need to keep it under review.

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/23/54   Month 5 Finance Report (agenda item 7)
RA presented the financial position for month 5 stating we are almost half way through the year and there is lots of work currently ongoing to try and lock in our year end position:-

Key headlines:-

- Current year challenge has been increased, due to the medic pay award being accounted for in August, and back dated to April. Actual payments are due to be transacted in September (both income and expenditure) which will confirm the value of the funding gap.
- Month 5 reported a surplus of £449k which is ahead of plan, much of this is due to the profiling of collaboratives.
- This month has seen an increase in the reporting on our collaboratives to try and incorporate some best practice.. Also, maternal mental health will need to be factored in once this comes in.
- The trust core position is still a surplus in month, by £9k, so still positive and £180k better than plan.
- In terms of core trust we are £400k behind plan for the year to date, so again not far off plan but it is under, this is opposed to the trend over the last couple of years where we have been ahead of plan throughout the course of the year, we are now at the point of trying to manage up to ensure we can secure the breakeven forecast.
  Main impacts of this:-
    o   Pressures from pay award.
    o   Continue to have pressures of non-pay spend being above plan. In month this has been offset by an income adjustment relating to Microsoft licences where last month the ICB took funding from us and have now given us it back whilst they work out what they want to do, which is not helpful to us, but helps the ICB's overall position.
    o   OOA spend has gone down.

    RA stated overall it has been a really positive month which hopefully stands us in good stead to be able to close the gap off for the rest of the year.

- Current income risks relating to slippage on new mental health investments and potential impact of CQUIN performance get picked up on the risk paper so for the year to date they are not included in our numbers; finance is not losing sight of these.
- There has been a forward shift on our workforce growth position in month which is a change in trend from previous months. The main headline behind this is the impact of the newly qualified nurses intake and continued international recruitment.
- It is anticipated that the impact on agency and bank will be seen in future months after initial induction periods of substantive staff.
- The forecast models an additional 80 worked WTE by March 2024. At 4,936 this represents an increase of 345 WTE compared to the prior year. This is also an increase of 52 WTE from that forecast in July 2023. This movement will have a significant impact on the overall forecast scenario and future plan modelling.

- Agency spend in August is £808k, which is reduction for the second consecutive month, and slightly lower than the average run rate in 2022/23, this still remains higher than the monthly target.
- The Trust Agency Scrutiny and Management Group continues to provide oversight ensuring that processes are followed, and agency spend is appropriate and minimised. The Trust continues to assess needs based upon safety, quality and financial implications.
- Non-Pay is mostly showing as over against budget. There is ongoing wider analysis taking place which feeds specifically into the Non-pay Review.
- Value for Money/efficiencies - £49k behind plan year to date. Profile assumed increased / new schemes in H2, these need to be identified and progressed.
- Capital – moving behind plan for the year to date. Reporting externally that allocation will be fully utilised; continued forecast modelling internally on how this will be practically achieved.
- consideration of IFRS16 which currently sits outside our allocation was discussed and how that may impact our overall capital expenditure plans.
- Balance sheet. There is a focus on the accruals number as it is higher than expected at this time of year. Much of this relates to South Yorkshire Adult Secure Collaborative whereby a number of NHS providers have not invoiced us at all this year.
- Cash remains positive and we continue to pay invoices on time as shown by the Better Payment Practice Code performance. There are a number of increasing accruals (invoices not received) especially for the South Yorkshire Adult Secure Collaborative and these are being chased. To mitigate these, we continue to ensure that all invoices are raised as soon as possible and chase prompt payment, and there has been recognition of this positive performance from NHS England.

AS stated he wanted to emphasise the point about splitting out the provider collaborative which is positive, and the way we deal with it is appropriate. He said we also need to be mindful of the fact that we do not want to get ourselves into a position whereby provider collaboratives are propping up the core business of the Trust and he thought the revised reporting style that differentiates between the two is helpful.

It was RESOLVED to NOTE the Month 5 Finance update.

FIP/23/55 Financial forecast (agenda item 8)
RA presented the update stating that finance have tried to provide a bit more clarity as to where we are with our financial position, he said the ICB as a whole in West Yorkshire is challenged financially.

RA explained the baseline forecast for August 2023 is a deficit of £455k. This is a movement of £560k from month 4 due to new medic pay award gap and increased workforce growth assumptions. At this stage no care group, or support function, has formally agreed a variance from plan. These has been flagged through the Organisational Manager Group (OMG) with an expectation that each area will bring a report outlining the reasons for variance, actions being taken to resolve these, and any wider support required. This would then escalate through EMT with a summary provided into here at FIP as part of the assurance process. This would be in line with Trust Standing Financial Instructions (SFIs) and agreed processes.

RA confirmed the forecast continues to be reported externally as breakeven and in line with plan. Any changes to this would need to be agreed both internally and also within the ICB in accordance

with NHS England protocols. A summary of the total (Trust AND lead provider collaboratives) highlights that, with current modelling and assumptions, at this stage the most likely forecast is a surplus position of c. £1m but under a worst-case scenario could be a significant deficit of £11.5m

AS stated RA constructs the report for a 2023/24 forecast position, which is exactly what we need it to be. When you delve behind some of those risks and opportunities when we get into the medium-term planning we need to be mindful of the recurrent/non recurrent items on that list, as many of the current opportunities are non-recurrent and some of the risks are recurrent.
AS agreed with RA in that we would hit our plan for 2023/24,

AS remarked that he also wanted to draw the committee's attention to the variances at care group level that are over budget, we are therefore invoking our processes whereby care groups need to have a look at what they are expending and their plans to bring that back into balance, as we have not had to do this for a number of years, through Covid, as we have had a surplus of funds. We are still saying we have a surplus of funds this year but very much non recurrent, so we need those care groups to actually explain their plans going forward because we need to factor that into our medium-term financial plan. AS felt that no doubt some of this is related to over establishment in inpatient units and CL and her team are working on this, as we need to understand what the cost implications are and build these into future years budgets.
AS stated that this probably continues the theme from last year which is we have some non-recurrent headroom to get us through the year, but we need to be mindful that this is becoming harder to come by

AS advised that this paper is due to be taken to the private board in the same format as presented here today, and whilst it will provide the Board with assurance that we will hit our financial plan, it will also show the broader conversations around what does this mean across the system that we operate in and where the system is at.

It was RESOLVED to NOTE the Financial Forecast update.

FIP/23/56 Financial sustainability (agenda item 9)
RA provided the update stating the trust continues to develop and refine its medium-term financial plan, and values have been updated as of August 2023 to reflect current guidance and assumptions. He confirmed that since the initial headlines were shared with Trust Board around the recurrent gap, this position has deteriorated further due to the application of the medics pay. At this stage none of the planning assumptions (tariff, pay award impact etc) has changed. These will be confirmed by national planning guidance later in 2023.

Key headlines:-

- The current position shows that for the year to date, as a total, this is £34k behind plan, this is being delivered in different ways and some mitigated by non-recurrent savings.
- The Value for Money (VFM) workstream had been largely paused during Covid. There has been a return to normal in terms of operating expenditure for 2023/24, and the savings target is £11,969. This forms an integral part of the overall plan to deliver the target of breakeven or better.
- The interest receivable, provider collaborative and cessation of the additional bank incentive schemes, within the current plan, are in place and will continue to be for the remainder of the year. No further action is being taken at this time other than business as normal such as maximising cash in order to maximise interest receivable.
- Finance continues to utilise pre-existing reporting mechanisms, and governance processes, wherever possible although the Strategy team is reviewing best approaches to consolidate these for consistent clarity.

- Out of area (OOA) placements – positive reduction in activity in August as separately reported.
- Workforce schemes including agency, pay premiums and effective e-rostering – whilst remaining potential key lines of enquiry no material progress reported to date.
- Non pay review group – this group is co-ordinating and capturing efficiencies linked to non-pay expenditure. This group is still forming and will ensure that the outcome of actions are recorded effectively; verbal updates provided to date suggest actions have been undertaken but these need to be evidenced.
- Progress of each scheme, and the overall VFM programme is discussed monthly at OMG and escalated to EMT.

DW agreed with AS and RA, and for him it was more around the challenge in future years, and who are the individual owners who will be held accountable for each of these areas of savings, he said this needed to be made clear.
We are also getting some support from the change team to make sure this is not just purely a financial process and that we consider the quality aspects to all of this.
RA stated from his perspective having some more dedicated resource will also help, as the finance planning lead post has been vacant for some time, and this will provide more focus to help move this forward in the next couple of months and we can then see where this links into the plan.

KQ thanked RA for the update and really helpful paper. She asked if all findings/actions had been addressed in relation to the internal audit undertaken by 360 Assurance. RA replied they are still working on actions, and it is moving forward, although it is still lagging behind on the CIPs and savings. In terms of the self-assessment, it is not up to level 5 where they would want it to be, and in terms of the review of this it will come back to the meeting in January.

KQ thanked RA for the update.

AS remarked that because of the West Yorkshire ICB position there is also a requirement to enact a range of NHS England controls and they are working through this with them, and whilst they are not quite the same as the HMFA checklists, there are some overlaps, so we are making sure we do both.

It was RESOLVED to NOTE the Financial Sustainability update.

FIP/23/57 National Cost Collection (agenda item 10)
RA provided the update stating there has been lots of delays and false starts with this. The window is opening next month, and finance will make submissions up to the start of December. He stated that the team are on top of it, they know what they are doing, and the sign off process will be carried out by the Audit Committee, and the outputs as and when they are received will come through FIP. The 2021/22 outputs have still not been received, and RA has huge concerns that when these are received how meaningful are they going to be.

It was RESOLVED to NOTE the National Cost Collection update.

FIP/23/58 West & South Yorkshire Collaborative Financial Updates (agenda item 11)
RA provided the update stating he will take the paper as read, this is the normal update in terms of the risks that we are seeing. Adult Secure for West Yorkshire is fine, CAMHS and Eating Disorders have got pressures, South Yorkshire also has pressure which get picked up in papers at various other committees.

DW stated he had no further questions as he felt these had been covered to some extent in the wider finance update.

It was RESOLVED to NOTE the Provider Collaborative update.

FIP/23/59 Monthly Performance Review (agenda item 12)
JW provided the update stating that Mel Wood (MW), and Leslie Hewitt (LH) would be joining the meeting to provide the committee with an update on the IPR development and national IPR metrics, also an update on benchmarking.

MW advised as the uptodate IPR development plan had been circulated she did not intend to go through this in detail. She stated that today they wanted to showcase the national metric section of the IPR which is now live and was able to be used as part of the reporting last month and has been demonstrated in OMG. It has some excellent drill down capabilities, and this showcases where we are at with it.

Leslie Hewitt (LH) guided the committee through the national metrics demonstration.

JW stated that the key thing for committee members to note is the automation, there is no hand tooling of any of the data to create a report for OMG, EMT and ultimately Trust Board. It is the same data flowing through that is being manipulated to give different views. Although Board will have the Trust level view this gives us the ability to drill down into that view to answer any questions that they may have on what is causing the variance in a particular indicator.
These are the building blocks for the IPR and how it is going to look, and how we will be able to manipulate the data to suit the needs of the organisation.

AS remarked that hopefully it will also give the Board assurance that what is in the IPR at Trust level correlates completely to what is shared with OMG or with care groups, so there is no room for error in terms of interpretation. If we have data quality concerns we can flag it in the construction, so if we use appraisals for example, where we clearly had some concerns, and at an aggregate level it was about 75%, then when we drilled into it in some service areas it was much lower, we should now be able to answer that question to the Board/OMG much quicker, but also have a meaningful tool for the care groups that do the bottom up review. This is also user training led rather than performance team led and that is another benefit of automating the process.

JW stated it will also allow for validation all the way through the organisation from individual teams up to OMG level and will make the job for the operational services in terms of validating data much simpler.

DW remarked that this looks great and having seen a very early draft a few months ago the key thing for him is the data integrity of the information, and everyone being able to see the right thing at the right level.

MW stated that the IPR development Tag identified that the next area of focus would be the People data and there have been some delays with progression around this and they are working through some of these issues. In the interim they are also trying to work on some of the quality metrics, so some of the metrics that sit within SystmOne with data already available.

JW commented that the People data challenges have been flagged to the Committee previously and also flagged at Board and they are working closely with the People directorate to try and resolve these.

KQ remarked that this is fantastic work and great progress, and she wanted to thank everyone involved, as this is going to provide so much assurance down the line.

JW commented that although the Board are only getting the snapshot in the IPR, it is the same data flow that has been through the relevant operational and quality groups. There will also be a deep dive into individual care groups on a rotation basis so they will get to see more of the information.

DW thanked MW & LH for the update.

LH left the meeting.

It was RESOLVED to RECEIVE the monthly Performance Update

FIP/23/60 Benchmarking (agenda item 13)

MW provided the update, the team have been progressing with this year's benchmarking submissions, the majority of which are annual submissions, quite a large proportion of additional new submissions that have come into effect this year related to workforce data, that they have been working on and supporting the People directorate with. All the submissions that are part of the NHS benchmarking programme have been submitted to date. There have been a couple of validation queries predominantly around people data which they are working on to resolve these. MW advised they are awaiting the reports from the Benchmarking Network so they can analyse those, this will help to prioritise and build a work programme through the trust benchmarking group. These reports are expected imminently.

AS stated that he had been keen to triangulate reports with our costing outputs, but the challenges around costing means we are not able to do this in the short term, he said this does need to remain an aspiration of ours.

KQ thanked everyone involved in providing this helpful information.

MW left the meeting.

It was RESOLVED to RECEIVE the Benchmarking update.

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FIP/23/61 Waiting Time Report (agenda item 14)

Vicky Humble joined the meeting to (VH) present the update stating this report which has been shared with the committee sits under improvement access to care governance review. It was formerly received by Clinical Governance and Clinical Safety Committee (CG&CSC) and the function had been transferred to this committee in June 2023.

Key headlines:-

- We now have access to ethnicity monitoring as well as deprivation monitoring, we need to be mindful in areas such as CAMHs as this is not age weighted data, it is whole population data, and this is taken into consideration as part of the analysis when producing the report.
- Analysis so far suggests there is no ethnic group being disproportionately impacted by the weights, however it does not take into account disparity at the point of referral, or even prior to that, so access to those services who may complete the referrals.
- VH working with teams to ensure we can understand case loads and weight according to our indices and multiple deprivation.
- Significant waits within our ADHD services, there are ongoing conversations with commissioners in terms of are we meeting our commissioned responsibilities.

- There is no disproportionate impact for people who are waiting, however there is a slightly higher representation of individuals from our least deprived areas.
- It is important to view things from a Trust level, but we do need to break that information down. For example, in Huddersfield, due to Huddersfield University being in that area, and it is really important that we understand this at that level, rather than viewing across Place population or trust level.
- Barnsley core CAMHS – most children continue to be seen within 3 months. We have noticed an increase in the above average wait and increasing numbers on the list and we need to monitor this.
- Kirklees core referrals peaked in May and June and that has had a direct impact on waiting times and numbers waiting. Both services continue to effectively manage that increase in demand at the moment and most children are being seen within 3-6 months.
- Wakefield core CAMHs has managed the surge in the number of referrals that were noted in the previous report and they have since returned to normal variation with most children being seen within 6-9 months. Staff absence may well have been a contributing factor and this has stabilised recently and so this has helped with the waiting times.
- In terms of CAMHs Neuro developmental pathways, this is a priority programme certainly in Calderdale and Kirklees within the integration change team and we have been working with them to do deep dives into their individual service metrics to understand what is happening.
- Learning and disability services – performance is generally good with assessment being completed within two weeks in almost all of our areas. One thing to note is the numbers involved in the calculations for those metrics are relatively low and that increases the swing of the data. Where we see a change of a considerable percentage between those reports it is likely to be just the small numbers that are affecting that swing.
- Learning disability services are being onboarded onto the SystmOne waiting list functionality, this will improve our ability to report and analyse and we will be able to complete further review of the individual areas to understand how the care is affected in all of those Places.
- MSK services are achieving the 19 weeks target, but they are reporting an increase in demand and staffing challenges. They are currently managing these; however, it is noted as a watching brief to ensure we continue to see if this does transfer on to adversely affected waiting times.
- Barnsley core psychology continues to undergo a period of data validation, it did transfer onto the SystmOne functionality a little while ago and they are confident in the data, and they are continuing to apply the validation process.
- Patients on the core psychology waiting list for therapy have already received 6 weeks of psychology induction and assessment which means there has been some offer of resilience ability to those individuals who are waiting. This is a priority programme within the integrated change team.
- Paediatric audiology was added as a late addition to this report. They were experiencing issues with their waiting times; however, they have now entered a more stable phase and we are now seeing a reduction in both average and longest waits for that service which is good news.

DW thanked VH for a great update.

KQ stated that was a very detailed and comprehensive update. She asked if we had information about the number and quality of referrals into our services, also numbers referred to GPs because they do not have the right information etc, in terms of the demand, as understanding our capacity and demand is crucial and referral is part of that.
VH replied yes and some of that work was completed as part of the demand report that was circulated within the improving access to care report which some of the committee may not have

seen. It has been circulated to EMT and other groups, but not circulated wider. It does not form part of the waiting time report, but something they monitor.

JW remarked that she would like the committee to recognise the amount of work that VH has undertaken in terms of compiling this report.

The committee thanked VH for the excellent update and hard work that had gone into producing this.

Vicky Humble left the meeting.

It **was RESOLVED to RECEIVE the Waiting List Update**

FIP/23/62 Older Peoples Business Case (agenda item 15)

AS explained the reason this is on the FIP agenda is because it falls into the investment part. He thought it would be useful to bring it here, even though it has been to Board at high level, so the committee can understand some of those concepts that we are about to consult on.

Ryan Hunter (RH) shared a current inpatient model presentation with the committee that he had recently shared with the ICB.

Key highlights:-

- RH stated that he wanted to flag to the committee that currently people are on mixed needs wards, these are individuals with mixed functional needs, so dementia, depression, psychosis, and other functional needs, and this is what they want to change, as these people do not mix very well which then creates challenges.
- Challenges in all the wards at the Dales, particularly on Beechdale, which is a16 bed mixed dementia ward. It lacks space, so it is difficult to make changes to this ward and it is also on a PFI Site.
- Ward 19 in Dewsbury has a male and female ward, it has similar challenges with the mix of dementia and functional, it does have more space for people to move around in, but it does not have ensuite which is one of the challenges with this ward.
- In Wakefield there are two wards, Crofton, which is on the Fieldhead site, there is potentially extra space where they could create some extra capacity.
- Poplars in Hemsworth is the only dedicated dementia site on the footprint. That comes with the challenges of being isolated and it means they cannot accept people directly to the ward, and so this is not sustainable to maintain.
- Barnsley have a functional only ward and they do not commission any dementia beds; we have a spot purchasing arrangement. We do not plan on changing Willow Ward and for that purpose Barnsley is outside the scope for transformation.

RH stated we are looking at West Yorkshire and what we can do within our own footprint, and we are looking at reconfiguring the estates and the offer to deliver that specialist dementia and specialist function only. The only two sites that would have the capacity to do the specialist dementia would be Dewsbury, or Wakefield.

RH explained the next step is to start taking this through formal governance within the next 2/3 month and it has been brought here for the committees view on the financial aspects of this, it will also be taken through the Quality and Safety Committee in advance of going to board next month.

RA remarked he would like to provide the committee with assurance in terms of the finances. He stated in the full board paper we highlight how we have developed the finance information in partnership with our commissioning colleagues.

DW commented that where we are now is that we have options available, but we cannot do much until after the public consultation, this will then direct us more towards what we do, and until such times this remains sensitive, and we just have to keep an eye on it as it progresses.
AS agreed with DW.

KQ remarked that she had found this update extremely helpful. She asked if we had used the NHSE capital business case checklist for this.
Nick Phillips (NP) replied that we did, and we also use the Better Case Business Model for all our business cases.
RH confirmed training courses are run for large scale transformations, and they provide different templates, so for example a finance template details exactly what they expect to see, and the Trust have been mindful of this as they are worked through this.

Ryan Hunter left the meeting.

It was RESOLVED to RECEIVE the update on the Older Peoples Business Case

FIP/23/63 Capital Programme (agenda item 16)

NP presented the update stating the capital programme is falling behind programme and there are a couple of reasons for this which are now under control.

Major Capital

Seclusion Rooms

The first scheme in the programme is nearing the point of tender and is presently running on time. There is a need for planning permission that was part of an add on to the scheme and this is being resolved in line with the overall plan. There are plans now to commence design of further schemes in the overall programme to allow them to be put together as a package of works in order to obtain improved cost certainty.
Following discussion with Procurement the tender for this has been expanded to allow for further awards for minor capital schemes in order to speed delivery of minor capital schemes. The tender process completes in September. They are hoping to appoint a contractor who can then go on a become a partner contract to deliver the rest of the minor works programme.

Kendray infrastructure

This project is in design and as reported at the last update the utility providers part of the scheme has not progressed as anticipated meaning that expenditure on the scheme will be behind plan and will move into a future year in part. It is proposed to review the budget to approximately £600k in year and pull projects forward from next year.
NP confirmed the infrastructure scheme will be brought to a stage where all SWYPFT preparatory work is done, and the stage 2 physical pipework and infrastructure installation can complete as a separate project so can be done in 2024/25 year or a following year dependent on capital allocation being potentially prioritised for OPS transformation This proposal will go through the necessary governance stages which started with Estates TAG.

NP stated that overall, the plan is still projected to outturn on plan in terms of finance but with the changes outlined to the committee. The Trust continues to report into the wider ICB plan which is reporting as on plan at the present time. He confirmed the market continues to be volatile, and the Trust is seeking to reduce exposure to that market volatility by adopting the new approach to procurement mentioned above. Progress on this will be included in the next update.

AS stated NP has just highlighted the inherent challenges of managing capital on a one year basis but that is what the NHS has to do, so pulling schemes forward when other schemes slip is just part of what we have to do.

DW remarked this all sounds sensible, if not the original plan.

Nick Phillips left the meeting.

It was RESOLVED to RECEIVE the Capital update.

FIP/23/64 Bids and Tenders/MHIS update (agenda item 17)

AS provided the update stating this month's report only contains detail on the Mental Health Investment. It is a fairly lengthy report because it picks up Q4 22/23 and the beginning of 23/24, he remarked that he was not going to go through it any detail but had a few things he wanted to draw out. Previously, Natalie McMillan (NM) had raised a challenge around when can we move on from the KPIs just been about the finance, and actually what is the mental health investment standard delivery. He stated this is starting to happen now where we have a number of KPIs in there that talk about outcomes, waiting times and access times and links into some of the other things we are doing.

Learning disabilities is providing particularly challenging to recruit to and so some of the mental health investment ambitions are not being realised because we have not got the staff and we are still focusing on how we can get the required level of staff. The learning disabilities team did have ambitions to bid for more resources, collectively we agreed this was not the right thing to do because we could not demonstrate we were expending what we had already been given, so we have to stick with the baseline we have got for now.

AS stated as we have moved through into 2023/24 it has not been a straight forward process to get everything agreed in a timely fashion, one of the reasons for this is the financial pressure that everyone is under. Another is that processes are different in each Place. For various reasons Kirklees have not yet formally signed off on the Mental Health Investment this year. They have informally said what we are working to is right, but they have not formally been able to put it into the contract and we have been working with some level of risk albeit minor risk to start to implement that and that formal approval is starting to flow through. We have not necessarily lost any time on it because we have been proceeding anyway but there is a level of concern from the contracting team that this has taken a disproportionate amount of time just to agree the money, and we are half way through the year.

AS stated that we get positive feedback from our commissioners on what we are doing on the improvements that are starting to show. He said he wanted to link back to the forecast paper that RA presented earlier and that we do not yet know what our Commissioners will do around slippage, and they may claw it back because they need to invest in a different area to hit the MHIS, or they may claw it back because they are under significant financial pressure, so we are dealing with this through the finance routes.

AS stated this is just an up sum of where we are at and if okay with DW we can spend a bit more time on this when we do the Q2 report and look at the KPIs and performance.

DW agreed that this made sense.

It was RESOLVED to RECEIVE the Bids & Tender update.

FIP/23/65 Work plan (agenda item 18)

AS commented that when they initially set the agenda for this meeting it did not look like a heavy

agenda, and he said the positive we can take from this is that we are getting the balance better. He suggested that at the next agenda setting meeting with DW and himself they try and make an assessment of how long every item needs.

DW felt this was a good idea, and as the Committee only now meet 8 times a year he had realised this was going to be a longer meeting and he thought there might have been a need to extend it by half an hour, but actually we have covered it within the timescale. He agreed with AS though in that they should keep an eye on it going forward.

FIP23/66 Any other Business (agenda item 19)

DW confirmed there were no further items to discuss.

**Minutes of the Finance, Investment & Performance Committee
held on 18 September 2023
(Virtual meeting, via Microsoft Teams)**

Present:	David Webster Kate Quail	Non-Executive Director (Chair of the Committee) Non-Executive Director
Apologies	Natalie McMillan Carol Harris	Non-Executive Director (Deputy Chair of the Committee) Chief Operating Officer
In attendance:	Adrian Snarr Rob Adamson Chris Lennox Nick Phillips Julie Williams Jane Wilson	Director of Finance, Estates & Resources Deputy Director of Finance Director of Services, Adults and Older People Mental Health Deputy Director, Estates & Facilities Deputy Director of Corporate Governance Note taker

FIP/23/48   Welcome, introduction, and apologies (agenda item 1)
The Chair of the Committee, David Webster (DW) welcomed everyone to the meeting.
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/23/49   Declaration of interests (agenda item 2)
There were no further declarations of interests to declare.

FIP/23/50   Minutes from the meeting held on 17ᵗʰ July 2023 (agenda item 3)
It was RESOLVED to APPROVE the minutes from the Finance, Investment & Performance Committee meeting held on 17ᵗʰ July 2023

FIP/23/51   Items delegated from Trust Board held on 25 July 2023 (agenda item 4)
DW commented that items were raised around agency and the continuing challenge and negative trend. The biggest concern for Mark Brooks, Chief Executive was Out of Area (OOA) usage, and it was agreed that a review would take place here, following this feedback would be provided to the Board.

Chris Lennox discussed the Care Closer to Home and Reduction of Agency Usage presentation which had been shared with the committee in advance of the meeting.

Key highlights covered were:
- Reducing OOA placements: agreed trajectory for improvement
- Care Closer to Home priority programme: how we will improve
- Key Impacts and risks of reducing OOA placements including potential impacts on agency usage.
- Impacts and risks of reducing OOA placements: inpatient quality perspective.
- Reducing agency usage
- Impacts and risks of agency usage reduction – inpatient perspective.

- Way forward and mitigations

KQ remarked that this is a system problem, and it feels like the partnership working with our colleagues and also learning from peers feels like the right approach. She commented that when we got the consultants it did have an impact and the numbers rose again and is this due through demand, complexity, and acuity or is it because we did not implement everything they said or is it a bit of everything.

CL replied that she did not think we could attribute the success last time entirely to the Specialist Support Group (SSG) people who came in, however it was undoubtedly helpful for us to have those ideas and to have that focus on improvement in the organisation and at Place. She felt that what happened in between was the Covid years, and the Trust held it down for a considerable period of time. Covid did have a huge impact and the acuity of people coming out of Covid had a huge impact in terms of the levels of challenge we have seen. Also, there has been pressure in community teams which was not seen in previous years to the same extent, so the staffing challenges, the turnover, the vacancy rates, the levels of challenge that they are having to cope with in terms of supporting their service users, and their ability to keep people in the community has not been as strong as it used to be 4 or 5 years ago and that is another focus for us.

DW stated this looks like a really solid plan and we are moving in the right direction. He suggested bringing a further update back to the November meeting.

ACTION: Chris Lennox

FIP/23/36   Matters arising and action log from the meeting held on the 17th July 2023 (item 5)

It was agreed that the following actions could be closed:-
23/35, 23/36, 23/38, 23/41, 23/42, 23/09, 23/21, 23/29, 23/30, 23/31,147.

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

FIP/23/37   Consideration of items from the Organisational Risk Register allocated to the FIP Committee (agenda item 6)
AS presented the review of committee related risks stating there were no real changes since the September update.

Risk 1114 Capital
AS confirmed this risk is prevalent across the NHS, it is getting increased air time because of the reinforced autoclaved aerated concrete (RAAC) issues that were publicised across schools. Although we are not directly impacted by this, as a system we are because Airedale Trust was RAAC. There will be a capital update later on the agenda, also a significant agenda item on the older people's plan which is going to be a significant part of our capital plans for the next couple of years. AS did not feel there was a need to change the risk at this point in time.

Risk 1585 - Revenue
AS stated there is quite a lot on the agenda today that talks about our in-year position, our forward look, and also our forecast and some of the risks and mitigations that we have in place. He said there is nothing that warrants the risk changing the risk, but there are levels of volatility in the business environment we operate at the minute, so we just need to keep it under review.

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/23/38   Month 5 Finance Report (agenda item 7)

RA presented the financial position for month 5 stating we are almost half way through the year and there is lots of work currently ongoing to try and lock in our year end position:-

Key headlines:-

- Current year challenge has been increased, due to the medic pay award being accounted for in August, and back dated to April. Actual payments are due to be transacted in September (both income and expenditure) which will confirm the value of the funding gap.
- Month 5 reported a surplus of £449k which is ahead of plan, much of this is due to the profiling of collaboratives.
- This month has seen an increase in the reporting on our collaboratives to try and incorporate some best practice.. Also, maternal mental health will need to be factored in once this comes in.
- The trust core position is still a surplus in month, by £9k, so still positive and £180k better than plan.
- In terms of core trust we are £400k behind plan for the year to date, so again not far off plan but it is under, this is opposed to the trend over the last couple of years where we have been ahead of plan throughout the course of the year, we are now at the point of trying to manage up to ensure we can secure the breakeven forecast.
  Main impacts of this:-
    o Pressures from pay award.
    o Continue to have pressures of non-pay spend being above plan. In month this has been offset by an income adjustment relating to Microsoft licences where last month the ICB took funding from us and have now given us it back whilst they work out what they want to do, which is not helpful to us, but helps the ICB's overall position.
    o OOA spend has gone down.

    RA stated overall it has been a really positive month which hopefully stands us in good stead to be able to close the gap off for the rest of the year.

- Current income risks relating to slippage on new mental health investments and potential impact of CQUIN performance get picked up on the risk paper so for the year to date they are not included in our numbers; finance is not losing sight of these.
- There has been a forward shift on our workforce growth position in month which is a change in trend from previous months. The main headline behind this is the impact of the newly qualified nurses intake and continued international recruitment.
- It is anticipated that the impact on agency and bank will be seen in future months after initial induction periods of substantive staff.
- The forecast models an additional 80 worked WTE by March 2024. At 4,936 this represents an increase of 345 WTE compared to the prior year. This is also an increase of 52 WTE from that forecast in July 2023. This movement will have a significant impact on the overall forecast scenario and future plan modelling.

- Agency spend in August is £808k, which is reduction for the second consecutive month, and slightly lower than the average run rate in 2022/23, this still remains higher than the monthly target.
- The Trust Agency Scrutiny and Management Group continues to provide oversight ensuring that processes are followed, and agency spend is appropriate and minimised. The Trust continues to assess needs based upon safety, quality and financial implications.
- Non-Pay is mostly showing as over against budget. There is ongoing wider analysis taking place which feeds specifically into the Non-pay Review.
- Value for Money/efficiencies - £49k behind plan year to date. Profile assumed increased / new schemes in H2, these need to be identified and progressed.
- Capital – moving behind plan for the year to date. Reporting externally that allocation will be fully utilised; continued forecast modelling internally on how this will be practically achieved.
- consideration of IFRS16 which currently sits outside our allocation was discussed and how that may impact our overall capital expenditure plans.
- Balance sheet. There is a focus on the accruals number as it is higher than expected at this time of year. Much of this relates to South Yorkshire Adult Secure Collaborative whereby a number of NHS providers have not invoiced us at all this year.
- Cash remains positive and we continue to pay invoices on time as shown by the Better Payment Practice Code performance. There are a number of increasing accruals (invoices not received) especially for the South Yorkshire Adult Secure Collaborative and these are being chased. To mitigate these, we continue to ensure that all invoices are raised as soon as possible and chase prompt payment, and there has been recognition of this positive performance from NHS England.

AS stated he wanted to emphasise the point about splitting out the provider collaborative which is positive, and the way we deal with it is appropriate. He said we also need to be mindful of the fact that we do not want to get ourselves into a position whereby provider collaboratives are propping up the core business of the Trust and he thought the revised reporting style that differentiates between the two is helpful.

It was RESOLVED to NOTE the Month 5 Finance update.

FIP/23/39 Financial forecast (agenda item 8)
RA presented the update stating that finance have tried to provide a bit more clarity as to where we are with our financial position, he said the ICB as a whole in West Yorkshire is challenged financially.

RA explained the baseline forecast for August 2023 is a deficit of £455k. This is a movement of £560k from month 4 due to new medic pay award gap and increased workforce growth assumptions. At this stage no care group, or support function, has formally agreed a variance from plan. These has been flagged through the Organisational Manager Group (OMG) with an expectation that each area will bring a report outlining the reasons for variance, actions being taken to resolve these, and any wider support required. This would then escalate through EMT with a summary provided into here at FIP as part of the assurance process. This would be in line with Trust Standing Financial Instructions (SFIs) and agreed processes.

RA confirmed the forecast continues to be reported externally as breakeven and in line with plan. Any changes to this would need to be agreed both internally and also within the ICB in accordance

with NHS England protocols. A summary of the total (Trust AND lead provider collaboratives) highlights that, with current modelling and assumptions, at this stage the most likely forecast is a surplus position of c. £1m but under a worst-case scenario could be a significant deficit of £11.5m

AS stated RA constructs the report for a 2023/24 forecast position, which is exactly what we need it to be. When you delve behind some of those risks and opportunities when we get into the medium-term planning we need to be mindful of the recurrent/non recurrent items on that list, as many of the current opportunities are non-recurrent and some of the risks are recurrent.
AS agreed with RA in that we would hit our plan for 2023/24,

AS remarked that he also wanted to draw the committee's attention to the variances at care group level that are over budget, we are therefore invoking our processes whereby care groups need to have a look at what they are expending and their plans to bring that back into balance, as we have not had to do this for a number of years, through Covid, as we have had a surplus of funds. We are still saying we have a surplus of funds this year but very much non recurrent, so we need those care groups to actually explain their plans going forward because we need to factor that into our medium-term financial plan. AS felt that no doubt some of this is related to over establishment in inpatient units and CL and her team are working on this, as we need to understand what the cost implications are and build these into future years budgets.
AS stated that this probably continues the theme from last year which is we have some non-recurrent headroom to get us through the year, but we need to be mindful that this is becoming harder to come by

AS advised that this paper is due to be taken to the private board in the same format as presented here today, and whilst it will provide the Board with assurance that we will hit our financial plan, it will also show the broader conversations around what does this mean across the system that we operate in and where the system is at.

It was RESOLVED to NOTE the Financial Forecast update.

FIP/23/40 Financial sustainability (agenda item 9)

RA provided the update stating the trust continues to develop and refine its medium-term financial plan, and values have been updated as of August 2023 to reflect current guidance and assumptions. He confirmed that since the initial headlines were shared with Trust Board around the recurrent gap, this position has deteriorated further due to the application of the medics pay. At this stage none of the planning assumptions (tariff, pay award impact etc) has changed. These will be confirmed by national planning guidance later in 2023.

Key headlines:-

- The current position shows that for the year to date, as a total, this is £34k behind plan, this is being delivered in different ways and some mitigated by non-recurrent savings.
- The Value for Money (VFM) workstream had been largely paused during Covid. There has been a return to normal in terms of operating expenditure for 2023/24, and the savings target is £11,969. This forms an integral part of the overall plan to deliver the target of breakeven or better.
- The interest receivable, provider collaborative and cessation of the additional bank incentive schemes, within the current plan, are in place and will continue to be for the remainder of the year. No further action is being taken at this time other than business as normal such as maximising cash in order to maximise interest receivable.
- Finance continues to utilise pre-existing reporting mechanisms, and governance processes, wherever possible although the Strategy team is reviewing best approaches to consolidate these for consistent clarity.

- Out of area (OOA) placements – positive reduction in activity in August as separately reported.
- Workforce schemes including agency, pay premiums and effective e-rostering – whilst remaining potential key lines of enquiry no material progress reported to date.
- Non pay review group – this group is co-ordinating and capturing efficiencies linked to non-pay expenditure. This group is still forming and will ensure that the outcome of actions are recorded effectively; verbal updates provided to date suggest actions have been undertaken but these need to be evidenced.
- Progress of each scheme, and the overall VFM programme is discussed monthly at OMG and escalated to EMT.

DW agreed with AS and RA, and for him it was more around the challenge in future years, and who are the individual owners who will be held accountable for each of these areas of savings, he said this needed to be made clear.
We are also getting some support from the change team to make sure this is not just purely a financial process and that we consider the quality aspects to all of this.
RA stated from his perspective having some more dedicated resource will also help, as the finance planning lead post has been vacant for some time, and this will provide more focus to help move this forward in the next couple of months and we can then see where this links into the plan.

KQ thanked RA for the update and really helpful paper.   She asked if all findings/actions had been addressed in relation to the internal audit undertaken by 360 Assurance. RA replied they are still working on actions, and it is moving forward, although it is still lagging behind on the CIPs and savings. In terms of the self-assessment, it is not up to level 5 where they would want it to be, and in terms of the review of this it will come back to the meeting in January.

KQ thanked RA for the update.

AS remarked that because of the West Yorkshire ICB position there is also a requirement to enact a range of NHS England controls and they are working through this with them, and whilst they are not quite the same as the HMFA checklists, there are some overlaps, so we are making sure we do both.

It was RESOLVED to NOTE the Financial Sustainability update.

FIP/23/41 National Cost Collection (agenda item 10)
RA provided the update stating there has been lots of delays and false starts with this. The window is opening next month, and finance will make submissions up to the start of December. He stated that the team are on top of it, they know what they are doing, and the sign off process will be carried out by the Audit Committee, and the outputs as and when they are received will come through FIP. The 2021/22 outputs have still not been received, and RA has huge concerns that when these are received how meaningful are they going to be.

It was RESOLVED to NOTE the National Cost Collection update.

FIP/23/42 West & South Yorkshire Collaborative Financial Updates (agenda item 11)
RA provided the update stating he will take the paper as read, this is the normal update in terms of the risks that we are seeing. Adult Secure for West Yorkshire is fine, CAMHS and Eating Disorders have got pressures, South Yorkshire also has pressure which get picked up in papers at various other committees.

DW stated he had no further questions as he felt these had been covered to some extent in the wider finance update.

It was RESOLVED to NOTE the Provider Collaborative update.

FIP/23/43 Monthly Performance Review (agenda item 12)
JW provided the update stating that Mel Wood (MW), and Leslie Hewitt (LH) would be joining the meeting to provide the committee with an update on the IPR development and national IPR metrics, also an update on benchmarking.

MW advised as the uptodate IPR development plan had been circulated she did not intend to go through this in detail. She stated that today they wanted to showcase the national metric section of the IPR which is now live and was able to be used as part of the reporting last month and has been demonstrated in OMG. It has some excellent drill down capabilities, and this showcases where we are at with it.

Leslie Hewitt (LH) guided the committee through the national metrics demonstration.

JW stated that the key thing for committee members to note is the automation, there is no hand tooling of any of the data to create a report for OMG, EMT and ultimately Trust Board. It is the same data flowing through that is being manipulated to give different views. Although Board will have the Trust level view this gives us the ability to drill down into that view to answer any questions that they may have on what is causing the variance in a particular indicator.
These are the building blocks for the IPR and how it is going to look, and how we will be able to manipulate the data to suit the needs of the organisation.

AS remarked that hopefully it will also give the Board assurance that what is in the IPR at Trust level correlates completely to what is shared with OMG or with care groups, so there is no room for error in terms of interpretation. If we have data quality concerns we can flag it in the construction, so if we use appraisals for example, where we clearly had some concerns, and at an aggregate level it was about 75%, then when we drilled into it in some service areas it was much lower, we should now be able to answer that question to the Board/OMG much quicker, but also have a meaningful tool for the care groups that do the bottom up review. This is also user training led rather than performance team led and that is another benefit of automating the process.

JW stated it will also allow for validation all the way through the organisation from individual teams up to OMG level and will make the job for the operational services in terms of validating data much simpler.

DW remarked that this looks great and having seen a very early draft a few months ago the key thing for him is the data integrity of the information, and everyone being able to see the right thing at the right level.

MW stated that the IPR development Tag identified that the next area of focus would be the People data and there have been some delays with progression around this and they are working through some of these issues. In the interim they are also trying to work on some of the quality metrics, so some of the metrics that sit within SystmOne with data already available.

JW commented that the People data challenges have been flagged to the Committee previously and also flagged at Board and they are working closely with the People directorate to try and resolve these.

KQ remarked that this is fantastic work and great progress, and she wanted to thank everyone involved, as this is going to provide so much assurance down the line.

JW commented that although the Board are only getting the snapshot in the IPR, it is the same data flow that has been through the relevant operational and quality groups. There will also be a deep dive into individual care groups on a rotation basis so they will get to see more of the information.

DW thanked MW & LH for the update.

LH left the meeting.

It was RESOLVED to RECEIVE the monthly Performance Update

FIP/23/43 Benchmarking (agenda item 13)

MW provided the update, the team have been progressing with this year's benchmarking submissions, the majority of which are annual submissions, quite a large proportion of additional new submissions that have come into effect this year related to workforce data, that they have been working on and supporting the People directorate with. All the submissions that are part of the NHS benchmarking programme have been submitted to date. There have been a couple of validation queries predominantly around people data which they are working on to resolve these. MW advised they are awaiting the reports from the Benchmarking Network so they can analyse those, this will help to prioritise and build a work programme through the trust benchmarking group. These reports are expected imminently.

AS stated that he had been keen to triangulate reports with our costing outputs, but the challenges around costing means we are not able to do this in the short term, he said this does need to remain an aspiration of ours.

KQ thanked everyone involved in providing this helpful information.

MW left the meeting.

It was RESOLVED to RECEIVE the Benchmarking update.
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FIP/23/44 Waiting Time Report (agenda item 14)

Vicky Humble joined the meeting to (VH) present the update stating this report which has been shared with the committee sits under improvement access to care governance review. It was formerly received by Clinical Governance and Clinical Safety Committee (CG&CSC) and the function had been transferred to this committee in June 2023.

Key headlines:-

- We now have access to ethnicity monitoring as well as deprivation monitoring, we need to be mindful in areas such as CAMHs as this is not age weighted data, it is whole population data, and this is taken into consideration as part of the analysis when producing the report.
- Analysis so far suggests there is no ethnic group being disproportionately impacted by the weights, however it does not take into account disparity at the point of referral, or even prior to that, so access to those services who may complete the referrals.
- VH working with teams to ensure we can understand case loads and weight according to our indices and multiple deprivation.
- Significant waits within our ADHD services, there are ongoing conversations with commissioners in terms of are we meeting our commissioned responsibilities.

- There is no disproportionate impact for people who are waiting, however there is a slightly higher representation of individuals from our least deprived areas.
- It is important to view things from a Trust level, but we do need to break that information down. For example, in Huddersfield, due to Huddersfield University being in that area, and it is really important that we understand this at that level, rather than viewing across Place population or trust level.
- Barnsley core CAMHS – most children continue to be seen within 3 months. We have noticed an increase in the above average wait and increasing numbers on the list and we need to monitor this.
- Kirklees core referrals peaked in May and June and that has had a direct impact on waiting times and numbers waiting. Both services continue to effectively manage that increase in demand at the moment and most children are being seen within 3-6 months.
- Wakefield core CAMHs has managed the surge in the number of referrals that were noted in the previous report and they have since returned to normal variation with most children being seen within 6-9 months. Staff absence may well have been a contributing factor and this has stabilised recently and so this has helped with the waiting times.
- In terms of CAMHs Neuro developmental pathways, this is a priority programme certainly in Calderdale and Kirklees within the integration change team and we have been working with them to do deep dives into their individual service metrics to understand what is happening.
- Learning and disability services – performance is generally good with assessment being completed within two weeks in almost all of our areas. One thing to note is the numbers involved in the calculations for those metrics are relatively low and that increases the swing of the data. Where we see a change of a considerable percentage between those reports it is likely to be just the small numbers that are affecting that swing.
- Learning disability services are being onboarded onto the SystmOne waiting list functionality, this will improve our ability to report and analyse and we will be able to complete further review of the individual areas to understand how the care is affected in all of those Places.
- MSK services are achieving the 19 weeks target, but they are reporting an increase in demand and staffing challenges. They are currently managing these; however, it is noted as a watching brief to ensure we continue to see if this does transfer on to adversely affected waiting times.
- Barnsley core psychology continues to undergo a period of data validation, it did transfer onto the SystmOne functionality a little while ago and they are confident in the data, and they are continuing to apply the validation process.
- Patients on the core psychology waiting list for therapy have already received 6 weeks of psychology induction and assessment which means there has been some offer of resilience ability to those individuals who are waiting. This is a priority programme within the integrated change team.
- Paediatric audiology was added as a late addition to this report. They were experiencing issues with their waiting times; however, they have now entered a more stable phase and we are now seeing a reduction in both average and longest waits for that service which is good news.

DW thanked VH for a great update.

KQ stated that was a very detailed and comprehensive update. She asked if we had information about the number and quality of referrals into our services, also numbers referred to GPs because they do not have the right information etc, in terms of the demand, as understanding our capacity and demand is crucial and referral is part of that.
VH replied yes and some of that work was completed as part of the demand report that was circulated within the improving access to care report which some of the committee may not have

seen. It has been circulated to EMT and other groups, but not circulated wider. It does not form part of the waiting time report, but something they monitor.

JW remarked that she would like the committee to recognise the amount of work that VH has undertaken in terms of compiling this report.

The committee thanked VH for the excellent update and hard work that had gone into producing this.

Vicky Humble left the meeting.

It **was RESOLVED to RECEIVE the Waiting List Update**

FIP/23/45 Older Peoples Business Case (agenda item 15)

AS explained the reason this is on the FIP agenda is because it falls into the investment part. He thought it would be useful to bring it here, even though it has been to Board at high level, so the committee can understand some of those concepts that we are about to consult on.

Ryan Hunter (RH) shared a current inpatient model presentation with the committee that he had recently shared with the ICB.

Key highlights:-

- RH stated that he wanted to flag to the committee that currently people are on mixed needs wards, these are individuals with mixed functional needs, so dementia, depression, psychosis, and other functional needs, and this is what they want to change, as these people do not mix very well which then creates challenges.
- Challenges in all the wards at the Dales, particularly on Beechdale, which is a16 bed mixed dementia ward. It lacks space, so it is difficult to make changes to this ward and it is also on a PFI Site.
- Ward 19 in Dewsbury has a male and female ward, it has similar challenges with the mix of dementia and functional, it does have more space for people to move around in, but it does not have ensuite which is one of the challenges with this ward.
- In Wakefield there are two wards, Crofton, which is on the Fieldhead site, there is potentially extra space where they could create some extra capacity.
- Poplars in Hemsworth is the only dedicated dementia site on the footprint. That comes with the challenges of being isolated and it means they cannot accept people directly to the ward, and so this is not sustainable to maintain.
- Barnsley have a functional only ward and they do not commission any dementia beds; we have a spot purchasing arrangement. We do not plan on changing Willow Ward and for that purpose Barnsley is outside the scope for transformation.

RH stated we are looking at West Yorkshire and what we can do within our own footprint, and we are looking at reconfiguring the estates and the offer to deliver that specialist dementia and specialist function only. The only two sites that would have the capacity to do the specialist dementia would be Dewsbury, or Wakefield.

RH explained the next step is to start taking this through formal governance within the next 2/3 month and it has been brought here for the committees view on the financial aspects of this, it will also be taken through the Quality and Safety Committee in advance of going to board next month.

RA remarked he would like to provide the committee with assurance in terms of the finances. He stated in the full board paper we highlight how we have developed the finance information in partnership with our commissioning colleagues.

DW commented that where we are now is that we have options available, but we cannot do much until after the public consultation, this will then direct us more towards what we do, and until such times this remains sensitive, and we just have to keep an eye on it as it progresses.
AS agreed with DW.

KQ remarked that she had found this update extremely helpful. She asked if we had used the NHSE capital business case checklist for this.
Nick Phillips (NP) replied that we did, and we also use the Better Case Business Model for all our business cases.
RH confirmed training courses are run for large scale transformations, and they provide different templates, so for example a finance template details exactly what they expect to see, and the Trust have been mindful of this as they are worked through this.

Ryan Hunter left the meeting.

I**t was RESOLVED to RECEIVE the update on the Older Peoples Business Case**

FIP/23/45 Capital Programme (agenda item 16)

NP presented the update stating the capital programme is falling behind programme and there are a couple of reasons for this which are now under control.

Major Capital

Seclusion Rooms

The first scheme in the programme is nearing the point of tender and is presently running on time. There is a need for planning permission that was part of an add on to the scheme and this is being resolved in line with the overall plan. There are plans now to commence design of further schemes in the overall programme to allow them to be put together as a package of works in order to obtain improved cost certainty.
Following discussion with Procurement the tender for this has been expanded to allow for further awards for minor capital schemes in order to speed delivery of minor capital schemes. The tender process completes in September. They are hoping to appoint a contractor who can then go on a become a partner contract to deliver the rest of the minor works programme.

Kendray infrastructure

This project is in design and as reported at the last update the utility providers part of the scheme has not progressed as anticipated meaning that expenditure on the scheme will be behind plan and will move into a future year in part. It is proposed to review the budget to approximately £600k in year and pull projects forward from next year.
NP confirmed the infrastructure scheme will be brought to a stage where all SWYPFT preparatory work is done, and the stage 2 physical pipework and infrastructure installation can complete as a separate project so can be done in 2024/25 year or a following year dependent on capital allocation being potentially prioritised for OPS transformation This proposal will go through the necessary governance stages which started with Estates TAG.

NP stated that overall, the plan is still projected to outturn on plan in terms of finance but with the changes outlined to the committee. The Trust continues to report into the wider ICB plan which is reporting as on plan at the present time. He confirmed the market continues to be volatile, and the Trust is seeking to reduce exposure to that market volatility by adopting the new approach to procurement mentioned above. Progress on this will be included in the next update.

AS stated NP has just highlighted the inherent challenges of managing capital on a one year basis but that is what the NHS has to do, so pulling schemes forward when other schemes slip is just part of what we have to do.

DW remarked this all sounds sensible, if not the original plan.

Nick Phillips left the meeting.

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

FIP/23/47 Bids and Tenders/MHIS update (agenda item 17)

AS provided the update stating this month's report only contains detail on the Mental Health Investment. It is a fairly lengthy report because it picks up Q4 22/23 and the beginning of 23/24, he remarked that he was not going to go through it any detail but had a few things he wanted to draw out. Previously, Natalie McMillan (NM) had raised a challenge around when can we move on from the KPIs just been about the finance, and actually what is the mental health investment standard delivery. He stated this is starting to happen now where we have a number of KPIs in there that talk about outcomes, waiting times and access times and links into some of the other things we are doing.

Learning disabilities is providing particularly challenging to recruit to and so some of the mental health investment ambitions are not being realised because we have not got the staff and we are still focusing on how we can get the required level of staff. The learning disabilities team did have ambitions to bid for more resources, collectively we agreed this was not the right thing to do because we could not demonstrate we were expending what we had already been given, so we have to stick with the baseline we have got for now.

AS stated as we have moved through into 2023/24 it has not been a straight forward process to get everything agreed in a timely fashion, one of the reasons for this is the financial pressure that everyone is under. Another is that processes are different in each Place. For various reasons Kirklees have not yet formally signed off on the Mental Health Investment this year. They have informally said what we are working to is right, but they have not formally been able to put it into the contract and we have been working with some level of risk albeit minor risk to start to implement that and that formal approval is starting to flow through. We have not necessarily lost any time on it because we have been proceeding anyway but there is a level of concern from the contracting team that this has taken a disproportionate amount of time just to agree the money, and we are half way through the year.

AS stated that we get positive feedback from our commissioners on what we are doing on the improvements that are starting to show. He said he wanted to link back to the forecast paper that RA presented earlier and that we do not yet know what our Commissioners will do around slippage, and they may claw it back because they need to invest in a different area to hit the MHIS, or they may claw it back because they are under significant financial pressure, so we are dealing with this through the finance routes.

AS stated this is just an up sum of where we are at and if okay with DW we can spend a bit more time on this when we do the Q2 report and look at the KPIs and performance.

DW agreed that this made sense.

I**t was RESOLVED to RECEIVE the Bids & Tender update.**

FIP/23/48 Work plan (agenda item 18)

AS commented that when they initially set the agenda for this meeting it did not look like a heavy

agenda, and he said the positive we can take from this is that we are getting the balance better. He suggested that at the next agenda setting meeting with DW and himself they try and make an assessment of how long every item needs.

DW felt this was a good idea, and as the Committee only now meet 8 times a year he had realised this was going to be a longer meeting and he thought there might have been a need to extend it by half an hour, but actually we have covered it within the timescale. He agreed with AS though in that they should keep an eye on it going forward.

FIP23/49 Any other Business (agenda item 19)

DW confirmed there were no further items to discuss.

Trust Board 31 October 2023
Agenda item 10.1

Private/Public paper:	Public
Title:	**Integrated Performance Report (IPR)**
Paper presented by:	**Director of Finance & Resources/Director of Strategy & Change**
Paper prepared by:	**Deputy Director of Corporate Governance**
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for September 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 Integrated Care Boards (ICB) with assurance that the Trust has an effective performance management system to contribute to the delivery of the ICB's strategic priorities and delivery plans
Any background papers / previously considered by:	The IPR is reviewed at public Trust Board eight times a year. On months when public meetings are not held, it is circulated to Board members, and published on the Trust website.
	The IPR is reviewed monthly by the Executive Management Team (EMT)
	The IPR is reviewed monthly at the Organisational Management Meeting (OMG)
Executive summary:	This executive summary provides an overview of key points from the IPR for September 2023. A further breakdown of care group metrics for inpatients by ward has been added this month to give insight into any

particular hotspot areas. Key areas of note relating to this can be seen in the care group section of this covering paper.

Following system changes supervision data is now available, work is ongoing to encourage supervision and accurate reporting.

Developments around the Equality and Inequality data reported in the IPR this month include the revised thresholds for the timely completion of service equality impact assessments – 75% within 12 months, policy timeliness remains at 95% within 12 months. In next months report, an improvement trajectory for the completeness of sexual orientation and disability will be set and monitored against.

The reducing inequalities section of the report has been removed as this is a duplicate of what Trust board already receive in terms of an update from the Equality, Involvement and Inclusion committee.

Further developments of the IPR are ongoing in line with the development plan.

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 96.6% against a target of 90%. For the Trust derived indicators, as of September 2023, disability 45.4%, sexual orientation 44.6% and postcode 99.8% of service users have had their equality data recorded. Whilst 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. No policy is agreed without an EIA in place and therefore we have investigated why the performance is under 100%. It appears that the difference is because the tracker used to monitor EIAs in policies is not updated when it has been agreed that a policy will be extended. This is

being rectified and therefore it is anticipated that this will be reflected in the performance in the next report.

- Referral to assessment within 2 weeks for mental health single point of access - the overall Trust position increased to 82.7% in September against a target of 75%, the highest reported monthly since January 2023. Single points of access (SPA) continue to prioritise risk screening of all referrals to ensure any urgent demand is met within 24 hours. 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 187 days used in September, this is an improvement compared to the previous two months (589 and 400). 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 5 people placed in out of area beds at the end of September. 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 75.3% in September from 64.1% reported in August, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service only. The care group escalated a concern regarding access in paediatric audiology when performance for diagnostic appointments first started to fall at the start of the year. An improvement plan was initiated. More recently, the care group reported a concern with reaching the agreed trajectory to full performance by October 2023. This relates to staffing capacity which is an issue shared across South Yorkshire providers and to increased numbers of children 'not brought' to the assessment where the assessment cannot be rebooked within 6 weeks. Not all appointments are for diagnosis. Overall the average waiting time for an appointment in audiology is

3.6 weeks so if parents need support and advice for their child a general appointment can be arranged.

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

There has been a strong focus on improved performance with regards to the completion of care plans and risk assessments. This focus continues to be driven within the Care Plan and Risk Assessment Improvement Group, with an enhanced focus now on the quality of the completed care plans and risk assessments.

The September data for care planning shows performance of 87.5% and has now sustained performance above the 80% threshold since April 2023.

For risk assessments, the September data shows a slight decrease in performance from the previous month within inpatient services (87.5%) and community services (91.8%). For both areas, this remains under the improvement trajectory though worth noting that small numbers do significantly impact the performance. Whilst performance is broadly holding steady, our gap against trajectory will be reviewed for action within the care plan and risk assessment improvement group. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality.

Waiting Lists

- CAMHS continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period.
- Waiting times and waiting numbers for neurodevelopmental services within CAMHS continue to remain high. As previously reported, waiting list initiatives are in place to work towards stabilising this position. Children do not need to have a diagnosis 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 71.9% (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. Slight improvement in performance in September (impacting 16 people) though underperformance against this metric is contributed to by increased demand for diagnostic assessment from young people transitioning from children's services and the capacity of specific professionals. Improvement work, including recruitment continues.
- 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 incidents reported in September 2023 resulted in no harm or low harm or were not under the care of the Trust, an overview of key indicators is below:
- The number of restraint incidents sustained a lower level of incidences for the third consecutive month with 92 incidents reported (146 in August). 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.
- 90% of prone restraint incidents were for a duration of three minutes or less, there was one incident out of ten over the 3-minute threshold and this was a complex case and appropriate measures were taken and support was given to both the service users and staff involved in the incident.
- There were 8 information governance personal data breaches during September 2023 which is a decrease on previous months. No hotspot areas were identified as they were spread across care groups and services. Most incidents related to information being disclosed in error. The marketing and communications team has worked with information governance colleagues to identify real life and recurrent themes, which has been developed into case studies, these have now been launched through our communications channels and is available on the intranet.
- The number of inpatient falls in September was 34% of these service user falls had a previous falls history. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated.

Our People

- The Trust had robust plans in place to minimise the impact to patients of the junior doctor and consultants strike during September. The Trust has an established oversight group to plan and review impact of strikes and as a result, impact to service provision to date has been minimal and risk to patients has been reduced.

- Supervision data is now available and included in the report at Trust level and by care group and inpatient ward. As part of the review of the supervision of the workforce policy an improvement programme is underway to increase uptake and recording of supervision within the clinical workforce.

- Proportion of staff in senior leadership roles who are from BME background and females are now included in the IPR. Other protected characteristics will be included as data becomes available. Of the clinical band 7 and above staff (including consultants, excluding bank staff) 134 (12.6%) are from BME population. The number of women in these roles is 798 (74.9%).

- The Trust had 17 violence and aggression incidents against staff on mental health wards involving race during September - any increases are monitored by the Patient Safety team and Equity Guardians are alerted to all race related incidents against staff. A robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role.

- Our substantive staff in post position continues to remain stable and has increased slightly in September. The number of people joining the Trust outnumbered leavers in September. Year to date, we have had 354.5 new starters and 285.9 leavers. Focus remains on recruitment and retention.

- Overall turnover rate in September was 12.1% and is the lowest it has been for the last twelve months and improved on the 22/23 position.

- Sickness absence in September was 4.9% and below local threshold, with a rolling 12-month position of 5.3%.

- Rolling appraisal compliance rate for September saw a deterioration, from 74.5% to 72.5%. An improvement trajectory of 78% was set by the Executive Management Team (EMT) in May, this is being reviewed to develop a clear plan 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 92.1% compliance which exceeds the Trust target of 80%, this has reduced marginally from last month 92.5%. Information Governance is the only area in month below the Trust target at 94.6%. Targeted actions are in place and compliance is reported monthly to the Executive Management Team (EMT) with hot spot reports reviewed by the Operational Management Group (OMG).

Care Groups

Staffing vacancies and absence 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 September and we have also provides a breakdown of the mental health inpatient data split by ward. Areas to note 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 continued 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.
- The Trust currently has higher than usual levels of vacancies in mental health community teams for qualified practitioners and proactive attempts to fill these have had limited success with action plans in place for certain teams and continue to be proactive and innovative in approaches to recruitment and workforce modelling.
- 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 and the numbers have reduced further in September compared to previous months this year.
- 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 September, the overall number of cases that were clinically ready for discharge remain at 5.7%, this has been identified as a risk and is being managed 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 continues across local systems to ensure that care is provided in the best place for children who are waiting for a bed.
	Finance • A deficit of £59k, was reported in September 2023 which means that the year-to-date position is a surplus of £1.1 million. This is slightly behind plan. • Agency spend in September was £915k which is an increase on the previous two months and remains higher than plan. • 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 £78.9m; this is higher than plan. • Out of area placements have continued to reduce in September. Overall this is now £196k underspent for the year to date. Activity continues to be monitored and forecast trajectories updated. • Performance against the Better Payment Practice Code is 97%.
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**

Integrated Performance Report
Strategic Overview

September 2023

With **all of us** in mind.

Table of Contents

Click on each section heading to navigate to that section

Introduction

Please find the Trust's Integrated Performance Report (IPR) for September 2023. The development of the IPR continues, from September it now includes a ward level breakdown of key metrics within the care group section of the report.

Majority of the agreed metrics identified to monitor performance against our strategic objectives have been populated, two metrics are still in development with indicative timescales provided.

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 96.6% against a target of 90%. For the Trust derived indicators, as at September 2023, disability 45.4%, sexual orientation 44.6% and postcode 99.8% of service users have had their equality data recorded. Whilst 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. No policy is agreed without an EIA in place and therefore we have investigated why the performance is under 100%. It appears that the difference is because the tracker used to monitor EIAs in policies is not updated when it has been agreed that a policy will be extended. This is being rectified and therefore it is anticipated that this will be reflected in the performance in the next report.
   • Referral to assessment within 2 weeks for mental health single point of access - the overall Trust position increased to 82.7% in September against a target of 75%, the highest reported monthly since January 2023. Single points of access (SPA) continue to prioritise risk screening of all referrals to ensure any urgent demand is met within 24 hours. 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 187 days used in September, this is an improvement compared to the previous two months (589 and 400). 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 5 people placed in out of area beds at the end of September. 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 75.3% in September from 64.1% reported in August, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service only. The care group escalated a concern regarding access in paediatric audiology when performance for diagnostic appointments first started to fall at the start of the year. An improvement plan was initiated. More recently, the care group reported a concern with reaching the agreed trajectory to full performance by October 2023. This relates to staffing capacity which is an issue shared across South Yorkshire providers and to increased numbers of children 'not brought' to the assessment where the assessment cannot be rebooked within 6 weeks. Not all appointments are for diagnosis. Overall the average waiting time for an appointment in audiology is 3.6 weeks so if parents need support and advice for their child a general appointment can be arranged.

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
There has been a strong focus on improved performance with regards to the completion of care plans and risk assessments. This focus continues to be driven within the Care Plan and Risk Assessment Improvement Group, with an enhanced focus now on the quality of the completed care plans and risk assessments. The September data for care planning shows performance of 87.5% and has now sustained performance above the 80% threshold since April 2023. For risk assessments, the September data shows a slight decrease in performance from the previous month within inpatient services (87.5%) and community services (91.8%). For both areas, this remains under the improvement trajectory though worth noting that small numbers do significantly impact the performance. Whilst performance is broadly holding steady, our gap against trajectory will be reviewed for action within the care plan and risk assessment improvement group. To monitor safe practice, the operational management group reviews data on breaches of target and associated actions and the clinical governance group monitors quality.

Waiting Lists
  • CAMHS continue to prioritise children with high levels of need and if a child's needs escalate whilst they are waiting for a service, the service provides additional support during the waiting period.
  • Waiting times and waiting numbers for neurodevelopmental services within CAMHS continue to remain high. As previously reported, waiting list initiatives are in place to work towards stabilising this position. Children do not need to have a diagnosis 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 71.9% (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. Slight improvement in performance in September (impacting 16 people) though underperformance against this metric is contributed to by increased demand for diagnostic assessment from young people transitioning from children's services and the capacity of specific professionals. Improvement work, including recruitment continues.
  • 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 incidents reported in September 2023 resulted in no harm or low harm or were not under the care of the Trust, an overview of key indicators is below:

• The number of restraint incidents sustained a lower level of incidences for the third consecutive month with 92 incidents reported (146 in August). 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.

• 90% of prone restraint incidents were for a duration of three minutes or less, there was one incident out of ten over the 3-minute threshold and this was a complex case and appropriate measures were taken and support was given to both the service users and staff involved in the incident.

• There were 8 information governance personal data breaches during September 2023 which is a decrease on previous months. No hotspot areas were identified as they were spread across care groups and services. Most incidents related to information being disclosed in error. The marketing and communications team has worked with information governance colleagues to identify real life and recurrent themes, which has been developed into case studies, these have now been launched through our communications channels and is available on the intranet.

• The number of inpatient falls in September was 34.35% of these service user falls had a previous falls history. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are investigated.

Our People

• The Trust had robust plans in place to minimise the impact to patients of the junior doctor and consultants strike during September. The Trust has an established oversight group to plan and review impact of strikes and as a result, impact to service provision to date has been minimal and risk to patients has been reduced.

• Supervision data is now available and included in the report at Trust level and by care group and inpatient ward. As part of the review of the supervision of the workforce policy an improvement programme is underway to increase uptake and recording of supervision within the clinical workforce.

• Proportion of staff in senior leadership roles who are from BME background and females are now included in the IPR. Other protected characteristics will be included as data becomes available. Of the clinical band 7 and above staff (including consultants, excluding bank staff) 134 (12.6%) are from BME population. The number of women in these roles is 798 (74.9%).

• The Trust had 17 violence and aggression incidents against staff on mental health wards involving race during September - any increases are monitored by the Patient Safety team and Equity Guardians are alerted to all race related incidents against staff. A robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role.

• Our substantive staff in post position continues to remain stable and has increased slightly in September. The number of people joining the Trust outnumbered leavers in September. Year to date, we have had 354.5 new starters and 285.9 leavers. Focus remains on recruitment and retention.

• Overall turnover rate in September was 12.1% and is the lowest it has been for the last twelve months and improved on the 22/23 position.

• Sickness absence in September was 4.9% and below local threshold, with a rolling 12-month position of 5.3%.

• Rolling appraisal compliance rate for September saw a deterioration, from 74.5% to 72.5%. An improvement trajectory of 78% was set by the Executive Management Team (EMT) in May, this is being reviewed to develop a clear plan 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 92.1% compliance which exceeds the Trust target of 80%, this has reduced marginally from last month 92.5%. Information Governance is the only area in month below the Trust target (94.6%). Targeted actions are in place and compliance is reported monthly to the Executive Management Team (EMT) with hot spot reports reviewed by the Operational Management Group (OMG).

Care Groups

Staffing vacancies and absence 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 September and we have also provides a breakdown of the mental health inpatient data split by ward. Areas to note 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 continued 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.

• The Trust currently has higher than usual levels of vacancies in mental health community teams for qualified practitioners and proactive attempts to fill these have had limited success with action plans in place for certain teams and continue to be proactive and innovative in approaches to recruitment and workforce modelling.

• 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 and the numbers have reduced further in September compared to previous months this year.

• 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 September, the overall number of cases that were clinically ready for discharge remain at 5.7%, this has been identified as a risk and is being managed 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 continues across local systems to ensure that care is provided in the best place for children who are waiting for a bed.

Finance

• A deficit of £59k, was reported in September 2023 which means that the year-to-date position is a surplus of £1.1 million. This is slightly behind plan.

• Agency spend in September was £915k which is an increase on the previous two months and remains higher than plan.

• 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 £78.9m; this is higher than plan.

• Out of area placements have continued to reduce in September. Overall this is now £196k underspent for the year to date. Activity continues to be monitored and forecast trajectories updated.

• Performance against the Better Payment Practice Code is 97%.

The following section highlights the performance against the Trust's strategic objectives and priority programmes for 2023/24.
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.

| Strategic Objective	Priority Programme	Headlines
Improving health	Address inequalities involvement and equality in each of our places with our partners	Work continues with each of our partners in place and with both South and West Yorkshire integrated care systems. Health inequalities is a golden thread through all our priorities and we continue to work on improving the data collection and reporting. This month we have focused on the performance data of percentage of people who have their information recorded in relation to disability and sexual orientation. We have identified the actions we will take to improve this performance (see additional section).
Improving care	Transform our Older People inpatient services	Key deadlines for the next phase Governance approvals: • NHS England (NHSE) assurance review, (October '23) • SWYPFT Governance: Finance Investment and Performance Committee September, Quality and Safety Committee – October, Trust Board October • Integrated Care Board (ICB) – Reach approval to establish joint committee – September, joint committee – (likely to be held in November 2023) • Joint Oversight and Scrutiny Committee – (likely to be held in November 2023) Public consultation planning: ongoing – video filming completed, consultation document revisions, consultation questions developed, local assets and advocacy contacted, venues for public meetings identified. Consultation start: Late 2023 or January 2024 depending on timing of completion of governance approvals.
	Improve our mental health services so they are more responsive, inclusive and timely	1. Inpatient priority programme: A full data source mapping exercise has been completed for the inpatient programme and dashboards identified for baseline collection of the KPIs/metrics that will be confirmed by the end of October to collect data against the identified improvement initiatives. A training package has been created for staff to aid them in using the inpatient outcomes dashboard which will be beneficial for each of the workstreams/working groups established in the inpatient programme. 2. Care closer to home (Out Of Area (OOA)): Reviewed timing of the daily patient flow meeting to meet demand and to decrease pressures on flow, lengths of stay and provide focus on psychiatric intensive care unit (PICU) stepdown has seen a continued reduction in out of area placements. Governance and active ownership of the person's journey has been a key driver in contributing to this improvement. A staff survey will shortly be sent out based on the quality priorities identified in the programme and the results/themes will form the agenda for the summit planned for January. An initial planning meeting to look at an individual locality system pilot in Barnsley has taken place. 3. Improving access to care: The community learning disability standardised framework is now live in all localities. A further review is planned for November to evaluate and review the data and plan next steps. Issue related to child and adolescent mental health neurodevelopment assessment in Kirklees and the Evolve contract continues and has been escalated to executive management team,(EMT). Conversations with commissioners are taking place. A programme of work including a Trustwide review of single point of access (SPA) provision to adult mental health services has been agreed, working group established and baseline data gathering commenced. The group aims to undertake a Trustwide review of mental health SPA provision seeking to create a set of common principles and identify improvements that can be made to service provision. Core psychology demand and capacity and process mapping completed in Barnsley and initial areas for exploration identified. Work continues to codevelop the service demand review and waiting list report. 4. Community mental health transformation: The group is focused on reconfiguring community mental health service design across all four localities of the Trust in line with the NHS England (NHSE) roadmap for transformation with clear and concise pathways of care. A high-level overview of the Trust's offer within localities has been created. The next step is operational mapping coordinated by task and finish groups exploring how the place-based models have been configured and mapping how SWYPFT aligns into them. 5. Improving mental health (IMH) partnership group: The first meeting of the IMH Partnership group took place on 4th October. The group aims to provide the opportunity to enhance collaboration, improve sharing of resources and intelligence in supporting the delivery of all of the SWYPFT improving mental health strategic priority programmes outlined above with membership including partner representatives from place, Healthwatch and other service user and staff representatives.
	Improve safety and quality	Care planning and risk assessment: A quarterly update will be provided following Clinical Governance and Clinical Safety Committee or by exception. Personalised care (moving on from care programme approach (CPA)): The group have produced a stock take report updating on our approach to this and distributed a high-level communications piece about the Trust's intent on this programme of work. The group have also aligned with the Triangle of Care Implementation Group (TGIC) and are involving carers in shaping the programme. Work is progressing with defining key worker function and roles and the move from generic care co-ordination to meaningful intervention-based care.

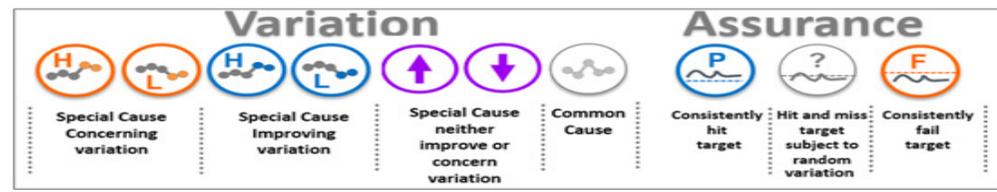|		
Improving use of resources	Spend money wisely and increase value	Quarterly update following the Finance Investment and Performance Committee: • An overarching financial sustainability plan is being developed which includes all currently identified cost improvement schemes and work is underway to scope these schemes fully with operational leads. • "Thinking Differently" sessions have been scheduled for care groups/services and teams to participate in a session to look at other ways they can identify ways to be more efficient and effective with our use of resources and ultimately provide better services. These sessions are being held during November 2023. • An I-Hub conversation has launched to enable all Trust staff to share ideas on ways we spend money wisely, improve value and be more efficient and effective. This conversation will run until the end of November 2023 and feed into the non-pay review group for consideration.
	Make digital improvements	Digital dictation - Procurement and contract award of single digital dictation supplier was expected in September 2023. However, during the contract award standstill period, the Trust received some clarification questions and a challenge from one of the unsuccessful bidders. The standstill period has been put on hold whilst the Trust considers the challenge and responds accordingly following legal advice. Dedicated project manager in place to oversee implementation by December 2023. Recruitment underway and good to go received on candidate. A start date will now be negotiated. Implementation plan in place by December 2023 is on target. The implementation will be led by the Integrated Change Team and work will commence with the chosen supplier following contract award.
Great place to work	The Great Place to Work priority programmes are being updated to incorporate stocktake of current strengths and identification of improvement activity required on the journey towards implementing NHS Long Term Workforce Plan. As well undertaking the #all of us improve activity in recruitment processes, we are also carrying on other work:	
	Inclusive recruitment, retention and wellbeing	Work continues to shape and develop the initiative aligned to the social responsibility and sustainability strategy to improve localised recruitment. Work aligning to other priority programmes continues such as inpatient workforce plan and community mental health transformation. Over 95 local health and wellbeing champions are now in place to support local wellbeing initiatives and influence trust wide plans. Collaborative work continues in partnership with the other two mental health learning disability autism (MHLDA) Trusts and Touchstone voluntary, community and social enterprises (VCSE) to support inclusive recruitment and breaking down barriers. The work undertaken so far was nationally recognised and won the Fairer Award for Diversity, Equity and Inclusion awarded by RL Datix. Following feedback from the Equality Inclusion and Involvement Committee (EIIC), People Renumeration Committee (PRC) and the Executive Management Team (EMT), work has commenced on streamlining the Workforce race equality standard (RES) and disability equality standard (DES) action plans with activity aligned to intended outcomes. This has been benchmarked against other organisations and reviewed by external Race Equality experts. Presentation to EIIC on Inclusive Leadership Culture Programme approach led by Monique Caryoll. Work has begun on phase one discovery work and preparation for Appreciative inquiry sessions commencing 27th October. Update to EMT scheduled for November 2023.
	Living our values	Background work has been taking place to support/align current activities such as just culture and inclusive leadership. Work is due to recommence to confirm scope and develop the action plan.

Improving health

Metrics	Threshold	Jul-23	Aug-23	Sep-23	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	96.8%	96.7%	96.6%		
Percentage of service users who have had their equality data recorded - disability	To be determined for 23/24	45.1%	45.5%	45.4%		The threshold for 23/24 has been developed and will go to the next equality inclusion and involvement sub committee for approval. Once approved the thresholds will be included in the report to be monitored against.
Percentage of service users who have had their equality data recorded - sexual orientation		44.7%	44.8%	44.6%		
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	Service timely completion - 75%	77.3% Service	73.5% Service	89.5% Service		All services have an EIA in place. We have previously agreed with the Equality Inclusion and Involvement Committee that the threshold for service is 75% and have therefore aligned this report to reflect this.
	Policy - 95%	97.4% Policy	97.4% Policy	96.3% Policy		
Completion of equality mandatory training	>=80%	96.0%	95.9%	96.1%		
Number of people who sustain 26 weeks employment via Trust Individual placement support service	Trend monitor	0	0	0		2023/24 to be used as a baseline once sufficient data is available.
Carbon Impact (tonnes CO2e) - business miles	76	63	63	53	(common cause)	Data showing the carbon impact of staff travel / business miles. In September staff travel contributed 53 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 November 2023			(common cause)	Q1 - 65.0% 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

Carbon Impact

Post Covid Lockdown 3
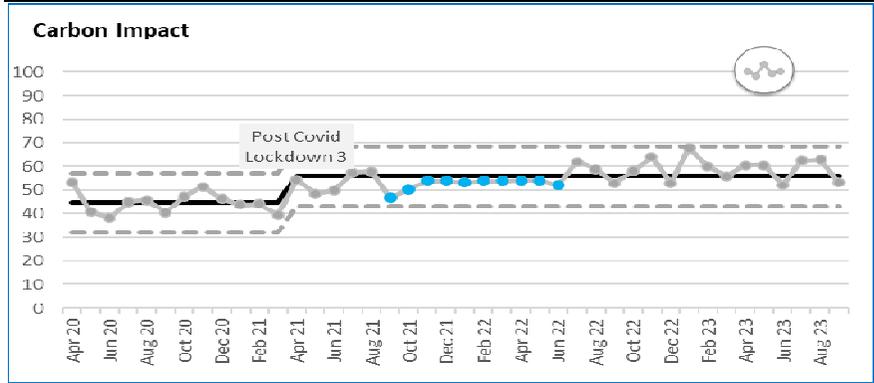
The SPC chart has had the upper and lower control levels recalculated following the last Covid-19 lockdown in April 2021. It is understood that the lockdowns that happened as a result of the Covid-19 outbreak impacted on our carbon impact due to the changes in ways of working and move away from face to face contacts. Since then you can see we have entered a steady state and remain in common cause variation. Levels are not expected to return to those seen pre-Covid-19 as a more blended approach to working is expected going forward.

Variation   Assurance

| H L Special Cause Concerning variation | H L Special Cause Improving variation | ↑ ↓ Special Cause neither improve or concern variation | Common Cause | P Consistently hit target | ? Hit and miss target subject to random variation | F Consistently fail target |

Improve Care

Metrics	Threshold	Jul-23	Aug-23	Sep-23	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	87.2%	88.0%	87.5%	H F	September data shows a slight decrease in performance within both inpatient and community services. Risk assessment completion is based upon completion within a set timeframe but does not account for a robust and high quality risk 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.
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	Improvement trajectory: June 90%, July 92%, Aug 94%, Sept 95%	92.9%	92.1%	91.8%	H F	
% Service users on CPA offered a copy of their care plan	80%	87.5%	87.4%	87.5%	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.
Registered substantive staff in post mental health and learning disabilities services	Establishment	Due November 2023				Definitions, thresholds and targets to be agreed as part of the IPR development plan by November 2023.
Staff in neighbourhood teams	Establishment					
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	14	13	17	~	Increases will be monitored by the Patient Safety Team. Equity guardians are alerted to all race related incidents against staff. A robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role.
Inappropriate out of area bed placements (days)	Q1 - 455, Q2 - 368, Q3 - 276, Q4 - 0	589	400	187	~ F	See statistical process chart overleaf for further detail.
% service users clinically ready for discharge	<=3.5%	4.8%	5.7%	5.7%		The risk is being managed through the organisational risk register. 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".
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	760	747	737		This calculates length of wait in days for those discharged that month. Clients are seen in order of need and not by how long they have waited. Onset of Right to Choose has impacted on the number choosing to come to SWYPFT for assessment. The numbers of assessments taking place every month outweighs current numbers coming in so the waiting list numbers will start to reduce. There is still a backlog of individuals who will have waited a long time for assessment from referral. Work continues with our partners and West Yorkshire collaborative.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	531	581	588		Calderdale - The longest wait for those seen in the month was 865 days, the shortest was 423 days. Number on waiting list at end of September - 180. The longest waiter on the waiting list had waited 821 days. Kirklees - The longest wait for those seen in the month was 652 days, the shortest was 571 days. Number on waiting list at end of September - 1727. The longest waiter on the waiting list had waited 648 days.
Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	82.3% 51/62	67.9% 38/56	71.9% 41/57	~ ?	Increase in performance in September (though remains below threshold) is contributed to by increased demand for diagnostic assessment from young people transitioning from children's services and the capacity of specific professionals. Improvement work, including recruitment continues.
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	87.7%	90.7%	88.5%	~ P	
Community health services two hour urgent response standard	70%	88.1%	89.5%	86.4%		
Referral to assessment within 2 weeks (external referrals)	75%	52.5%	65.7%	82.7%	~ ?	See statistical process charts overleaf for further detail. Rapid improvement work in (SPA) together with some progress in recruitment has contributed to an improved performance this 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)
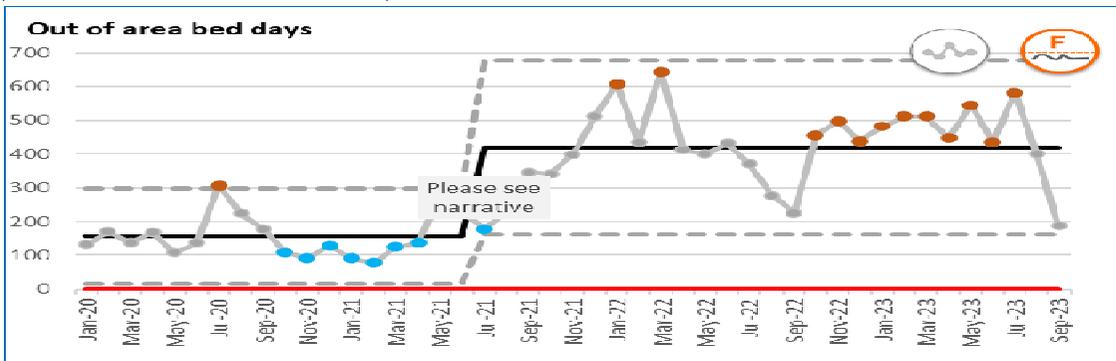
Out of area bed days

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. See the National Metrics section for further analysis of this key performance indicator.

The Trust had 5 people placed in out of area beds at the end of September 2023, a decrease of 6 on the previous month.

Referral to assessment within 2 weeks (external referrals)
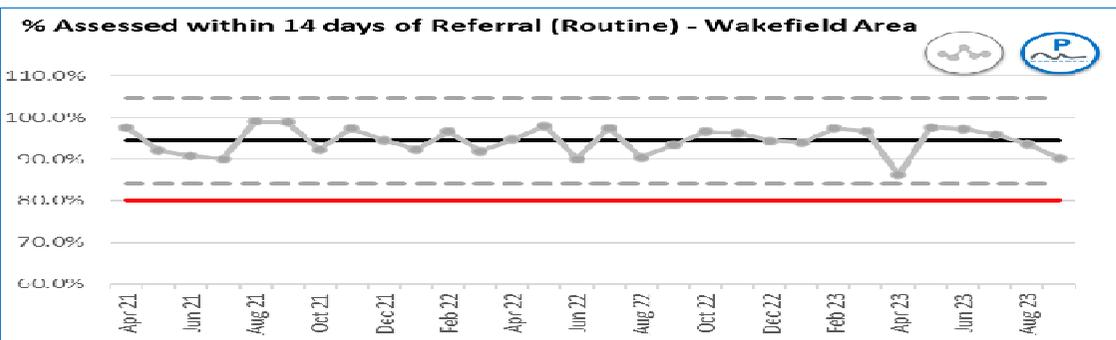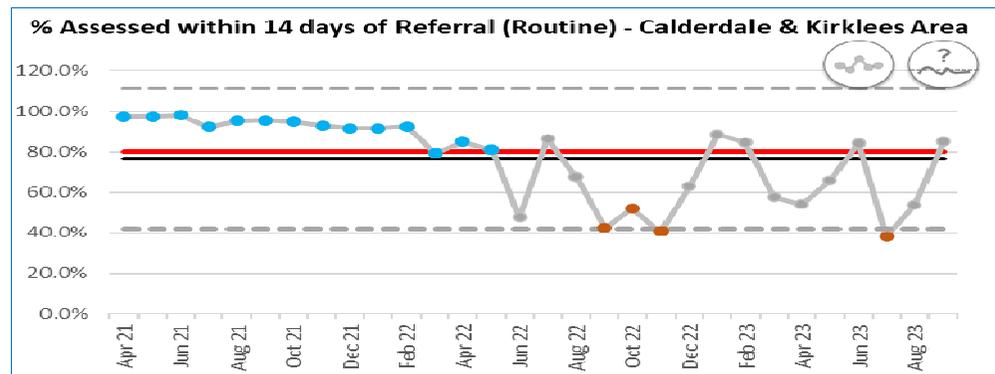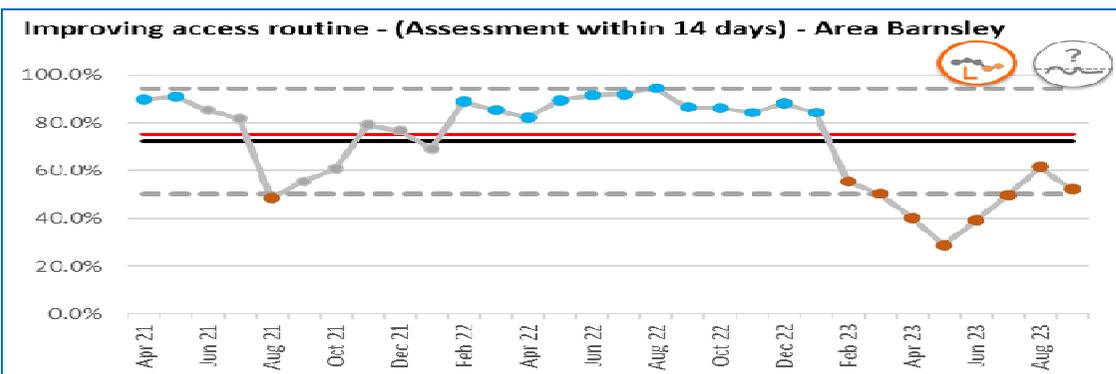
Improving access routine – (Assessment within 14 days) - Area Barnsley

% Assessed within 14 days of Referral (Routine) - Calderdale & Kirklees Area

% Assessed within 14 days of Referral (Routine) – Wakefield Area

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.

Variation — Assurance

| Special Cause Concerning variation | Special Cause Improving variation | Special Cause neither improve or concern variation | Common Cause | Consistently hit target | Hit and miss target subject to random variation | Consistently fail target |

Improve resources

Metrics	Threshold	Jul-23	Aug-23	Sep-23	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	(£373k)	£446k	(£6k)		A deficit of £59k in month, being £6k behind plan was reported in September 2023. The year to date position is a surplus of £1,112k which is £201k behind plan.
Capital spend against plan (monthly)	£8.8m	(£287k)	(£256k)	(£676k)		The year to date position is £1.1m behind plan with spend of £1.2m. Work continues to ensure that the full capital allocation is appropriately utilised in year. The funding allocation of IFRS 16 (leases) remains an unknown risk.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	£855k	£808k	£915k		Agency spend has increased in September within ward / inpatient areas. This is an increase of both registered and unregistered nurses.
Financial sustainability and efficiencies delivered over time (monthly)	£12m	£906k	£1,137k	£675k		The cumulative savings to date are £4.3m and form part of the overall financial position.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0		3			All three reported incidents relate to violence and aggression. In all three reports, staff have been supported through their recuperation. There were no enquiries from either the Health and Safety Executive or CQC related to any RIDDOR notifications during Q2.
Estates Urgent Response Times - Service level agreement (SLA)	95%	95.2%	96.9%	95.5%		Service level agreement 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 (Urgent SLA 2 ligature jobs screened)	100%	61.8%	100.0%	100.0%		Estates senior management have reviewed this metric and from August 23 only jobs screened as category SLA 2 will be included going forward due to some inconsistencies in the categorisation of jobs when initially logged.

Make SWYPFT a great place to work

Metrics	Threshold	Jul-23	Aug-23	Sep-23	Variation/ Assurance	Notes
Turnover external (12 month rolling)	>12% - 13%<	13.0%	13.1%	12.1%		Rolling turnover decreased by 1.0%
Registered workforce growth	3% (by March 24)	2.8%				
Sickness absence - rolling 12 months	<=4.8%	5.3%	5.3%	5.3%		Absence rate in month increased to 4.9%. Further detail is provided in the relevant section of this report.
Workpal appraisals - rolling 12 months	>=78%	76.5%	74.5%	72.5%		For the month of September, the percentage rate decreased by 2% to 72.5% and continues to remain below threshold.
% staff recommending the Trust as a place to work	65%	65.0%	N/A			Quarterly pulse survey. Next results due November 23.
% staff recommending the Trust as a place to receive care and treatment	65%	67.0%	N/A			
Staff supervision rate	80%	Due October 23		60.7%		As part of the review of the supervision of the workforce policy an improvement programme is underway to increase uptake and recording of supervision within the clinical workforce
Mandatory training - Cardiopulmonary resuscitation	80%	81.0%	79.9%	80.0%		Slight increase in mandatory traing following seasonal impact noted in August.
Mandatory training - Reducing restrictive practice interventions	80%	76.2%	82.6%	82.8%		Performance has slightly increased September and remains above threshold. 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%	92.0%	91.4%	91.2%		
Mandatory training - Information governance	95%	96.9%	95.3%	94.8%		Reminders circulated regarding IG training compliance

Quality Headlines

Section	KPI	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	TBC	66.0%	68.0%	70.0%	72.0%	74.0%	78.0%	76.0%	81.0%	84.0%	84.0%	81.0%	80.0%	N/A
Complaints	% of feedback with staff attitude as an issue 12	< 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	19% 3/16	17.6% (3/17)	10% (1/10)	1
	Complaints - Number of responses provided within six months of the date a complaint received	100%	Reporting commenced in March 2023					29% (4/14)	27% (4/15)	38% (3/8)	17% (2/12)	29% (4/14)	38% (5/14)	38.9% (7/18)	
Service User Experience	Friends and Family Test - Mental Health	84%	84%	86%	85%	83%	85%	83%	82%	85%	91%	90%	90%	95%	1
	Friends and Family Test - Community	95%	93%	93%	94%	93%	95%	97%	94%	97%	96%	93%	97%	96%	1
	Number of compliments received	N/A	5	28	39	83	22	26	50	66	33	35	22	17	N/A
Quality	Notifiable Safety Incidents (where Duty of Candour applies) 4	Trend monitor	32	33	30	40	30	33	26	35	24	25	37	30	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	Trend monitor	2	2	2	3	2	2	1	1	2	1	1	1	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	0	1	0	0	0	2	1	0	1	1	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	44.3%	43.8%	44.1%	50.5%	58.6%	75.1%	85.0%	85.7%	86.6%	87.5%	87.4%	87.5%	1
	Number of Information Governance breaches 3	<12	11	13	8	12	8	13	12	9	14	13	16	8	2
	% of inpatients clinically ready for discharge	3.5%	3.3%	2.7%	3.8%	4.3%	4.5%	3.5%	2.4%	2.1%	4.6%	4.8%	5.7%	5.7%	3
	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%	71.3%	79.1%	76.6%	83.6%	87.8%	89.9%	90.6%	87.7%	86.7%	87.2%	88.0%	87.5%	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		68.0%	69.5%	74.3%	68.2%	67.0%	79.4%	80.7%	92.9%	85.7%	92.9%	92.1%	91.8%	2
	Total number of reported incidents	Trend monitor	1243	1308	1188	1247	1196	1250	1196	1325	1257	1154	1179	1094	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	26	30	25	34	26	33	17	33	18	22	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	3	7	6	3	3	2	3	2	4	1	4	1	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Trend monitor	3	0	2	3	2	1	5	2	1	2	3	2	
	Safer staff fill rates	90%	117.4%	119.1%	118.1%	122.1%	121.4%	119.3%	123.5%	123.5%	123.7%	123.9%	123.8%	124.1%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	91.0%	90.8%	85.6%	90.5%	89.1%	89.7%	94.4%	95.7%	93.1%	93.6%	92.1%	91.4%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	49	48	39	55	46	38	29	42	40	36	42	32	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	1	1	4	0	2	1	2	1	0	1	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%	100%	92.0%	100.0%	95.2%	87.0%	100.0%	90.0%	86.6%	89.5%	95.2%	90.0%	90.0%	1
	Number of Falls (inpatients)	Trend monitor	68	63	59	51	49	39	34	41	43	33	33	34	
	Number of restraint incidents	Trend monitor	169	223	189	212	223	203	192	186	201	145	146	92	
	% of staff receiving supervision within policy guidance 15	80%	Reporting to start from Sept 23											60.7%	2
	Potential under-reporting of patient safety incidents														
	% people dying in a place of their choosing 14	80%	91.7%	93.3%	78.1%	93.8%	83.3%	100.0%	87.5%	92.1%	87.8%	83.8%	81.8%	90.6%	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	
	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

15 - % of band 5 and above clinical staff who have received supervision in the previous 90 days from the end of September

Quality Headlines

• Number of restraint incidents - during September there were 92. This is the lowest number reported in the last 12 months. Further detail is provided in the relevant section of this report.
• % of prone restraint with duration of 3 minutes or less was 90% and remains green. Further detail can be seen in the relevant section of the report.
• Performance for children's and adolescent mental health service (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.
• The number of people with a risk assessment/staying safe plan in place within timescale remained in line with last month at 88% for inpatient services and 91.8% for community services
• Clinically ready for discharge (previously delayed transfers of care) - This is in line with last months and remains above threshold at 5.7%. 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 September there were 34 fall incidents. Further detail is provided in the relevant section of this report.
• The number of information governance breaches in relation to confidentiality breaches has decreased to 8 during the month and is now below threshold - further detail is provided in the relevant section of this report.
• Complaints - number of responses provided within six months of the date a complaint received - 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.
• As part of the review of the supervision of the workforce policy an improvement programme is underway to increase uptake and recording of supervision within the clinical workforce

Patient Safety Incident Response Framework (PSIRF)
As reported in the previous Integrated performance report, we have been working on our preparations for implementing the Patient Safety Incident Response Framework. This is a 12 month journey with the plan to start implementation in late Autumn 2023. We have drafted our plan and policy and these are currently going through our internal governance processes. We have also shared content with internal and external stakeholders for consideration. Information for staff is being prepared. Our plan and policy will be available on our internet pages upon approval.

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 have LFPSE compliant software installed on our Datix live system by the end of September 2023.

The upgrade to the live system with the enhanced LFPSE functions took place on 24/09/2023. Following the upgrade we are working on the transition to LFPSE - this will be implemented following thorough testing. Information for staff is being prepared.

Patient Safety Training
Training for all staff (level 1) and essential to job role (level 2) is available on the Electronic Staff Record. Level 1 will become mandatory from November 2023. This is currently progressing well at 88% completed. Level 3 training (investigation and oversight) has being delivered for those in specialist or oversight roles. Training on engagement and involvement of those affected by patient safety incidents will be available for Team managers and Quality leads in November and December.

Patient Safety Partners
Patient Safety Team held discussions on the 6th October 2023 for patient safety partners.

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.
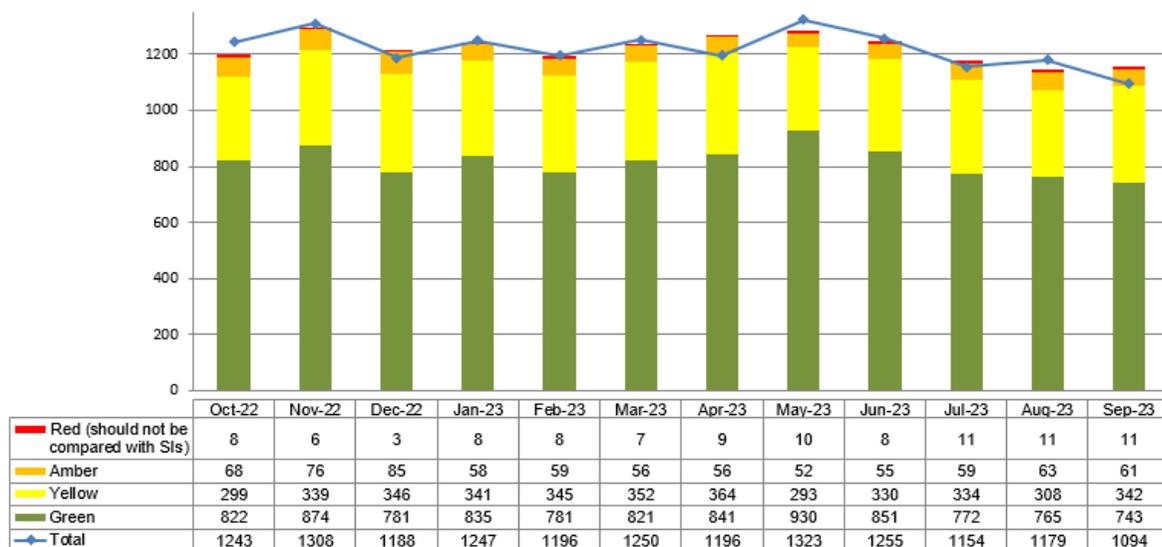
The Degree of Harm is used by all Trusts to grade the actual level of harm to ensure consistency of recording nationally. When staff report incidents, they will complete the Degree of Harm to rate the actual harm caused by the incident. Where this is not yet known, they will rate this as what they expect 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 September 2023 resulted in no harm or low harm or were not under the care of SWYPFT. This is based on the degree of actual harm.
Further details about severity and degree of harm can be found in the Incident Reporting and Management Policy.

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. Data in this report is refreshed monthly.

Incident reporting levels have been checked and remain within the expected range, any areas with higher or lower rates than normal are explored further.

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Red (should not be compared with SIs)	8	6	3	8	8	7	9	10	8	11	11	11
Amber	68	76	85	58	59	56	56	52	55	59	63	61
Yellow	299	339	346	341	345	352	364	293	330	334	308	342
Green	822	874	781	835	781	821	841	930	851	772	765	743
Total	1243	1308	1188	1247	1196	1250	1196	1323	1255	1154	1179	1094

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. As further information is received and decision made about review processes, red deaths may be regraded to green, e.g. when confirmed not related to a patient safety incident.

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

Risk panel meets weekly and scans for themes that require further investigation. Operational Management Group continues to receive a monthly report, the format and content is regularly reviewed.

No never events reported in September 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 September 2023:
24 moderate harm incidents including 13 pressure ulcer category 3 incidents, 5 self harm incidents,
1 incident categorised as severe harm, and sadly 2 patient safety related deaths during the month.

Incidents
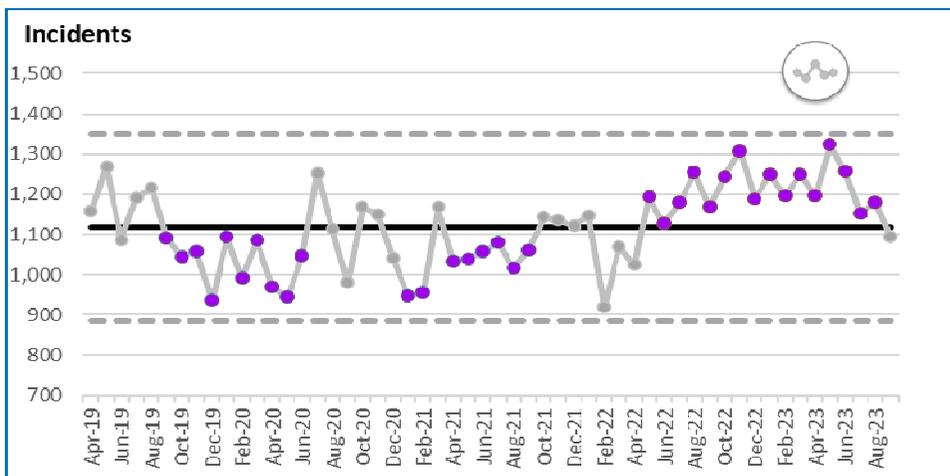
We have entered a period of common cause variation in September 2023, though it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting of incidents and near misses. An increase in reporting is a positive where the percentage of no/low 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).

Patient Safety Alerts

Patient safety alerts issued in September 2023

Alerts are issued by the Central Alerting System (CAS) which is a national web-based cascading system for issuing Patient Safety Alerts. Once received into the Trust, patient safety alerts are fully reviewed for understanding and action, sent to identified Trust clinical leads for reviewing safety alerts for a decision regarding whether it is applicable to the Trust or not, and if so, if it should be circulated. All alerts are entered on to Datix. Information is reported into the Medical Device and Safety Alert group on a monthly basis.

Patient Safety alerts not completed by deadline of September 2023 - None.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2023/011/DHSC	Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and guanfacine prolonged-release tablets.	27/09/2023	Yes - Circulated for action	11/10/2023	
NatPSA/2023/012/DHSC	Shortage of verteporfin 15mg powder for solution for injection	28/09/2023	No - alert not applicable to Trust	28/09/2023	

Safer Staffing Inpatients

Safer Staffing Fill Rate

Safer Staffing Registered Nurses
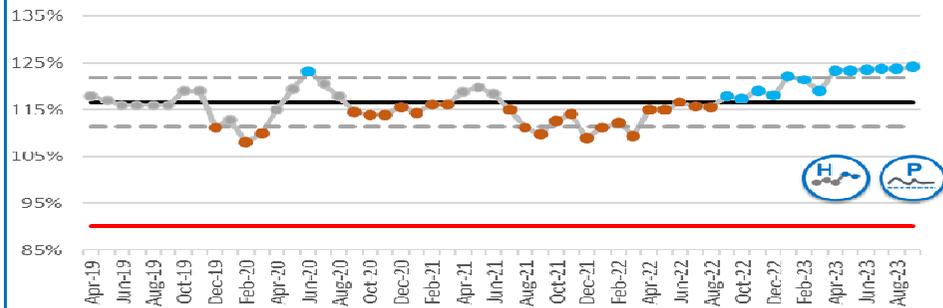
The chart above shows that as at September 2023 due to the continued increasing staffing rate, we remain in a period of special cause improving variation. Please see narrative below for further information.

The chart above shows that in September 2023 we remain in a period of special cause improving variation. Further information about staffing levels can be found on the previous page.

There has been a slight decrease in September on demand of the flexible staffing pool with a total of 171 less shift requests. The number of shifts filled has decreased by 168 shifts to a total of 5,374 and overall fill rates for inpatient areas increased by 0.3%. The continued high fill rate of requested shifts (90.34%) 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 by wards of shifts that have not been filled 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 fi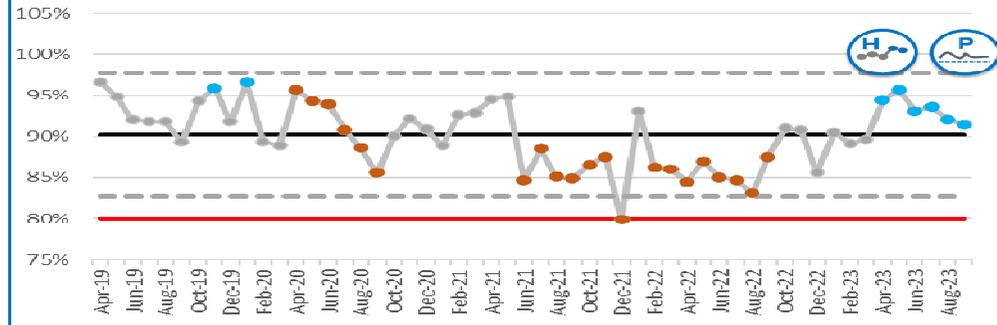gures (capacity) and not our acuity (demand). Traditionally September has seen an increase in fill rate and a decrease in bank and agency usage due to new starters from university filling some vacancies however, they do tend to be supernumerary for the first couple of weeks. We continue to monitor staffing related Datix, 27 in September (an increase of 5 on the previous month) and looking at hotspots and trend analysis of staffing deficits where possible.

Both bespoke adverts and centralised recruitment continues and there were 3 assessment centers throughout September for band 5 and 2 substantive, as well as band 5 and 2 bank (73 bank offers made already). There has been an increased trend of agency colleagues, particularly band 2, applying to join the bank as we decrease engagement with agencies.

We have flattened the recruitment process for students both on bank and external. We have completed a review of medical recruitment onto bank as well as the mapping process of bank recruitment. We are reviewing all agency block bookings to replace with bank if feasible. In the last 3 months we have recruited 124 bank only staff with 92 of those being external band 2.

Within the band 5 RN field we continue with bespoke adverts and, due to its success, we are reviewing the international recruitment (IR) program. To date we have had 83 IR band 5 nurses with 72 being on the wards throughout the trust, including on the Neuro Rehabilitation Unit. We are reviewing the program as a supportive measure of the workforce planning for 2023-24.

Escalation and continuity plans are followed to ensure the delivery of a 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 breaches, to support staff wellbeing.

We had a dedicated agency scrutiny group looking at medics which allowed us to focus on disengagement and recruitment plans. We are also seeing the positive impact the ongoing bank and substantive recruitment drives are having on band 2 agency spend.

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 14 wards, an increase of 1 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 remain under pressure to deliver a high quality of care, as well as being safe, and 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 September no ward fell below the 90% overall fill rate threshold, this is a decrease of 1 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. With an increase of 2 wards on the previous month, there were 25 (80.0%) of the 31 inpatient areas who achieved 100% or more overall fill rate. Of those 25 wards, 13 (a decrease of 2 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 Forensic services and the Dales with 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 0.6% to 83.5% in September compared with the previous month.
Registered Nurses Nights: Overall registered night fill rates have decreased by 0.8% in September to 99.9% compared with the previous month.
Overall Registered Rate: 91.4% (decreased by 0.7% on the previous month)
Overall Fill Rate: 124.1% (increased by 0.3% on the previous month)
Health Care Assistants showed an increase in the day fill rate of 2.0% to 149.8% and the night fill rate decreased by 0.9% to 151.2%.
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.

The figures below indicate that the number of unfilled RN shifts has decreased across the inpatient areas as has the number of unfilled HCA requests.

The figures below shows that we had a decrease of 171 in overall requests. Staffing deployment decisions are met after consideration is given to the skill mix of staff available, reallocations/utilisation of any resources has been considered before requesting bank or agency cover. Without the overtime fill rate, the requested sum of additional shifts, indictive of acuity including sickness absence, decreased by 171 to 5,934 (1,223 (+3) RN and 4,711 (-174) HCA) shifts.

Categories	Unfilled Shifts			Filled Shifts	
	No. of Shifts	Total Hours	Unfilled Percentage		
Registered	346 (+1)	3751.2	28.5% (-0.3%)	877	(+8)
Unregistered	214 (-3)	2399.0	5.1% (-0.6%)	4497	(-170)
Grand Total	**560 (-3)**	**6150.2**	**9.7% (+0.5%)**		

We are continuing to target areas where vacancies are within our recruitment campaigns. Block booking and prioritisation within bank booking varies on a daily/weekly basis dependent on acuity and clinical need.

Information Governance (IG)

8 personal data breaches were reported during September. An improvement plan continues to be implemented to reduce the numbers of incidents, which includes training, communications and some data quality activity.

All breaches involved information being disclosed in error. They were largely due to:
- letters being sent to former addresses,
- emails sent to the wrong recipient as predictive text used,
- documents being shared with the wrong recipient,
- paper information system accessed due to being left unsecure,
- failure to blind copy email parties so email addresses shared, and
- failure to appropriately identify callers and personal data shared with unauthorised party.

The marketing and communications team has worked with information governance colleagues to identify real life and recurrent themes, which has been developed into case studies, these have now been launched through our communications channels and is available on the intranet.

The Trust does not have any open cases with the Information Commissioner's Office relating to September's breaches.
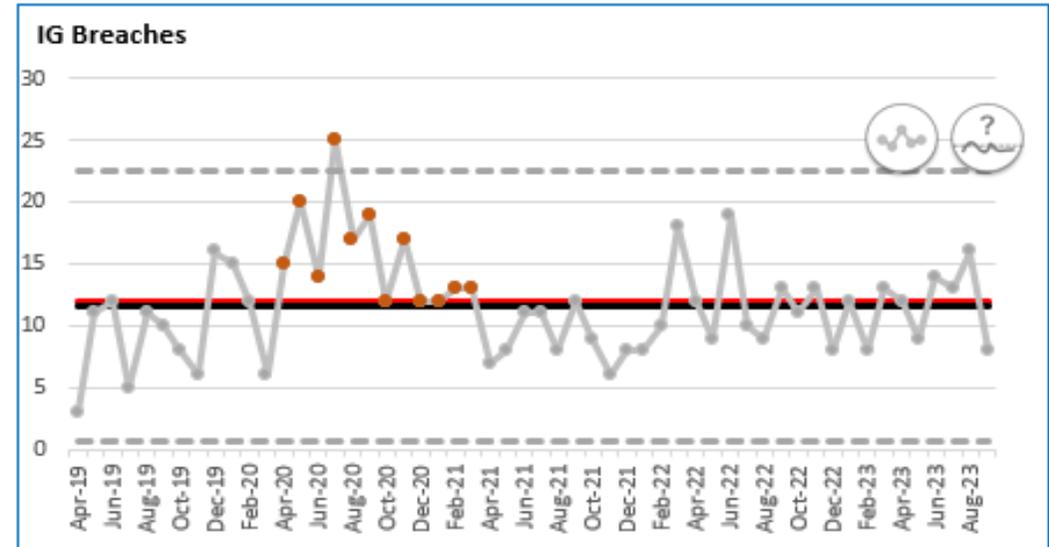
This SPC chart shows that as at September 2023 we remain in a period of common cause variation. Though we are now under the threshold with 8 breaches.

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. Submission for quarter two is due towards the end of November, update of the quarter two performance will be included in next months report. Some risk has been associated with full achievement of the following metrics: staff flu vaccinations and outcome monitoring in children and young people and community perinatal mental health services - actions plans are in place to mitigate this as far as possible and performance will continue to be reviewed via the CQUIN leads group.

Trustwide Falls

During September 2023 there were 44 slips, trips and falls related Datix reports. Below is a breakdown of falls and if they occurred in the community, inpatients, or staff group. There continues to be a generalised reduction in falls. The current average rate for our Trust is approximately 3.28 falls per 1000 bed days, this indicates that we are currently experiencing a downward trend in the total number of monthly falls. The national average is 3-5 falls per 1000 bed days.

Slips, trips and falls reported in Sept 2023

	Inpatients	Community	Staff	Total
Green incident	30	3	4	37
Yellow Incident	2	1	1	4
Amber Incident	2		1	3
Total	34	4	6	44
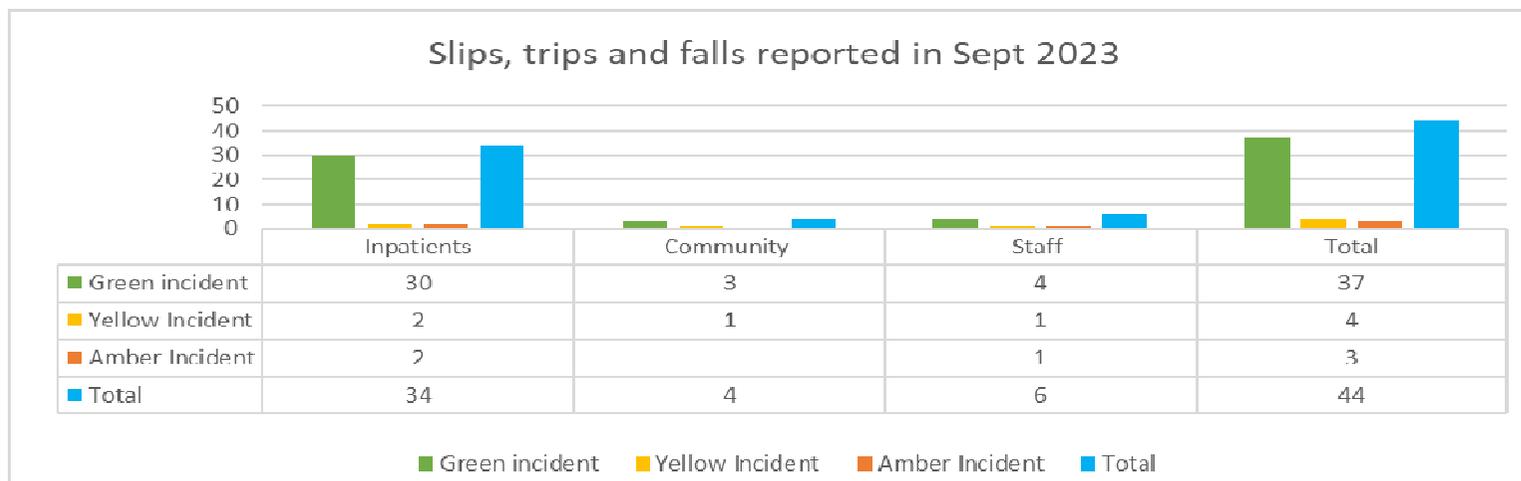
Amber incidents:
There have been 3 amber Datix reports following falls with injury.
• One fall occurred for a younger adult who sustained a fractured hip. This is being reviewed under a Service Level Investigation (SLI) and will include a review of documentation and the assessment /treatment of pain
• One fall occurred for an older adult with dementia and complex physical health needs. This is being reviewed as a fact find, initial findings have identified a good level of assessment, physical health reviews and care.
• A member of staff fell in the community. They have returned to work following their sustained injury.

Yellow incidents:
 A total of 4 yellow incidents have occurred for service users and one member of staff.
• Two yellow incidents were reported for younger service users who were on our inpatient wards. One service user fell in the garden, there were no significant injuries and no garden risk found. Another service user fell on the ward with no significant injury, they were later treated for a suspected urinary tract infection.

Green incidents:
The majority of reported slips, trips or falls were graded as green, indicating no harm or low-level injury. Two of these Datix reports occurred whilst service users were on leave from the ward.
• Reviewing the Datix incidents there have continued to be generalised falls occurring with no clear cause found. The falls co-ordinator continues to review all falls

Inpatient related falls: 34 reported slips, trips and falls for service users

Assurance and actions:
• Datix reports are continuing to be horizon scanned to seek themes and areas of potential improvement
• The falls co-ordinator is liaising with higher risk ward areas to improve staff uptake of falls eLearning
• The falls coordinator has met with some wards to offer specialist advice regarding falls management when they have a complex service user
• The falls coordinator has been reviewing the Trustwide inpatient falls risk paperwork, as the paperwork is repetitive and does not guide staff to complete a multifactorial falls assessment.
• The post falls protocol is a legal document that staff are requiring reminders to complete. The falls coordinator is reviewing this and has developed a quality improvement plan to support staff knowledge and completion of this document.
• The falls coordinator has been working with our Comms Team to develop a 'focus on falls' bimonthly newsletter. This will focus on an aspect of what creates a falls risk such as deconditioning, pain, sedation, to support staff and student knowledge.

Falls awareness week held between 18 – 22nd Sept 23 we had several initiatives throughout the Trust including:
• Inpatient wards ran falls quizzes, spot the safety hazard at home, Otago exercise classes (falls prevention), and staff education events
• Clinical Skills Team ran post-falls education for staff across our Trust
• Barnsley Integrated Care Team – ran several stalls at Barnsley market alongside BOPPAA (Barnsley Older Peoples Physical Activity Alliance), Well Being Coaching and 'How's The Ticker'. They had contact with approximately 300 people
• Information boards were placed at Fieldhead, Kendray, The Dales and Priestley Unit, with service users and families taking information about safety at home, good lighting, removing trip hazards and making sure they wore supportive footwear.

Falls (Inpatient)

The total number of inpatient falls was 34 in September. 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.

End of Life

The total percentage of people dying in a place of their choosing was 90.6% in September.

Falls (Inpatients)
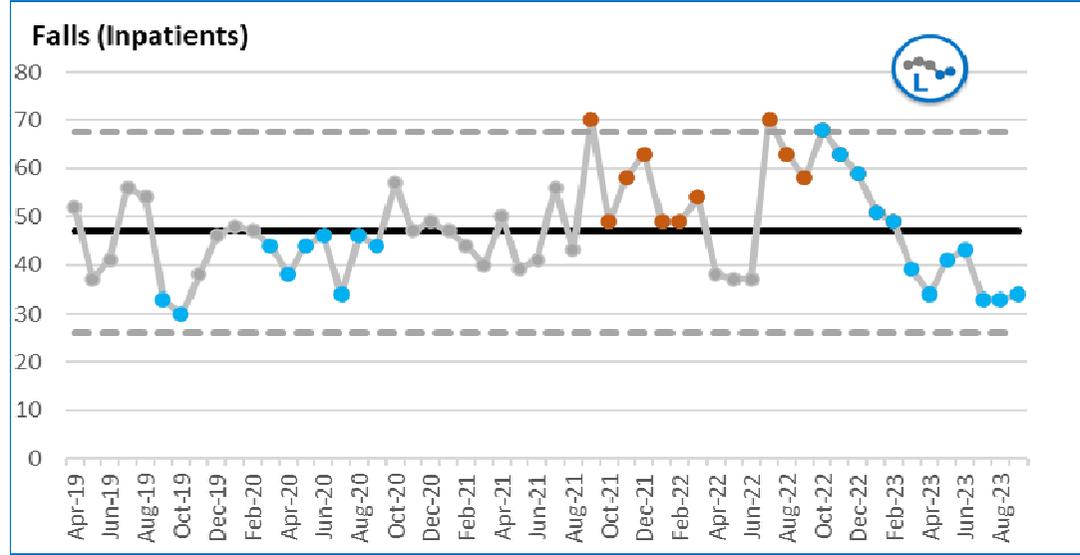
End of Life

The SPC chart above shows that in September 2023 we remain in a period of special cause improvement. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.
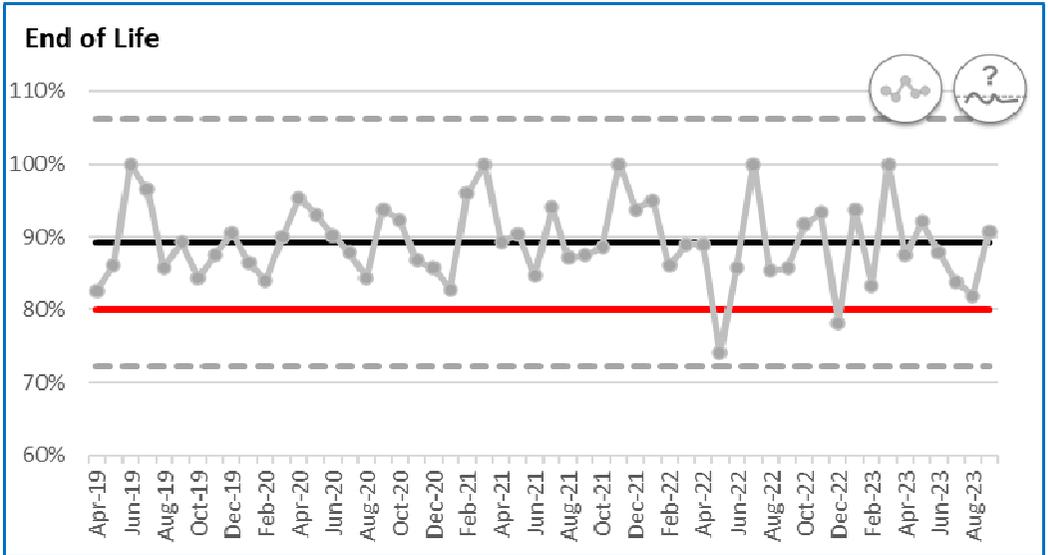
The chart above shows that in September 2023 the performance against this metric remains in common cause variation and therefore within normal range. As the mean performance for this measure is high (90%), the upper control limit (based on the average of the moving range) shows as above 100%.

Patient Experience

Friends and family test shows
- 96% would recommend community services
- 95% would recommend mental health services

	Target	July	August	September
Mental health community	85%	94%	90%	95%
Mental health inpatient	85%	83%	92%	83%
Learning Disabilities	85%	70%	91%	100%
ASD/ ADHD	85%	75%	75%	75%
CAMHS	75%	82%	100%	70%
Forensic	60%	80%	100%	100%
Mental health overall	**84%***	**90%**	**90%**	**95%**
Barnsley Gen ops	95%	**93%**	**97%**	**96%**
Trustwide	**85%**	91%	93%	94%

* weighted for 2023/24

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

- The response rating for September has seen an increase in mental health community and learning disability.
- Mental health inpatients and CAMHS have seen a decrease in their rating.
- ADHD and Forensic services have remained the same.
- Investigation into the drop in the number of returns in September has highlighted an issue with the Trust fire walls preventing the text message being sent, the issue is currently be resolved by Trust IT services and the provider are pushing text messages manually. This has mainly affected the mental health community services returns.
- Work continues with the ADHD service to engage with service users to understand the best way to capture feedback from service users, carers, and families.

Satisfaction across the Trustwide and mental health service has increased. Barnsley community services has declined slightly but remains above target. Mental health inpatient services satisfaction has declined but remains within normal variation.

The themes from Friends and Family Test feedback are in the table (left). Themes can be both positive and negative in nature.

Safeguarding

Safeguarding Adults:

In September 2023, there were 36 Datix categorised as safeguarding adults. Seventeen of these were graded as green, 15 were graded as yellow, and four were amber. The sub-categories of the safeguarding adults reporting on Datix were mainly emotional/psychological abuse, financial abuse, neglect concerns, physical abuse, domestic abuse, sexual abuse.

Amber Datix's were categorised as follows:
• Neglect, appropriate advice provided regarding the self-neglect protocol and a referral made to social care.
• Physical abuse which resulted in a safeguarding referral to the local authority.
• Financial abuse which resulted in contact with the police and social care.
• Neglect, care plans, risk assessment reviewed and a referral to social care made.

In addition to the safeguarding adults Datix, there were eight sexual safety Datix; one amber, one yellow and six green. In two of these Datix, service users were the affected persons, six of these had staff who were affected. In all cases reviewed appropriate actions were taken and local authority safeguarding referrals were made where required.

Safeguarding Children:

In September 2023 there were 16 Datix categorised as safeguarding children. Eleven of these were graded as green, three were graded as yellow and two were graded as amber. The subcategories of the safeguarding children Datix were mainly Physical abuse, Sexual Abuse, Neglect, Child Protection Other, request for service.
One of the amber incidents was managed through an urgent strategy meeting which resulted in a section 47 enquiry and the second incident resulted in liaison with the police.
In the 16 Datix submitted, the Trust safeguarding team were contacted for advice in 11 cases, 12 incidents resulted in a referral to children's social care, and four contacts were made to police.

Infection Prevention Control (IPC)

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

Mandatory training figures remain healthy and above Trust 80% threshold:
• Hand Hygiene -Trustwide Total – 96%
• Infection Prevention and Control - Trustwide Total – 94%

Policies and procedures, a 12-month extension request has been put in for policies that are for review in 2023, this is to accommodate implementation of the National IPC Manual, which has a target due date of March 2024. The current policies and procedures remain compliant, and there is no identified risk as a result of this.

Outbreaks
• 5 Covid-19 outbreaks in September 2023
• 2 Covid-19 clusters, areas monitored

Covid-19 Clinical Cases: There has been an increase in positive COVID-19 cases this is in line with national prevalence.

Complaints

• Acknowledgement and receipt of the complaint within three working days –10/10 (100% of formal complaints)
• Number of responses provided within six months of the date a complaint received – 7/18 (38.9%)
• Number of complaints waiting to be allocated to a customer service officer – 4 (decrease from 12 in August)
• Number of cases which breached the six months target who have not had a conversation to agree a new timeframe for completion 0%
• Longest waiting complainant to be allocated to a customer service officer –. 4 weeks as at 30th September. This continues to improve month on month.
• There were 10 new formal complaints in September 2023 (decrease from 17 in August).
• 17 compliments were received.
• 18 formal complaints were closed in September 2023. This is an increase compared to August where 13 were closed.
• Number of concerns (informal issues) raised and closed in September 2023 – 34
• Number of enquiries responded to in September 2023 - 92 (decrease from 104 in August)
• Number of complaints referred to the Parliamentary Health Service Ombudsman this financial year to date = 2, 0 referred in September 23

Reducing Restrictive Physical Intervention (RRPI)

• There were 92 reported incidents of Reducing Restrictive Physical Interventions used in September 2023 this was a reduction of 54 (37 %) from August 2023 (146 incidents).

• In September 2023 there were 16 incidents of Seclusion use Trustwide this is a reduction of 11 (40.7%) from August 2023 (27).

• 90% of Prone Restraints in September 2023 lasted under 3 minutes.

• In September 2023 10 incidents of Prone restraint (those remaining in Prone position and not rolled immediately) was reported (no change from August 2023.

Incidents of prone restraint lasting greater than 3 minutes:

• Ward 19 reported one incident of prone restraint which lasted 4 – 5 minutes. The prolonged duration was due to aggressive and sexually inappropriate behaviour. Each incident of prone restraint is reported on Datix and is reviewed by RRPI specialist advisors.

Restraint Position	Total Restraint Positions used	Percentage of Use
Standing	58	40.2%
Seated	29	20.1%
Safety Pod	14	9.7%
Restricted escort	11	7.6%
Prone	10	6.9%
Prone then rolled	7	4.8%
Side	6	4.1%
Kneeling	5	3.4%
Supine	4	2.7%

Team Using Prone Restraint	Total
Walton PICU	5
Newhaven Forensic Learning Disabilities Unit	3
Nostell Ward, Wakefield	1
Ashdale Ward	1
Total	10

Duration of Prone Restraint	Total
0 - 1 minute	3
1 - 2 minutes	6
4 - 5 minutes	1
Total	10
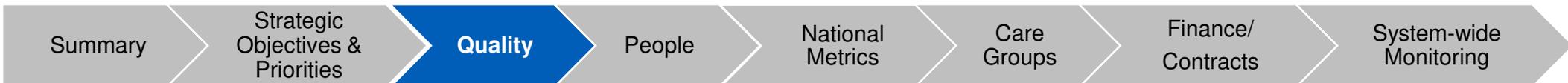
Reducing Restrictive Physical Intervention (RRPI)
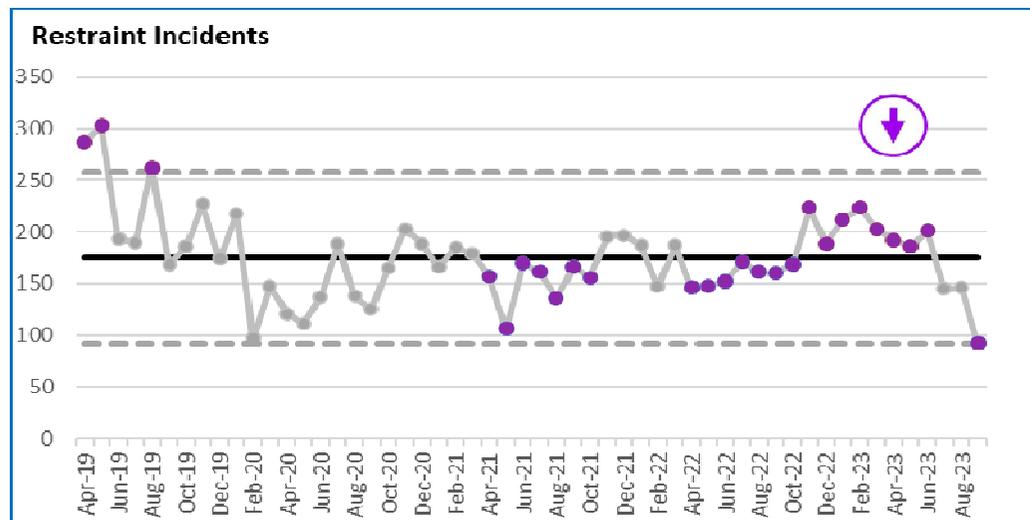
Restraint Incidents

This SPC chart shows that in September 2023 we remain in a period of common cause variation.

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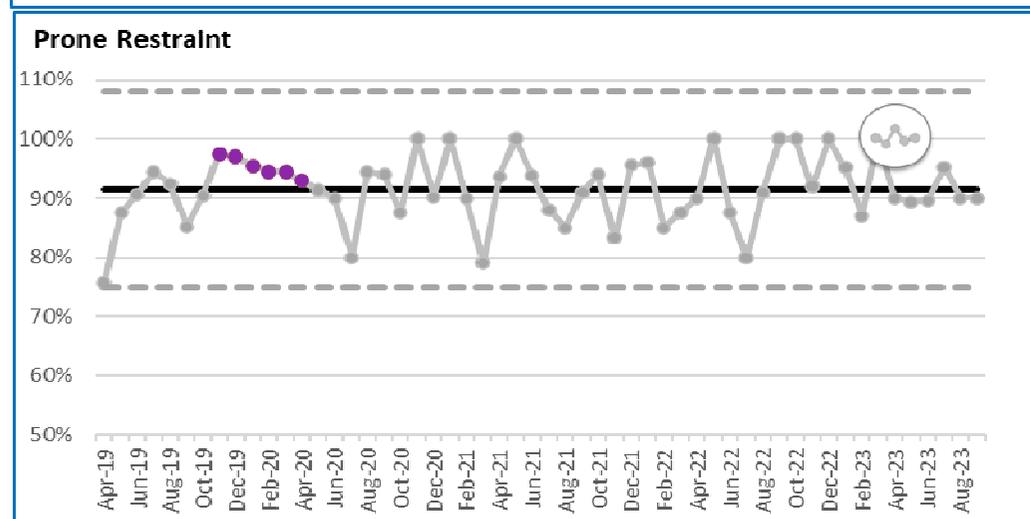
Prone Restraint

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

People - Performance Wall

Trust Performance Wall

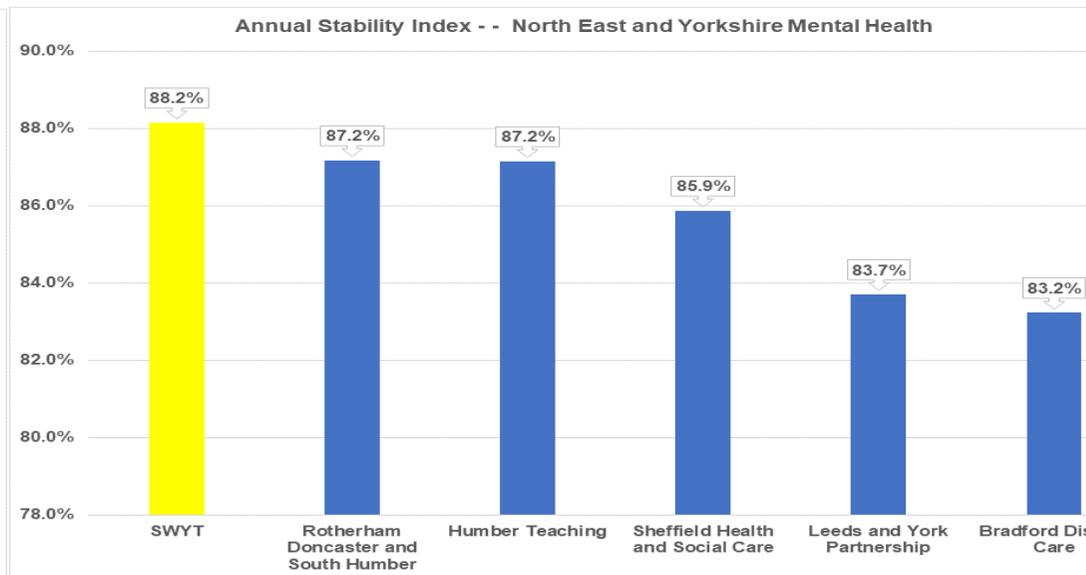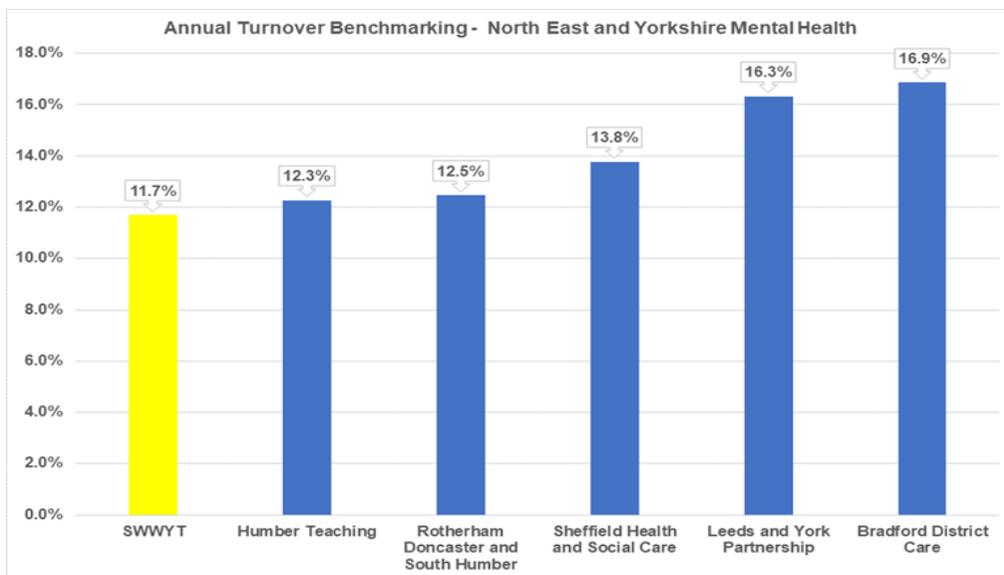|	Objective	CQC Domain	Threshold	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Establishment	Improving Resources	Well Led	-	5,145.9	5,156.5	5,197.9	5,237.9	5,246.6	5,267.2	5,157.4	5,174.0	5,193.8	5,196.6	5204.8	5321.0
Employed Staff (ESR last day in the month)			-	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	4,289.5	4,311.6	4358.0
Vacancies			-	881.8	895.2	942.0	936.8	944.8	926.9	818.9	822.0	818.4	796.1	772.1	867.8
Vacancy rate			<10%	17.1%	17.4%	18.1%	17.9%	18.0%	17.6%	15.9%	15.9%	15.8%	15.3%	14.8%	16.3%
Turnover external (12 month rolling)			>12% - <13%	14.4%	14.4%	14.2%	14.3%	13.7%	13.5%	13.0%	12.2%	13.1%	13.0%	13.1%	12.1%
Starters			-	56.9	50.5	26.6	65.4	70.2	58.1	45.8	54.9	57.5	53.9	64.0	63.3
Leavers			-	48.2	40.6	27.5	60.1	38.5	43.1	58.8	39.6	37.0	54.3	61.9	34.2
Number of international nurses recruited														9	10
% Bank Fill Rates - Registered Nurses														47.8%	49.6%
% Bank Fill Rates - Health Care Assistants														69.8%	70.2%
Proportion of staff in senior leadership roles who are from BME background (relates to staff in posts band 7 and above, excludes bank staff) *			-					Reporting commenced August 23						126 (11.8%)	134 (12.6%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)			-											769 (72.3%)	798 (74.9%)
Sickness absence - Rolling 12 month			<=4.8%	5.0%	5.1%	5.3%	5.3%	5.2%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%
Sickness absence - Month			<=4.8%	5.7%	5.9%	6.3%	5.3%	5.3%	5.1%	5.0%	4.6%	4.6%	5.1%	4.7%	4.9%
Employees with long term sickness over 12 months			-	2	2	2	4	2	2	1	0	0	0	0	2
Appraisals - rolling 12 months			May Trajectory>=78% Overall threshold: >=90%	56.0%	60.7%	62.9%	69.8%	71.5%	71.8%	74.4%	74.9%	78.5%	76.5%	74.5%	72.5%
Employee Relations - Suspensions (over 90 days)			-	2	2	3	3	1	1	0	0	0	3	3	3
Mandatory Training - TOTAL	Improving Care		>=80%	89.5%	89.5%	89.2%	89.4%	90.1%	90.2%	90.5%	90.9%	92.0%	92.1%	92.5%	92.1%
Mandatory Training - Reducing Restrictive Practice Interventions				70.3%	68.4%	66.4%	71.9%	74.5%	74.6%	73.8%	73.8%	76.7%	76.2%	82.6%	82.8%
Mandatory Training - Cardiopulmonary Resuscitation				72.5%	72.1%	72.0%	73.0%	75.1%	75.0%	75.5%	79.2%	81.3%	81.0%	79.9%	80.0%
Mandatory Training - Clinical Risk				96.3%	96.2%	96.0%	95.7%	94.9%	95.9%	95.6%	95.4%	95.4%	95.2%	94.8%	94.0%
Mandatory Training - Display Screen Equipment				95.1%	95.4%	95.8%	96.0%	96.3%	96.4%	96.5%	96.8%	97.0%	97.1%	97.4%	97.4%
Mandatory Training - Equality & Diversity				93.8%	94.2%	94.1%	94.6%	95.1%	95.8%	96.0%	96.2%	96.2%	96.0%	95.9%	96.1%
Mandatory Training - Fire Safety				87.3%	87.7%	87.5%	88.3%	88.4%	89.4%	90.2%	91.2%	92.8%	92.0%	91.4%	91.2%
Mandatory Training - Food Safety				78.6%	79.9%	79.5%	79.6%	79.8%	79.4%	78.0%	83.4%	86.4%	87.8%	89.4%	89.3%
Mandatory Training - Freedom To Speak Up (FTSU)				90.5%	91.3%	91.7%	92.0%	92.4%	92.5%	93.2%	93.7%	94.0%	94.3%	94.7%	94.9%
Mandatory Training - Infection Control & Hand Hygiene				88.4%	88.6%	88.4%	88.4%	88.6%	90.2%	91.5%	92.4%	94.1%	94.3%	94.3%	95.6%
Mandatory Training - Information Governance (Data Security)			>=95%	91.2%	89.8%	87.6%	87.3%	84.8%	86.5%	90.6%	95.9%	96.8%	96.9%	95.3%	94.8%
Mandatory Training - Moving & Handling				95.3%	95.8%	95.6%	93.0%	93.4%	95.5%	95.5%	94.9%	95.2%	95.1%	95.6%	94.8%
Mandatory Training - Nat Early Warning Score 2 (New S2)				87.4%	88.1%	89.6%	91.1%	92.0%	92.4%	92.5%	92.1%	93.8%	94.7%	95.2%	96.2%
Mandatory Training - Mental Capacity Act/Dols			>=80%	93.5%	93.4%	93.3%	95.6%	95.3%	94.0%	91.6%	93.6%	93.7%	93.4%	94.0%	96.7%
Mandatory Training - Mental Health Act				90.7%	91.0%	91.2%	90.4%	91.6%	92.2%	91.6%	91.3%	91.2%	91.1%	92.2%	99.8%
Mandatory Training - Prevent				95.0%	94.6%	94.4%	94.7%	95.2%	95.6%	95.4%	95.5%	92.1%	94.1%	94.2%	91.7%
Mandatory Training - Safeguarding Adults				89.4%	89.5%	89.0%	89.1%	89.9%	90.0%	90.0%	89.7%	89.3%	89.5%	89.7%	93.9%
Mandatory Training - Safeguarding Children				88.7%	88.9%	88.6%	88.8%	89.3%	89.8%	90.0%	90.7%	91.1%	91.2%	91.7%	89.7%

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 over 12 months. For earlier months this was year to date.
- * 5 records had no ethnicity stated

Stability of the Workforce
• We have seen an increase in the amount of employees remaining in the Trust by 4.4% overall.
• Our Turnover in month has also decreased by 0.6%
• Although we have remained static in terms of our new starters since last month, this is still an increase based on our start of year position (April 45.8 WTE whereas September is 63.3)
• We continue to onboard our international recruited new starters at a consistent of 10 employees per month
• We have had 2 support worker values based assessment centres during September

Annual Turnover Benchmarking - North East and Yorkshire Mental Health

Annual Stability Index - - North East and Yorkshire Mental Health

Keep Fit & Well

Absence
• 12 month rolling absence rate remains at 5.3%.
• Overall absence (in month) has increased by 0.2% to 4.9%, but the overall rolling rate remains unchanged at 5.3%. Majority of care groups saw a slight reduction in the monthly sickness position. The Forensics care group continues to rise (September 9.4%). Following discussions during the Workforce Planning meetings a full deep dive into sickness absence is being planned to better understand the position and what actions need to be taken to support a decrease. Workforce planning meetings taking place across all services in October.
• Estates and Facilities absence remains high in September (7.8% year to date)
• 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.
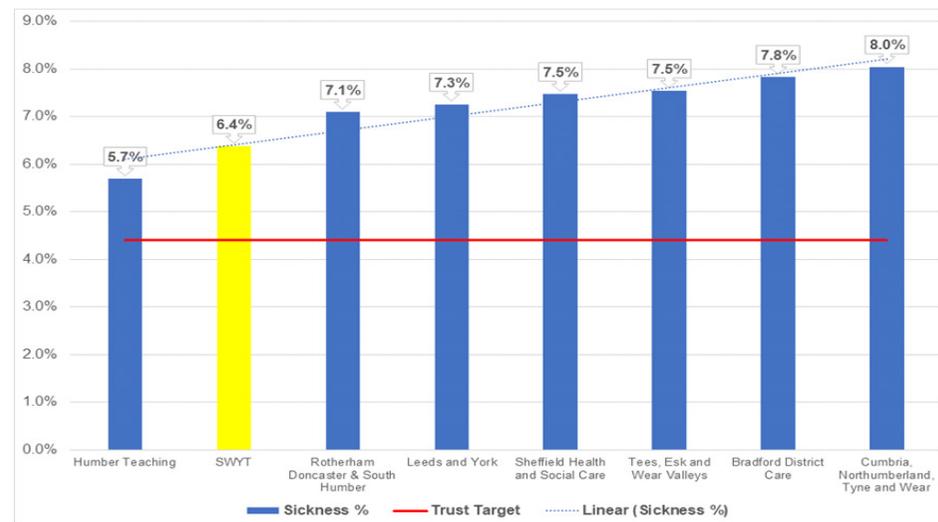
Supportive Teams

Appraisals
• Appraisal rates have decreased slightly this month, however further development is underway to enable managers to have the right level of information to manage appraisals along with proactive support from the L&D team to support managers to undertake appraisals in partnership with the new People Business Partners.

Mandatory Training
• Overall mandatory training reports 92.1% 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. Cardiopulmonary resusatation mandatory training compliance had seen a decline in August below threshold, this has now increased and is at threshold 80%.

Analysis

Trust Sickness Absence - Year to Date
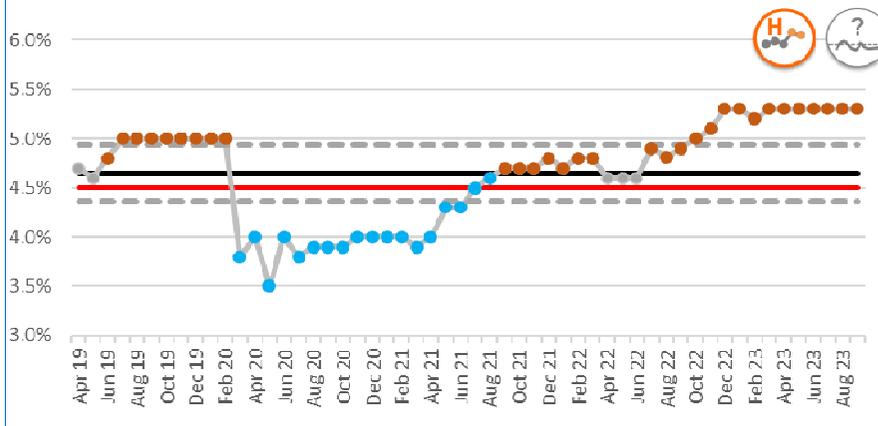
The SPC chart shows that in September 2023 we remain in a period of special cause concerning variation (orange markers). From July 2022 this also includes absence due to Covid-19.

Trust Agency Spend
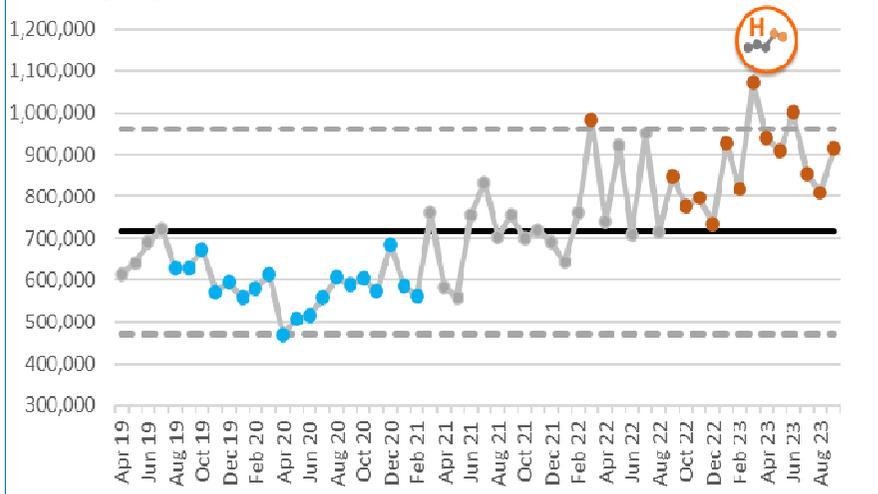
The Trust has a target of reducing agency spend from £10.0m to £8.7m. Spend in September is £0.9m which is higher than the two preceeding months and remains above the plan trajectory. The year to date position is 18% above plan.

- 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 commenced in June for all care groups to focus on individual long term agency placement (September group focus on medical locum/agency reduction)
- 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 in September with following recommendations and report due into Agency Scrutiny Group.
- Trustwide eRostering roll out continuing – Barnsley inpatient nearing completion. Target rollout end of December on course.
- Alternative marketing campaigns to engage wider markets. Several national and local recruitment events booked between now and November (Liverpool, Glasgow, Birmingham) alongside targeted hard to reach groups with Touchstone which includes on the day suitability interviews.
- Significant increase in assessment centre recruitment events – 11 since April (usually 1 per month). Centres run in September (3) have seen over 170 potential candidates into bank and substantive healthcare support worker and nurse posts. (80 offers made to bank posts in September). This will have a positive impact upon agency provision in future months. Further additional assessment centres planned to cater for demand in

Produced by Performance and Business Intelligence

National Metrics

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

This section of the report outlines the Trust's performance against a number of national metrics relating to operational performance.

The NHS Oversight Framework - From 1 July 2022 integrated care boards (ICBs) have been established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their integrated care system (ICS). NHS England will work with ICBs as they take on their new responsibilities, the ambition being to empower local health and care leaders to build strong and effective systems for their communities. 2022/23 will be a year of transition as Integrated Care Boards ICBs are formally established and new collaborative arrangements are developed at system level. Over the course of 2022/23 NHS England will consult on a long-term model of proportionate and effective oversight of system-led care. The oversight framework has been updated for 22/23. It aligns to the priorities set out in the 2022/23 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of ICBs and the merging of NHS Improvement (comprising Monitor and the NHS Trust Development Authority) into NHS England. Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs. ICBs will lead the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate.

This table only includes operational metrics, there are a number of other workforce, quality and finance metrics that are reported in the relevant section of the IPR.

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
M1	Incomplete Referral to Treatment (RTT) pathways of 52 weeks or more		0	P		0	0	0	0	0	0	0	0	0	0	0	0
M2	Inappropriate out of area bed days		0	F		406	453	408	451	483	480	434	545	435	589	400	187
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	?		91.5%	85.4%	85.3%	92.6%	91.4%	74.4%	87.1%	87.8%	88.6%	90.3%	92.6%	72.4%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%	?		51.4%	40.6%	52.4%	57.1%	53.8%	53.8%	52.5%	53.4%	53.2%	50.4%	51.5%	51.6%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P	H	86.9%	89.5%	93.5%	95.1%	95.7%	97.5%	97.9%	99.0%	99.6%	99.0%	99.5%	99.9%
M7	72 hour follow-up from psychiatric in-patient care		80%	?		87.8%	89.6%	88.9%	87.9%	89.6%	87.2%	92.5%	90.6%	92.6%	87.7%	90.7%	88.5%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?		13	10	0	8	30	43	15	11	29	9	18	8
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?		2	2	0	1	2	2	3	1	1	1	2	2
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%	P	H	98.0%	98.5%	98.5%	97.7%	97.6%	98.1%	97.8%	98.6%	99.4%	99.2%	98.3%	98.3%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%	P		100%	99.9%	99.5%	99.8%	100%	99.8%	99.8%	99.8%	100%	99.8%	99.8%	100%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?		100%	90%	100%	87.5%	80%	87.5%	50%	80%	100%	70%	66.7%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?		78.4%	79.3%	88.2%	88.6%	100%	95.8%	77.8%	95.8%	100%	92%	91.3%	100%
M15	Data Quality Maturity Index		95%	P		99.2%	99%	99.1%	99.4%	98.2%	98.2%	99.4%	99.2%	99.5%	98.8%	99.3%	99.5%
M19	Talking Therapies - number of people receiving advice/signposting or starting a course.					1399	1542	1192	1641	1414	1533	1306	1603	1579	1470	1404	1476
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%	P		99.0%	97.8%	98.5%	98.1%	99.1%	98.9%	98.9%	98.4%	99.0%	99.2%	99.7%	99.0%
M24	Number of people accessing individual placement and support (IPS) services during the month		13	?	H	16	29	36	36	44	30	25	34	26	36	38	34
M25	Number of individuals accessing specialist community perinatal or maternity mental health services					65	66	70	72	51	81	51	67	53	64	60	70

National Metrics

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
M30	Number of detentions under the Mental Health Act (MHA)					92	86	90	100	94	86	93	101	93	101	100	97
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					22.8%	20.9%	21.1%	19%	19.1%	22.1%	21.5%	18.8%	12.9%	26.7%	20%	22.7%
M32	% Admissions gate kept by crisis resolution teams		95%			94.6%	88.9%	93.3%	97.9%	91.9%	91.1%	90%	89.1%	90.7%	88.6%	94.7%	87.7%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			96.2%	96.5%	97.6%	96.3%	95.6%	97.9%	97.5%	97.6%	97.8%	98.3%	98.3%	96.8%
M34	% Clients in settled accommodation	⚠️	60%			86%	85.8%	85.2%	84.4%	84.4%	84.6%	84.2%	84%	84.3%	83.8%	84.3%	84.3%
M35	% Clients in employment	⚠️	10%			12%	11.6%	11.4%	11.7%	11.4%	11.2%	11.2%	11.5%	11.7%	12.0%	12.3%	12.6%
M41	Completion of a valid NHS number		99%			100%	100%	100%	100%	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%
M42	Completion of ethnicity coding for all service users		90%			99.4%	99.3%	99.3%	99.4%	99.4%	99.4%	99.4%	99.5%	99.4%	99.4%	99.5%	99.4%
M43	Community health services two hour urgent response standard		70%			88.1%	88.4%	84.3%	87.6%	85.0%	83.7%	87.3%	86.6%	86.2%	88.1%	89.5%	88.4%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500									1523	1719	2335	1509	1667	1656
M45	The number of incomplete Referral to Treatment (RTT) pathways		2400												1782	1982	2168
			2500									1933	1835	1592			
M46	Count of 2-hour urgent community response first care contacts delivered					757	862	771	796	648	761	826	953	911	936	1019	1003
M47	Virtual ward occupancy		80%									82.9%	44.3%	92.9%	51.4%	57.1%	60%
M48	Community services waiting list		5430												5024	5170	5048
			5652									5420	5298	5131			
M49	Number of people who receive two or more contacts from community mental health services for adults and older adults with severe mental illnesses											3910	3921	3917	3907	3888	3857
M50	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact											10957	11094	11099	11114	10934	11036
M170	Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)		99%			98.7%	100%	86.2%	88%	91.6%	79.8%	60.7%	53.3%	82.5%	66.7%	64.1%	75.3%
M171	% Admissions gate kept by crisis resolution teams		95%			100%	98.7%	100%	98.9%	99%	98.2%	100%	99%	100%	96.6%	100%	99.1%

National Metrics

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 99.9%

• 72 hour follow up remains above the threshold at 88.5%.

• The percentage of service users seen for a diagnostic appointment within 6 weeks in the paediatric audiology service remains below threshold at 75.3% in September. This has now entered a period of special cause concerning variation (please see SPC chart). The care group escalated a concern regarding access in paediatric audiology when performance for diagnostic appointments first started to fall at the start of the year. An improvement plan was initiated. More recently, the care group reported a concern with reaching the agreed trajectory to full performance by October 2023. This relates to staffing capacity which is an issue shared across South Yorkshire providers and to increased numbers of children 'not brought' to the assessment where the assessment cannot be rebooked within 6 weeks. Not all appointments are for diagnosis. Overall the average waiting time for an appointment in audiology is 3.6 weeks so if parents need support and advice for their child a general appointment can be arranged.

• The percentage of children and young people with an eating disorder designated as urgent cases who access NICE concordant treatment within one week and routine who access treatment have both reached 100% in September. Though as previously noted low numbers do impact the performance. Please see narrative in the Strategic Objectives & Priorities section of this report for further detail.

• During September 2023, there were two service users aged under 18 years placed in an adult inpatient ward with a total length of stay in the month of 8 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 51.6% for September. This metric is in common cause variation however fluctuations in the performance mean that achievement of the threshold cannot be estimated.

 • Percentage of service users on the care programme approach (CPA) having formal review within 12 months remains above threshold during the month of September. 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.

Out of area bed days

Please see narrative
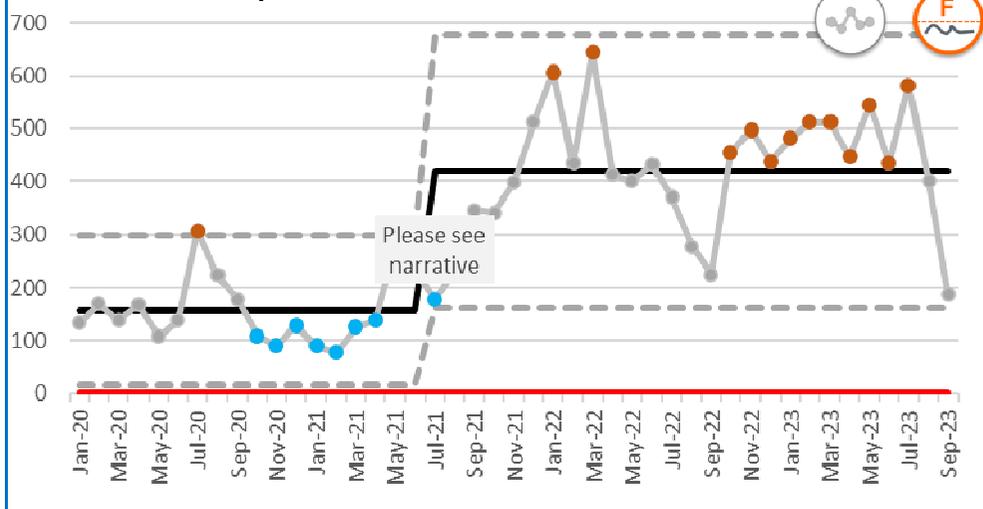
Inappropriate Out of Area Bed days - Barnsley Place
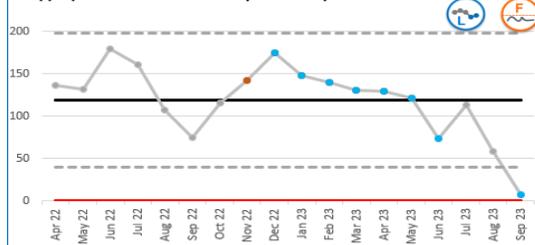
Inappropriate Out of Area Bed days - Calderdale Place
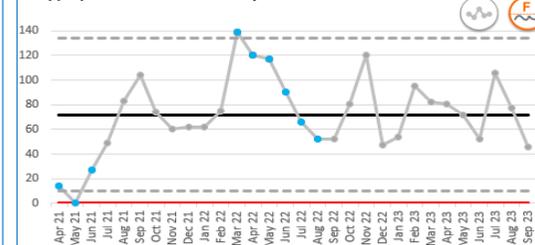
Inappropriate Out of Area Bed days - Kirklees Place
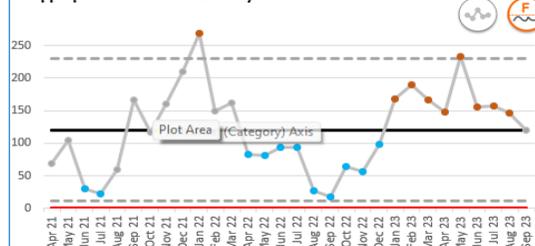
Inappropriate Out of Area Bed days - Wakefield Place
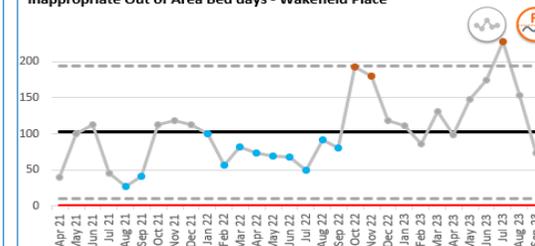
Inappropriate Out of Area Bed Days - This metric shows the total number of bed days occupied by clients who have been placed in a bed outside the geographical footprint of the Trust.

Summary	Actions	Assurance
The Trust has seen a large reduction in the number of inappropriate out of area bed days	The culmination of the work of the improvement programme which has focussed on: - Addressing barriers to discharge and reducing delays for people who are clinically ready for discharge - Effective coordination out of area care to ensure people are repatriated. - Addressing workforce issues to improve the care and treatment offer. Improving community treatment options as alternative to inpatient care are now being realised and further improvement and sustainability of the reduced figure is expected.	The improvement programme reports through the assurance framework to Board. Out of area placements are reported to EMT against the trajectory. System wide work streams report through the ICS.

Data quality:
An additional column has been added to the national metric dashboards 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 September the following data quality issue has been identified in the reporting:
 • The reporting for employment and accommodation shows 16.8% 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

Total bed days of Children and Younger People under 18 in adult inpatient wards

PICU at Red Kite View closed for 2 weeks

GAU at Red Kite View was closed till 29/04 due to Covid
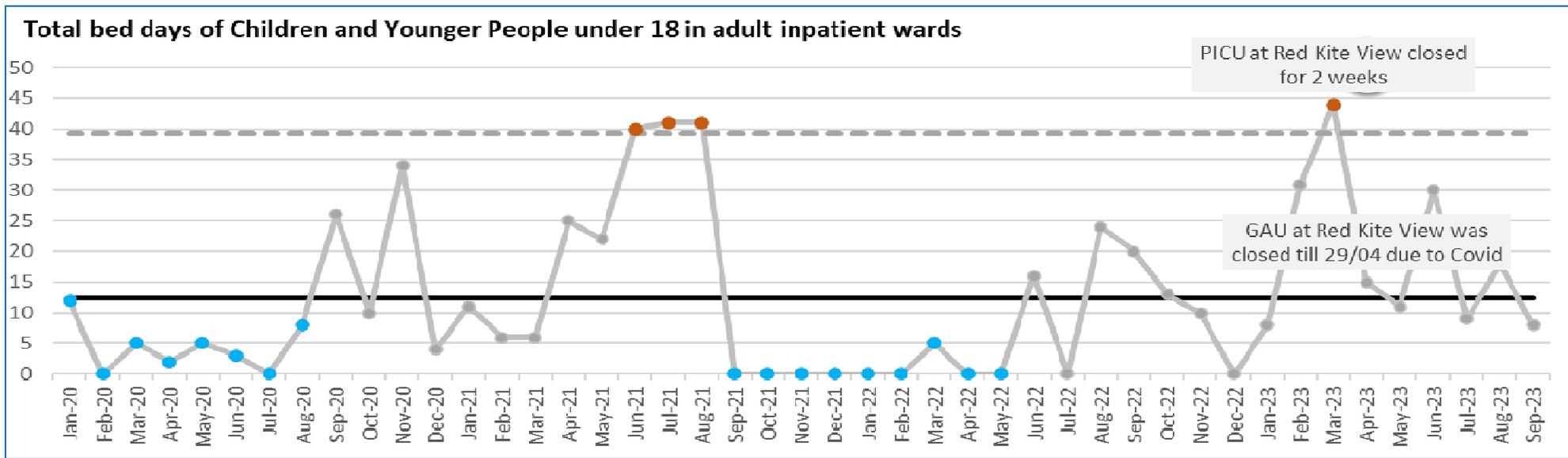
The statistical process control chart (SPC) above shows that in September 2023 we remain in a period of common cause variation regarding the number of beds days for children and young people in adult wards.

Analysis

Max time of 18 weeks from point of referral to treatment - incomplete pathway

Maximum 6-week wait for diagnostic procedures
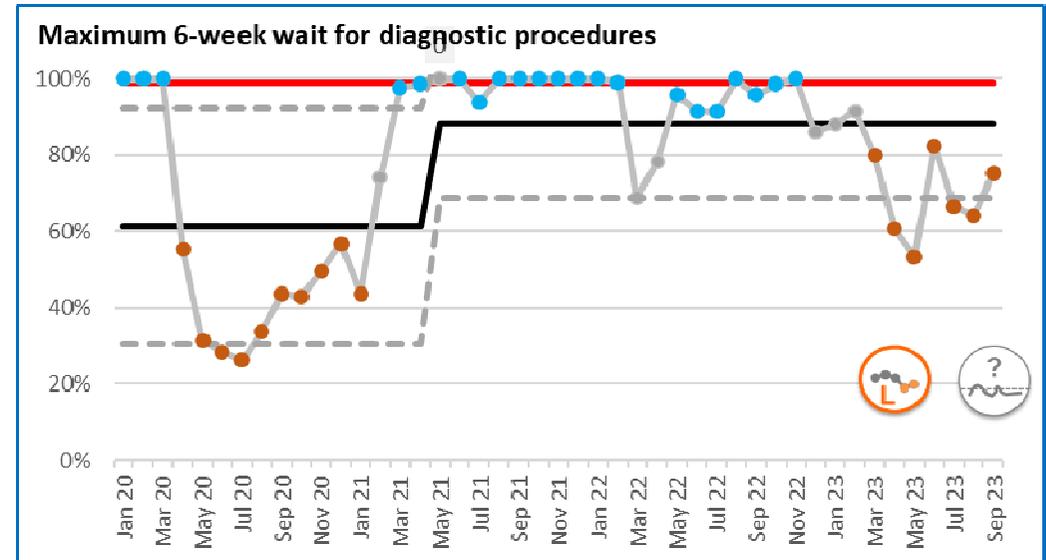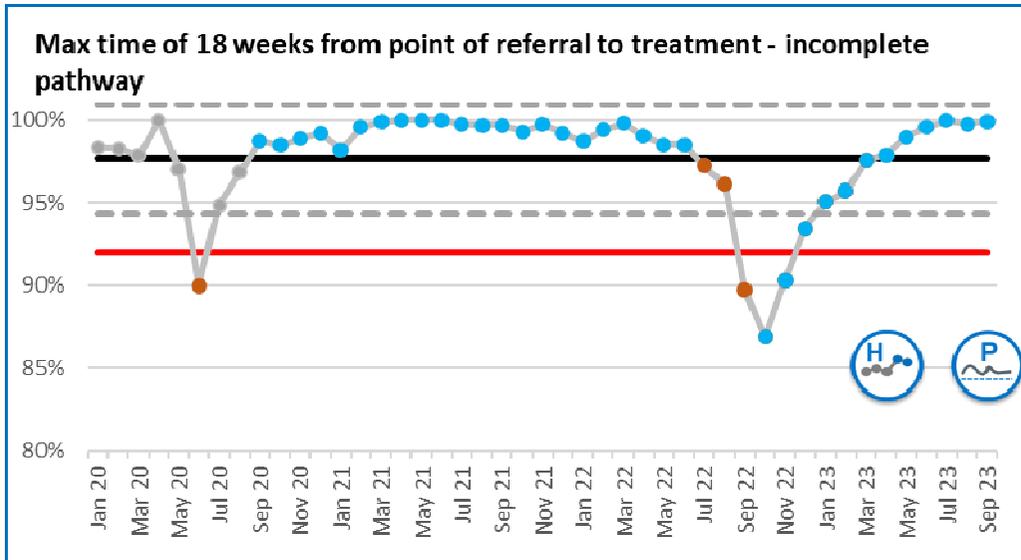
The SPC charts above show that for September 2023 we are currently in a period of special cause improvement for clients waiting a maximum of 18 weeks from referral to treatment and we are estimated to achieve the target against this metric. For clients waiting for a diagnostic procedure we remain in a period of special cause concerning variation and due to the fluctuating nature of this metric, whether we will meet or fail the target cannot be estimated. We remain below the threshold.

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

2.56

Key
OPEL Level 1	
OPEL Level 2	
OPEL Level 3	
OPEL Level 4	

Child and adolescent mental health services (CAMHS)

CAMHS

Metrics	Threshold	Aug-23	Sep-23	Variation/Assurance
% Appraisal rate	>=90%	71.3%	72.4%	
% Complaints with staff attitude as an issue	< 20%	0% 0/2	0% 0/0	
% of staff receiving supervision within policy guidance	80%	N/A	71.5%	
CAMHS - Crisis Response 4 hours	N/A	100.0%	91.7%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.1%	80.3%	
Eating Disorder - Routine clock stops	95%	91.3%	100.0%	
Eating Disorder - Urgent/Emergency clock stops	95%	66.7%	100.0%	
Information Governance training compliance	>=95%	94.4%	93.3%	
Reducing restrictive practice interventions training compliance	>=80%	69.0%	65.1%	
Sickness rate (Monthly)	4.5%	4.4%	4.5%	
% rosters locked down in 6 weeks				

CAMHS Referal to Treatment
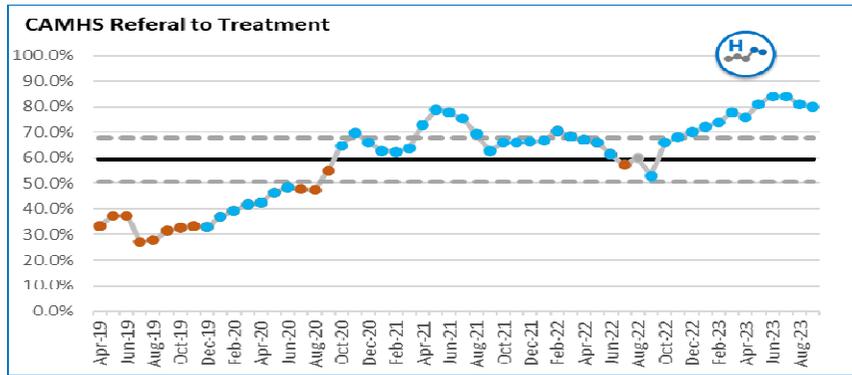
As you can see in September 2023, we remain in a period of special cause improving variation. For further information see narrative below.

Alert/Action

• Waiting time 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. Evolve contract (Kirklees) ends September which would reduce assessment capacity by 21 per month. Plans now in place for temporary (end March 2024) extension but long-term capacity concerns remain
• Shortage of specialist residential and tier 4 places due to reduced capacity nationally and ongoing capacity issues locally. Pressures less evident in this reporting period but issue remains 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.

Advise

• Waiting times from referral to treatment in Wakefield remain an outlier. Brief intervention and group work service offer continues to be strengthened, and medium term improvement is anticipated. Additional mental health support team investment has been confirmed which will enable further development of the schools-based offer.
• Eating disorder caseloads remain under pressure. Deterioration in reported Q2 performance requires further analysis. Some evidence of increasing case acuity/complexity but also some potential for data quality improvement.
• 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. Financial pressures in local Council has impacted adversely on resource envelope. The keep in Mind programme will be launched April 2024.
• Evident increase in sickness rates – most notable in Barnsley. Small number of long term sickness cases adversely impacting and being proactively managed.
• RRPI Mandatory training in red. Limited availability of face to face training offer – but improvement expected in Q3
• Self-harm incidents/risk are a key focus of improvement work at Wetherby Youth offender institute.
• Management priority being attached to improving appraisal rates across all service areas.

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.
• 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

Adults and Older People Mental Health

Mental Health Community (Including Barnsley Mental Health Services)

Metrics	Threshold	Aug-23	Sep-23	Variation/Assurance
% Appraisal rate	>=90%	76.3%	76.1%	
% Assessed within 14 days of referral (Routine)	75%	65.7%	82.7%	
% Assessed within 4 hours (Crisis)	90%	94.5%	97.1%	
% Complaints with staff attitude as an issue	< 20%	22% (2/9)	13% (1/8)	
% of staff receiving supervision within policy guidance	80%	N/A	60.9%	
% service users followed up within 72 hours of discharge from inpatient care	80%	90.7%	88.5%	
% Service Users on CPA with a formal review within the previous 12 months	95%	98.3%	96.6%	
% Treated within 6 weeks of assessment (routine)	70%	98.1%	97.1%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.9%	79.1%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	92.1%	91.8%	
Information Governance training compliance	>=95%	97.1%	94.4%	
Reducing restrictive practice interventions training compliance	>=80%	68.3%	66.8%	
Sickness rate (Monthly)	4.5%	3.6%	4.1%	
% rosters locked down in 6 weeks				

Mental Health Inpatient

Metrics	Threshold	Aug-23	Sep-23	Variation/Assurance
% Appraisal rate	>=90%	62.6%	62.2%	
% bed occupancy	85%	87.4%	86.6%	
% Complaints with staff attitude as an issue	< 20%	25% (1/4)	0% (0/1)	
% of staff receiving supervision within policy guidance	80%	N/A	77.6%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.1%	77.1%	
% of clients clinically ready for discharge	3.5%	8.0%	7.7%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	88.0%	95.7%	
Inappropriate Out of Area Bed days	152	400	187	
Information Governance training compliance	>=95%	93.5%	90.9%	
Physical Violence (Patient on Patient)	Trend Monitor	20	29	
Physical Violence (Patient on Staff)	Trend Monitor	68	53	
Reducing restrictive practice interventions training compliance	>=80%	82.1%	81.5%	
Restraint incidents	Trend Monitor	109	65	
Safer staffing	90%	131.3%	130.4%	
Sickness rate (Monthly)	4.5%	5.5%	4.0%	
% rosters locked down in 6 weeks				

Alert/Action

• Acute wards have continued to manage high levels of acuity.

• We have had high occupancy levels across wards and capacity to meet demand for beds remains difficult.

• Rehabilitation services are now commissioned to deliver a flexible bed base offer. Both rehab units still maintain the option of utilising all the beds, however it is a fluid resource shared with the community rehab provision and the use of the beds is required to balance with the community rehab caseload. The aim of the flexible bed base model is to allow for service users to progress in a timely manner from acute services and into the community with rehab input as soon as possible. Kirklees aim to work at a flexible bed base of 16-24, but can accommodate 27 inpatients and 3 social care patients but the community rehab caseload will reduce to accommodate this. Calderdale aim to work at a flexible bed base of 8-10, but can accommodate 14 inpatients, but again the community rehab caseload requires a reduction to accommodate this.

• 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, the numbers have reduced this month. We are monitoring the impact of reduced out of area beds on inpatient wards.

• 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'. The Barnsley percentage appears to show large patient numbers ready for discharge however given smaller ward populations this only relates to a small number of service users. Beamshaw currently has one service user clinically ready for discharge but delayed (Awaiting Ministry of Justice to approve his discharge) and Clark have two service users identified as clinically ready for discharge but delayed (extensive work is ongoing to progress with discharge for these two service users). Stanley had an exceptionally high number of service users clinically ready for discharge but delayed in September due to a number of complex cases. However currently there are only two service users identified as clinically ready for discharge but delayed (one is awaiting Ministry of Justice approval for discharge and there is extensive work being done to find a suitable placement for the second service user).

• There is increased pressure on the wards from the number of learners that require support, i.e. student nurses, international recruits and newly registered staff, which is creating patient safety concerns. In most cases the support is being provided to learners by 2-3 Registered Nurses, some of whom have recently completed their own preceptorship.

• 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.

• 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. In September performance has improved in Calderdale and Kirklees and is now above target. We are expecting performance to be below target in Barnsley this month. Action plans remain in place, with specific improvement work taking place in Barnsley.

• Rapid improvement work in SPAs and implementation of BCP in Calderdale & Kirklees together with some progress in recruitment should contribute to an improved performance in the coming months.

• The Kirklees Talking Therapies recovery rate for September is 50.05% just achieving the national standard of 50%. This is likely to be a seasonal trend as a similar reduction was noted in 2022-23 data. The recovery rate during this period has been affected by an increased number of non-recovered patients dropping out of treatment in addition to lower recovery rates of developing Trainee Psychological Wellbeing Practitioners (PWPs). Individual clinician performance is being monitored through supervision with development plans to support and improve performance from Trainee PWPs.

• Intensive Home Based Treatment (IHBT) teams in Calderdale and Kirklees are experiencing additional workforce challenges, however the picture has started to improve with some successful recruitment.

• We currently have higher than usual levels of vacancies in community teams for qualified practitioners and proactive attempts to fill these have had limited success with action plans in place for certain teams and continue to be proactive and innovative in approaches to recruitment and workforce modelling.

• All areas are focussing on 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.

• For FIRM risk assessments on inpatient wards there has been an issue with inclusion of data that should not be included in the data set and with the timeliness of the extract. The next extract is expected to resolve the issues but operational and performance colleagues will work on a solution if not. Transfers from acute wards to rehab wards have been treated as such by the receiving ward, and patients transferred already have a risk assessment in place in accordance with inpatient performance requirements. This has however been reflected against performance for new admissions, we will be working with performance colleagues to reflect performance more accurately going forward.

• 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.
• 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 achieving the target of all appraisals being completed.
• For all inpatient wards there has been a review of internal processes to ensure we are capturing all exclusions for supervision figures (there are some staff who are captured in these figures that should have been excluded due to long-term sickness for example). Admin staff will be supporting ward managers to ensure all exclusions are recorded on a monthly basis.
• 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.
• All team managers have been contacted where compliance rates are below expected thresholds for mandatory training (this includes Reducing Restrictive Practice/ Cardio-Pulmonary Resuscitation and Information Governance). General Managers have also discussed how the service manager might support with monitoring this moving forward.
• We continue to work towards required concordance levels for Cardio-Pulmonary Resuscitation training and aggression management - this has been impacted by some issues relating to access to training and levels of did not attends.
• We are working closely with specialist advisors and we also have plans in place across inpatient services to ensure appropriately trained staff are on duty across all shifts at all times.

Assure

• 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.
• We have reduced the use of out of area beds significantly with current usage confined to patients requiring gender specific psychiatric intensive care. This follows extensive work as part of the care closer to home improvement programme.

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) / Learning Disability (LD) Services

LD, ADHD & ASD

Metrics	Threshold	Aug-23	Sep-23	Variation/ Assurance
% Appraisal rate	>=90%	71.1%	70.6%	
% Complaints with staff attitude as an issue	< 20%	0% (0/2)	0% (0/1)	
% of staff receiving supervision within policy guidance	80%	N/A	72.3%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	41.5%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.1%	78.1%	
% of clients clinically ready for discharge	3.5%	60.2%	65.8%	
Information Governance training compliance	>=95%	94.5%	91.9%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	67.9%	71.9%	

LD, ADHD & ASD

Metrics	Threshold	Aug-23	Sep-23	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	12	16	
Reducing restrictive practice interventions training compliance	>=80%	72.0%	70.9%	
Safer staffing	90%	137.3%	145.4%	
Sickness rate (Monthly)	4.5%	4.5%	2.6%	
Restraint incidents	Trend Monitor	12	9	
% rosters locked down in 6 weeks				

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) services:

Alert/Action

• Referral rates for ADHD - remain high and waiting lists continue to grow. There are currently over 4300 people waiting for an ADHD assessment. This is a national challenge.
• Referral rates for Autism - Referral rates remain high but there are minimal waits for assessment across Barnsley, Kirklees and Wakefield. This is because of the screening and triage step in place in those areas (which is a recommendation of the NHSE Guidance for ICB's published in April 2023)
• Friend & Family Test – Friends and family test is 67%↓ which represents a small decrease within month is captured work to capture the service user voice.
• West Yorkshire ICB Neurodiversity Project – the service continues to contribute to this project.

Advise

• Workforce:5.83 of 45.47 posts are vacant, 4.50 of these have been offered and recruitment checks are underway, time taken to recruit places pressure on capacity.
• A Business Case Proposal has been submitted to support Barnsley Community Paediatrics 16-18. The 17+ Pathway and funding is in the final stages of agreement.
• The collaboration with Bradford District Care Foundation Trust is also going well. Service Users are screened via a face-to-face appointment within 4 weeks of referral date.

Assure

• All KPI targets met.
• All training is above the threshold.
• Relationship with Bradford working very well.
• Excellent levels of supervision and appraisal across the team.

Learning disability services:

Alert/Action

Appraisal
• Appraisal performance remains a concern. Due to the turnover of clinical staff, line managers have now been reallocated and appraisals are planned in on the staffing roster.
• Meetings have been restructured to include increased oversight and management of performance.
• Work is underway to ensure that reporting and recording issues are addressed.

Community Services
• Resource requirements identified to support the ADHD pathway for people with a learning disability and a business case for funding currently being drafted.

ATU (Assessment & Treatment Unit)
• The speech and language therapist post remains vacant and now back out to advert.
• Improvement work undertaken on the 12-point discharge planning process.
• We continue to progress on improvement actions and the service is now assessing itself against QNLD standards (Quality Network for Inpatient Learning Disability standards) internally and are sharing both ways with the Bradford ward seeking support from national peers.

Advise

Greenlight Toolkit
Recently presented to extended EMT and is a key priority for LD.
• Analysis of feedback from the group is being undertaken.
• Local teams to link in with LD champions; this work is ongoing.

Community & ATU (Assessment & Treatment Unit)
• Challenges continue with the recruitment of specialist in Speech and Language and Occupational Therapy.
• Wakefield Local Authority have commissioned a review of LD services on behalf of the Wakefield Alliance.
• Significant improvement in medical recruitment- All 4 communities and inpatient unit have named substantive consultants.

ATU (Assessment & Treatment Unit)
• Vacancies in nursing continues to reduce but inexperience of staff continues to require resources to support.
• Improvement work continues to be embedded into the service.

Assure

• Oliver McGowan training completed by 183 staff members to date.
• Improvement of waiting lists through optimisation of SystmOne which allows service users have earlier access to the whole multidisciplinary team whilst awaiting a specific intervention.
• Increase in uptake of Annual health checkups evidenced following input from strategic health facilitators.
• Optimisation of physical health through increased liaison with primary care, Primary care Mental Health NMP's (non-medical prescribers), acute hospital liaison, STOMP (stopping over medication for people with a learning disability).
• Autism pathways firmly embedded and more MDT members contributing to cut down rising waiting lists.
• Development of locality trio leadership structures-producing locality newsletters, addressing team challenges.
• Positive culture change in the inpatient settings with higher rates of recruitment in all disciplines.

Barnsley General Community Services

Barnsley General Community Services

Metrics	Threshold	Aug-23	Sep-23	Variation/Assurance
% Appraisal rate	>=90%	79.1%	77.9%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	0% (0/0)	
% people dying in a place of their choosing	80%	81.8%	90.63%	
% of staff receiving supervision within policy guidance	80%	N/A	33.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.3%	79.4%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	
Information Governance training compliance	>=95%	96.7%	94.3%	

Barnsley General Community Services

Metrics	Threshold	Aug-23	Sep-23	Variation/Assurance
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	99.8%	99.91%	
Maximum 6 week wait for diagnostic procedures	99%	64.2%	75.30%	
Reducing restrictive practice interventions training compliance	>=80%	33.3%	100.0%	
Safer staffing (inpatient)	90%	107.9%	106.7%	
Sickness rate (Monthly)	4.5%	4.3%	5.0%	
% rosters locked down in 6 weeks				

Alert/Action

• The Band 7 Nurse Prescriber left the service in November 2022, leaving only one Nurse Prescriber. We are currently working with Pharmacy and the Walk in Centre in Wakefield, to provide cover for the service as necessary. One additional team member is also being trained.

Advise

• Current staff concerns around increase workload regarding the service level agreement (SLA) with Barnsley Hospital NHS Foundation Trust for Diabetic Foot Clinic provision. New SLA currently with trust contracting and finance team and meeting to be scheduled in October with BHNFT re staff concerns.
• Paediatric Epilepsy Nursing Service continues to face staffing pressures due to ongoing secondments and a breakdown of planned backfill for these. It is anticipated this will be resolved in the next couple of months.
• Paediatric Audiology service has now recommenced school hearing screening in September for the first time since pre-covid, but this does take a member of staff away from clinic work. We are looking to recruit staff initially on a bank basis to support service delivery. We are also reviewing our SLA with the Acute Trust to ensure we are delivering within the parameters of the SLA.
• Waits continue to be longer in children's speech and language therapy. We are recruiting to the team, with a mix of newly qualified SALT who will need additional support/supervision and an experienced SALT.
• Children's community services are deemed a priory group in terms of vulnerability for Measles exposure. If exposed, staff will require a 21-day absence from their role if they cannot provide evidence of having had 2 Measles containing vaccines or immunity to the disease. Staff are being encouraged to check with Occupational Health.
• Neuro Rehabilitation Unit staffing remains an issue. Interviews for trained staff are taking place w/c 16th October and w/c 23rd October.
• The integrated care board (ICB) led procurement exercise to source a Virtual Ward electronic remote monitoring equipment provider for the three South Yorkshire locations (Sheffield / Rotherham / Barnsley) has now concluded and a supplier has been chosen. A procurement standstill period is currently underway after which contracting discussions with the supplier will commence. SWYPFT has been asked to hold the contract for Barnsley and received a £144,000 non recurrent payment from the ICB to fund the initial first year of the contract, after which SWYPFT could exit the contract if necessary. The successful supplier has proposed a stepped costing arrangement covering the three South Yorkshire providers where individual unit costs reduce as an increased quantity of units are deployed across the three providers. Based on the 'worse case' costing scenario the £144,000 income will fund approximately 48 deployments within the first year.
• Workforce modelling is being undertaken in relation to the Intermediate Care system wide review which is being linked to best practice guidance regarding the intermediate care framework for rehabilitation, reablement and recovery.

Assure

• From early September our Neighbourhood Nursing Service (NNS) will see 20+ staff join our team over a period of 6 weeks following a successful internal recruitment drive; this will leave a minimal vacancy factor. NNS position paper to be updated end Oct 23 and reported into to EMT for update. The Trust risk will also be closed at this time.
• Live Well Wakefield (LWW) were finalists at the Health Service Journal (HSJ) Patient Safety Awards, in the 'Patient Safety in Elective Surgery' category. The service recently conducted a 'Waiting Well' pilot along with ICB and Mid Yorks colleagues – proactively offering holistic and person-centred social prescribing and support self-management interventions to the longest waiters for elective surgery (52+ weeks). Patient feedback examples:
"I think this has helped me a lot. It's made me feel as though someone cares and is bothered about me as I am sat on my own day after day and can still feel lonely even though family are in contact. It has been 100% helpful and it has cheered me up you calling again. My son even said it is nice to know someone is interested. "
"It's a really good service. I think it's not always the medical side of things people need support with. People can almost get 'stuck in a rut' and this helps to open up doors."
"I think it is very good. It has made us aware there are other things out there. It has given us a bit of hope and helped map out what might be possible (for mum)."
• Registered nurse professional lead David Yockney has been awarded the title of Queen's Nurse, which recognises a commitment to improving standards of care, and to learning and leadership.
• Barnsley NRU (Neurological Rehabilitation Unit at Kendray) – the team have been shortlisted as Care Provider of the Year in the Neuro Rehab Times awards, for their high standards of care and a commitment to supporting patients.
• Barnsley Children's Speech and Language Therapy team have won a Royal College of Speech and Language Therapists 'Giving Voice' award for their 'Hey…It's ok to stammer' campaign.
• Barnsley Community Cardiac Rehab Team have been successful in securing £50k cardiac rehab funding from South Yorkshire ICB. This pilot will look at targeting priority 4 patients to enhance the service provided and to increase service offered.
• Barnsley Community Heart Failure Team have secured £10K from South Yorkshire ICB, this bid will be used as part of an initiation of a long-term vision to enhance heart failure services within Barnsley.

Forensic Services

Forensic

Metrics	Threshold	Aug-23	Sep-23	Variation/ Assurance
% Appraisal rate	>=90%	61.7%	59.5%	
% Bed occupancy	90%	86.6%	84.1%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	0% (0/0)	
% of staff receiving supervision within policy guidance	80%	N/A	84.5%	
% Service Users on CPA with a formal review within the previous 12 months	95%	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	79.3%	76.1%	
% 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%	96.5%	94.3%	
Physical Violence (Patient on Patient)	Trend Monitor	4	2	
Physical Violence (Patient on Staff)	Trend Monitor	12	7	
Reducing restrictive practice interventions (RRPI) training compliance	>=80%	81.3%	82.0%	
Restraint incidents	Trend Monitor	18	*17*	
Safer staffing	90%	110.1%	111.8%	
Sickness rate (Monthly)	5.4%	8.3%	9.4%	
% rosters locked down in 6 weeks				

Alert/Action

• Bed Occupancy – Newton Lodge 84.56%↑, Bretton 83.86%↓, Newhaven 81.52%↓. Occupancy has been highlighted by the commissioning hub as a risk to the provider collaborative given the number of out of area placements. Work has commenced within the service to explore service user flow across the pathway.
• Sickness absence/covid absence – continues to be a concern particularly at the Bretton Centre. Managers within the service are working with the People Directorate to support staff to return to work.
• Vacancies & Turnover –Service continues to focus on recruitment and retention. Number of Band 5 vacancies has reduced although many of these are preceptees or international recruits who are not yet able to undertake their full Band 5 roles therefore the impact on reducing bank and agency is yet to be realised.

Advise

• Regular meetings continue to assimilate Forensic Child and Adolescent Mental Health Services (FCAMHS) into the West Yorkshire Provider Collaborative and the options appraisal for commissioning arrangements moving forward is in the final stages of completion.
• Mandatory training overall compliance:
    Newton Lodge – 92.3%↓
    Bretton – 90.4%↓(impacted by high sickness figures)
    Newhaven –90.1↓
The above figures represent the overall position for each service. There are hotspots for reducing restrictive physical interventions and cardiopulmonary resuscitation and targeted action plans are in place
• The roll out of trauma informed care is going well and training sessions for staff continue to be well attended the service will continue to develop the roll out with a planned phase 2.
• Appraisal (61.7%) overall and displaying a marked variation across ward areas. This will be monitored closely through the governance structures within the care group to ensure target is reached.
• The well-being of staff also 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 (assessment and management of historical clinical risk) being completed within 3 months of admission.
• Friends and family test remains green
• CPA (care programme approach) 100%
• 25 hours of meaningful activity 100%.
• All Equality Impact Assessments across Forensic Services have been completed for 23/24.

Inpatients - Mental Health - Working Age Adults

Metrics	Threshold	Beamshaw Suite	Clark Suite	Melton Suite	Nostell	Stanley	Walton	Ashdale	Ward 18	Elmdale
Sickness	4.5%	5.8%	7.8%	14.1%	1.0%	1.2%	7.2%	4.3%	4.2%	5.3%
Supervision	80%	83.3%	71.4%	100.0%	91.7%	69.2%	100.0%	53.8%	90.0%	100.0%
Information Governance training compliance	>=95%	84.0%	100.0%	76.2%	88.9%	92.0%	87.5%	89.3%	90.3%	92.0%
Reducing restrictive practice interventions training compliance	>=80%	80.0%	94.7%	85.7%	100.0%	92.0%	76.9%	89.3%	71.0%	88.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	95.0%	81.0%	88.5%	80.0%	61.5%	78.6%	77.4%	80.0%
Bed occupancy	85%	105.7%	83.3%	102.8%	94.5%	102.0%	91.4%	90.7%	97.7%	96.9%
Safer staffing	90%	116.0%	120.5%	171.3%	134.2%	114.3%	137.8%	104.5%	116.9%	106.9%
% of clients clinically ready for discharge	3.5%	10.1%	15.9%	0.0%	8.0%	23.5%	0.0%	2.3%	6.6%	4.1%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	91.7%	83.3%	No Admissions	100.0%	92.3%	100.0%	87.5%	92.3%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0	1	1	1	4	1	0
Physical Violence (Patient on Staff)	Trend Monitor	2	2	0	0	0	9	2	2	1
Restraint incidents	Trend Monitor	3	7	1	6	0	11	2	3	1
Prone Restraint incidents	Trend Monitor	1	0	0	1	0	5	1	0	0

Inpatients - Mental Health - Older People Services

Metrics	Threshold	Crofton	Poplars CUE	Willow	Ward 19 - Female	Ward 19 - Male	Beechdale
Sickness	4.5%	0.0%	6.5%	3.4%	7.3%	3.2%	9.7%
Supervision	80%	100.0%	100.0%	77.8%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	96.0%	96.2%	100.0%	90.5%	100.0%	100.0%
Reducing restrictive practice interventions training compliance	>=80%	78.3%	88.0%	76.2%	70.0%	78.3%	88.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.0%	79.2%	57.1%	50.0%	87.0%	92.0%
Bed occupancy	85%	95.2%	71.6%	84.7%	96.0%	94.9%	98.8%
Safer staffing	90%	193.0%	224.5%	106.6%	101.2%	114.0%	163.6%
% of clients clinically ready for discharge	3.5%	0.0%	39.8%	18.0%	12.8%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	71.4%	No Admissions	100.0%	100.0%	100.0%	66.7%
Physical Violence (Patient on Patient)	Trend Monitor	0	12	1	4		1
Physical Violence (Patient on Staff)	Trend Monitor	0	9	10	4		5
Restraint incidents	Trend Monitor	1	11	9	2		5
Prone Restraint incidents	Trend Monitor	0	0	0	0		0

Inpatients - Forensic - Medium Secure

Metrics	Threshold	Appleton	Bronte	Chippendale	Hepworth	Johnson	Priestley	Waterton
Sickness	5.4%	4.9%	6.9%	6.4%	3.1%	9.3%	16.2%	9.7%
Supervision	80%	90.0%	100.0%	90.9%	84.6%	100.0%	91.7%	100.0%
Information Governance training compliance	>=95%	100.0%	100.0%	95.5%	96.6%	93.1%	100.0%	86.4%
Reducing restrictive practice interventions training compliance	>=80%	83.3%	95.2%	100.0%	72.4%	86.2%	66.7%	95.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	72.0%	90.5%	86.4%	60.7%	72.4%	100.0%	68.2%
Bed occupancy	90%	75.0%	93.3%	91.7%	87.3%	86.7%	73.3%	87.5%
Safer staffing	90%	93.5%	101.4%	121.8%	98.1%	155.9%	94.7%	122.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	No Admissions	No Admissions	No Admissions	No Admissions	No Admissions	No Admissions	No Admissions
Physical Violence (Patient on Patient)	Trend Monitor	1	0	0	0	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	1	0	0	0	0
Restraint incidents	Trend Monitor	0	0	4	1	0	0	0
Prone Restraint incidents	Trend Monitor	0	0	0	0	0	0	0

Inpatients - Forensic - Low Secure

Metrics	Threshold	Thornhill	Sandal	Ryburn	Newhaven
Sickness	5.4%	26.7%	12.4%	15.0%	9.8%
Supervision	80%	12.5%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	95.7%	96.3%	100.0%	89.7%
Reducing restrictive practice interventions training compliance	>=80%	87.0%	81.5%	81.8%	79.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	69.6%	63.0%	81.8%	79.3%
Bed occupancy	85%	93.8%	71.9%	90.0%	81.3%
Safer staffing	90%	102.7%	99.5%	98.9%	125.4%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	No Admissions	No Admissions	No Admissions	No Admissions
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0	1
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0	5
Restraint incidents	Trend Monitor	0	0	0	11
Prone Restraint incidents	Trend Monitor	0	0	0	4

Inpatients - Non-Mental Health

Metrics	Threshold	NRU	SRU
Sickness	4.5%	8.9%	4.6%
Supervision	80%	76.9%	7.9%
Information Governance training compliance	>=95%	100.0%	92.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.0%	63.1%
Bed occupancy	85%	68.3%	79.2%
Safer staffing	90%	104.9%	107.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0
Restraint incidents	Trend Monitor	0	0
Prone Restraint incidents	Trend Monitor	0	0

Inpatients - Mental Health - Rehab

Metrics	Threshold	Enfield Down	Lyndhurst
Sickness	4.5%	2.1%	2.4%
Supervision	80%	100.0%	0.0%
Information Governance training compliance	>=95%	93.9%	92.0%
Reducing restrictive practice interventions training compliance	>=80%	83.3%	64.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.4%	76.0%
Bed occupancy	85%	38.8%	59.0%
Safer staffing	90%	91.7%	104.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	-	No Admissions
Physical Violence (Patient on Patient)	Trend Monitor	2	0
Physical Violence (Patient on Staff)	Trend Monitor	3	0
Restraint incidents	Trend Monitor	1	0
Prone Restraint incidents	Trend Monitor	0	0

Inpatients - Mental Health - Learning Disability

Metrics	Threshold	Horizon
Sickness	4.5%	2.7%
Supervision	80%	66.7%
Information Governance training compliance	>=95%	88.6%
Reducing restrictive practice interventions training compliance	>=80%	72.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	68.8%
Bed occupancy	N/A	50.0%
Safer staffing	90%	145.4%
% of clients clinically ready for discharge	3.5%	65.8%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	No Admissions
Physical Violence (Patient on Patient)	Trend Monitor	0
Physical Violence (Patient on Staff)	Trend Monitor	14
Restraint incidents	Trend Monitor	9
Prone Restraint incidents	Trend Monitor	0

Overall Financial Performance 2023/24

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast 2023/24	Narrative
1	**Surplus / (Deficit)**	£1.1m	£0m	A deficit of £59k been reported in September 2023 which means that the year to date surplus is now £1.1m. This is £0.2m behind plan. This position is supported by the financial position of the provider collaboratives with the core Trust position included in the report.
2	**Agency Spend**	£5.4m	£10.1m	The Trust has a target of reducing agency spend from £10.0m to £8.7m. Spend in September is £0.9m which is higher than the two preceeding months and remains above the plan trajectory. The year to date position is 18% above plan.
3	**Financial sustainability and efficiencies**	£4.3m	£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 and for the year to date is £290k behind plan. This target remains challenging due to the increasing profile and the need to identify new opportunities.
4	**Cash**	£78.9m	£76.9m	The Trust cash position remains strong at £78.9m.
5	**Capital**	£1.2m	£8.8m	Excluding the impact of the impact of IFRS 16 (leases), year to date capital expenditure is £1.2m. Expenditure is forecast to significantly increase in the next quarter and the full allocation to be utilised in year.
6	**Better Payment Practice Code**	97%		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.

Finance Report

Month 6 (2023 / 24)

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With **all of us** in mind.

Key Performance Indicator		Year to Date	Forecast 2023 / 24	Narrative
1	Surplus / (Deficit)	£1.1m	£0m	A deficit of £59k been reported in September 2023 which means that the year to date surplus is now £1.1m. This is £0.2m behind plan. This position is supported by the financial position of the provider collaboratives with the core Trust position included in the report.
2	Agency Spend	£5.4m	£10.1m	The Trust has a target of reducing agency spend from £10.0m to £8.7m. Spend in September is £0.9m which is higher than the two preceeding months and remains above the plan trajectory. The year to date position is 18% above plan.
3	Financial sustainability and efficiencies	£4.3m	£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 and for the year to date is £290k behind plan. This target remains challenging due to the increasing profile and the need to identify new opportunities.
4	Cash	£78.9m	£76.9m	The Trust cash position remains strong at £78.9m.
5	Capital	£1.2m	£8.8m	Excluding the impact of the impact of IFRS 16 (leases), year to date capital expenditure is £1.2m. Expenditure is forecast to significantly increase in the next quarter and the full allocation to be utilised in year.
6	Better Payment Practice Code	97%		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

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					32,532	32,631	99	196,317	196,747	430	392,078	392,772	695
Other Operating Revenue					1,193	1,171	(23)	6,246	6,644	398	12,652	13,077	425
Total Revenue					**33,725**	**33,802**	**77**	**202,563**	**203,391**	**828**	**404,729**	**405,849**	**1,120**
Pay Costs	4,876	4,881	6	0.1%	(20,539)	(20,414)	124	(121,810)	(121,280)	530	(245,419)	(244,845)	574
Non Pay Costs					(12,815)	(13,149)	(334)	(76,833)	(78,912)	(2,079)	(154,284)	(156,876)	(2,593)
Gain / (loss) on disposal					0	0	0	0	5	5	0	5	5
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,876**	**4,881**	**6**	**0.1%**	**(33,353)**	**(33,564)**	**(210)**	**(198,643)**	**(200,186)**	**(1,543)**	**(399,702)**	**(401,716)**	**(2,013)**
EBITDA	**4,876**	**4,881**	**6**	**0.1%**	**372**	**238**	**(133)**	**3,920**	**3,204**	**(715)**	**5,027**	**4,133**	**(894)**
Depreciation					(503)	(508)	(5)	(3,061)	(3,074)	(13)	(5,949)	(5,991)	(42)
PDC Paid					(179)	(179)	0	(1,074)	(1,074)	0	(2,148)	(2,148)	0
Interest Received					257	390	133	1,529	2,056	527	3,070	4,006	936
Surplus / (Deficit) - ICB performance measure	**4,876**	**4,881**	**6**	**0.1%**	**(53)**	**(59)**	**(6)**	**1,313**	**1,112**	**(201)**	**(0)**	**(0)**	**(0)**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(116)	(116)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,876**	**4,881**	**6**	**0.1%**	**(53)**	**(78)**	**(25)**	**1,313**	**996**	**(317)**	**(0)**	**(232)**	**(232)**

Trust Monthly I & E Profile

Trust Cumulative I & E Profile
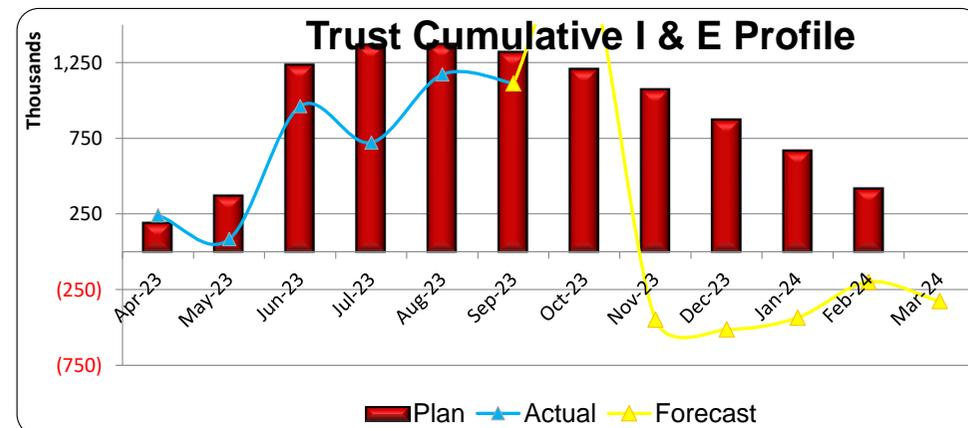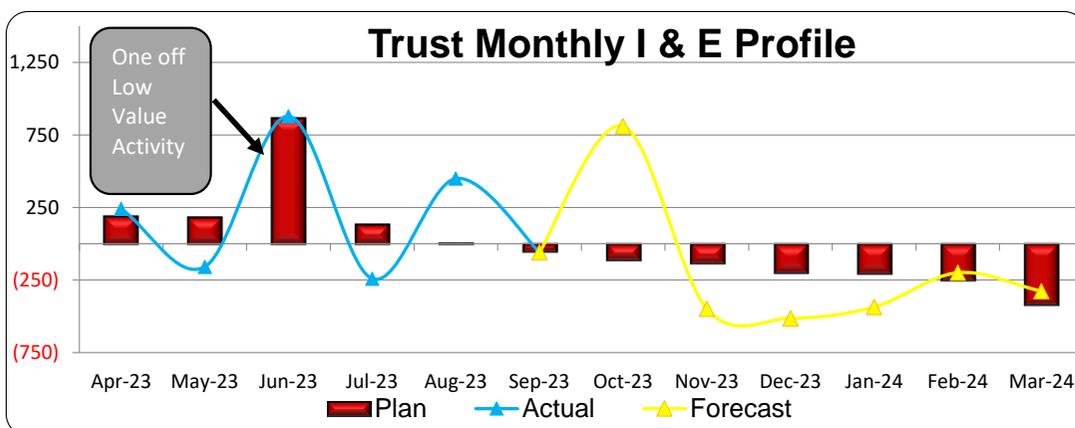
2.0	Impact of provider collaboratives

Since 2022 the Trust has taken on a co-ordinating role for a number of provider collaboratives. This has significantly increased the total income and expenditure reported within the overall consolidated financial position. The table below separately shows the relationship of Trust to collaboratives and how this consolidates to the total position. This replicates the segmental reporting approach included within the Trust Annual Accounts.

Provider Collaborative consolidation - year to date actual					
Description	Total consolidated	West Yorks Adult Secure	Forensic CAMHS	South Yorks Adult Secure	SWYPFT
	£k	£k	£k	£k	£k
Healthcare contracts	196,747	33,661	558	17,945	144,584
Other Operating Revenue	6,644				6,644
Total Revenue	203,391	33,661	558	17,945	151,228
Pay Costs	(121,280)	(795)	(62)	(366)	(120,057)
Non Pay Costs	(78,912)	(32,866)	(376)	(17,325)	(28,345)
Gain / (loss) on disposal	5				5
Impairment of Assets	0				0
Total Operating Expenses	(200,186)	(33,661)	(438)	(17,691)	(148,396)
EBITDA	3,204	0	119	253	2,831
Depreciation	(3,074)				(3,074)
PDC Paid	(1,074)				(1,074)
Interest Received	2,056				2,056
Surplus / (Deficit) - ICB	1,112	0	119	253	739
Depn Peppercorn Leases (IFRS16)	(116)				(116)
Revaluation of Assets	0				0
Surplus / (Deficit) - Total	996	0	119	253	623
Surplus / (Deficit) - Forecast	(0)	(0)	164	18	(182)

The year to date financial performance of each provider collaborative, which SWYPFT is lead for, is shown on the left.

The West Yorkshire collaboratives are subject to a financial risk / reward share agreement. This arrangement includes CAMHS and Adult Eating Disorder services which are co-ordinated by Leeds & Yorkshire Partnership NHS Foundation Trust, and at this stage are not incorporated into the reported SWYPFT financial position. The current risk is factored into the Trust forecast scenario modelling.

The South Yorkshire collaboratives do not currently have a risk / reward share arrangement and the full financial impact is shown against SWYPFT. Discussions continue to progress this issue.

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					24,008	23,945	(63)	145,297	144,584	(713)	290,061	288,825	(1,235)
Other Operating Revenue					1,193	1,171	(23)	6,246	6,644	398	12,652	13,077	425
Total Revenue					**25,201**	**25,116**	**(86)**	**151,542**	**151,228**	**(314)**	**302,712**	**301,902**	**(810)**
Pay Costs	4,853	4,848	(5)	0.1%	(20,390)	(20,194)	196	(120,891)	(120,057)	834	(243,636)	(242,324)	1,311
Non Pay Costs					(4,440)	(4,852)	(412)	(26,732)	(28,345)	(1,613)	(54,050)	(55,632)	(1,582)
Gain / (loss) on disposal					0	0	0	0	5	5	0	5	5
Impairment of Assets					0	0	0	0	0	0	0	0	0
Total Operating Expenses	**4,853**	**4,848**	**(5)**	**-0.1%**	**(24,830)**	**(25,046)**	**(216)**	**(147,623)**	**(148,396)**	**(774)**	**(297,685)**	**(297,951)**	**(266)**
EBITDA	**4,853**	**4,848**	**(5)**	**-0.1%**	**372**	**70**	**(302)**	**3,920**	**2,831**	**(1,088)**	**5,027**	**3,951**	**(1,076)**
Depreciation					(503)	(508)	(5)	(3,061)	(3,074)	(13)	(5,949)	(5,991)	(42)
PDC Paid					(179)	(179)	0	(1,074)	(1,074)	0	(2,148)	(2,148)	0
Interest Received					257	390	133	1,529	2,056	527	3,070	4,006	936
Surplus / (Deficit) - ICB performance measure	**4,853**	**4,848**	**(5)**	**-0.1%**	**(53)**	**(228)**	**(174)**	**1,313**	**739**	**(574)**	**(0)**	**(182)**	**(182)**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(116)	(116)	0	(232)	(232)
Revaluation of Assets					0	0	0	0	0	0	0	0	0
Surplus / (Deficit) - Total	**4,853**	**4,848**	**(5)**	**-0.1%**	**(53)**	**(247)**	**(194)**	**1,313**	**623**	**(690)**	**(0)**	**(414)**	**(414)**

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 various collaborative financial performances are 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 Consolidated Position	4,876	4,881	6	0.1%	(53)	(59)	(6)	1,313	1,112	(201)	(0)	(0)	(0)
Provider Collaboratives	22	33	11	49.6%	0	169	169	0	373	373	0	182	182
Total excluding Collaboratives (as shown above)	**4,853**	**4,848**	**(5)**	**-0.1%**	**(53)**	**(228)**	**(174)**	**1,313**	**739**	**(574)**	**(0)**	**(182)**	**(182)**

Income & Expenditure Position 2022 / 23

September 2023, excluding the financial impact of the provider collaboratives, is a £228k deficit. This is £174k worse 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 (both agenda for change and medic), and gap compared to commissioner income uplifts, presents a significant financial pressure to this plan position.

Payment of the medic pay award, both the income and expenditure aspects, has been made in month.

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. The most significant variances relate to activity recharges and are offset by underspends in pay / non-pay. Additional risk, such as against CQUIN performance, are included within the Trust forecast scenario modelling.

Pay

September has seen further workforce growth with 25 more worked WTE than the previous month and further forecast in the remaining 6 months. This is broadly in line with the workforce plan for the year. Expenditure remains less than budgeted due to the mix of staff recruited.

Agency spend has increased in September following 2 months of small reductions. Overall the run rate is higher than the average in 2022 / 23.

Non Pay

The non pay analysis highlights that most categories are overspent against plan although overall non pay spend is lower than the previous year. Pressures continue (both volume and inflationary cost increases) but there has been positive reductions in out of area placement spend in month which is shown within the purchase of healthcare highlight report.

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	19,968	20,628	20,005	21,138	19,895	19,895	19,881	19,881	19,911	241,772	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	2,804	2,578	2,741	2,740	2,740	2,740	2,740	2,740	2,740	32,950	26,001
Pay Award	0	0	0	0	0	0	0	0	0	0	0	0	0	9,058
Local Authority	490	516	510	318	481	453	543	540	540	553	553	552	6,049	5,311
Partnerships	514	584	546	591	472	608	446	532	532	532	532	532	6,423	5,052
Other Contract Income	197	96	144	102	144	138	137	137	135	134	134	134	1,631	2,256
Total	23,486	23,590	25,476	23,783	24,304	23,945	25,004	23,844	23,843	23,840	23,840	23,870	288,825	274,177
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	

Trust Income Profile

Low Value Activity income

Legend: Plan, Actual, Forecast
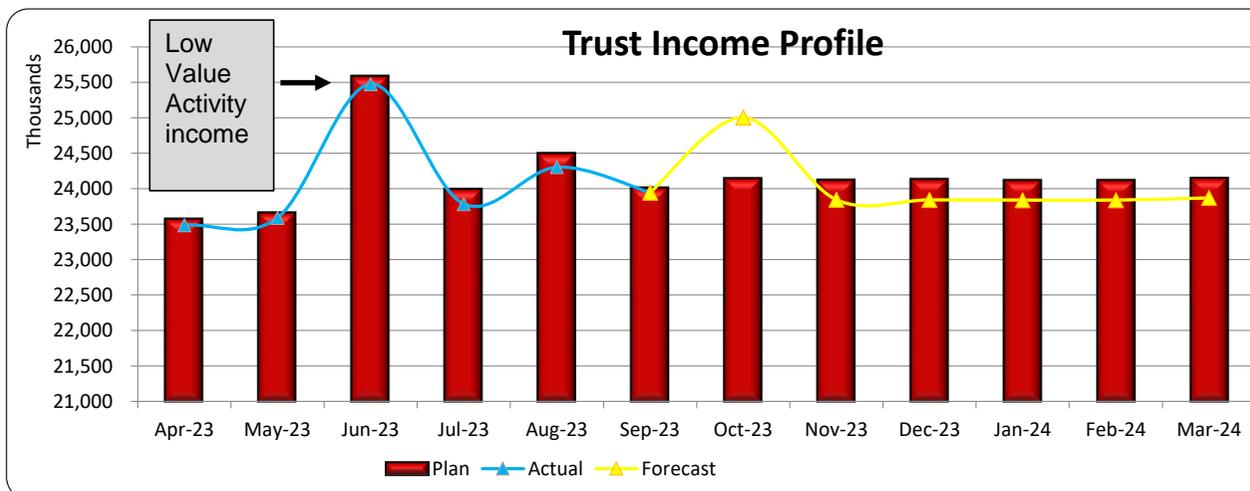
Income is in line with plan in month with no significant changes reported. Contracts with commissioners continue to progress to signature including the impact of mental health investment standard.

The Trust forecast risk scenario includes potential financial risks relating to slippage against this investment and also CQUIN performance risk.

Known shortfalls in income, against plan, are factored into the current position such as Sheffield Stop Smoking (less activity) and the Youth Offender contract (recruitment slippage). These will continue to be monitored.
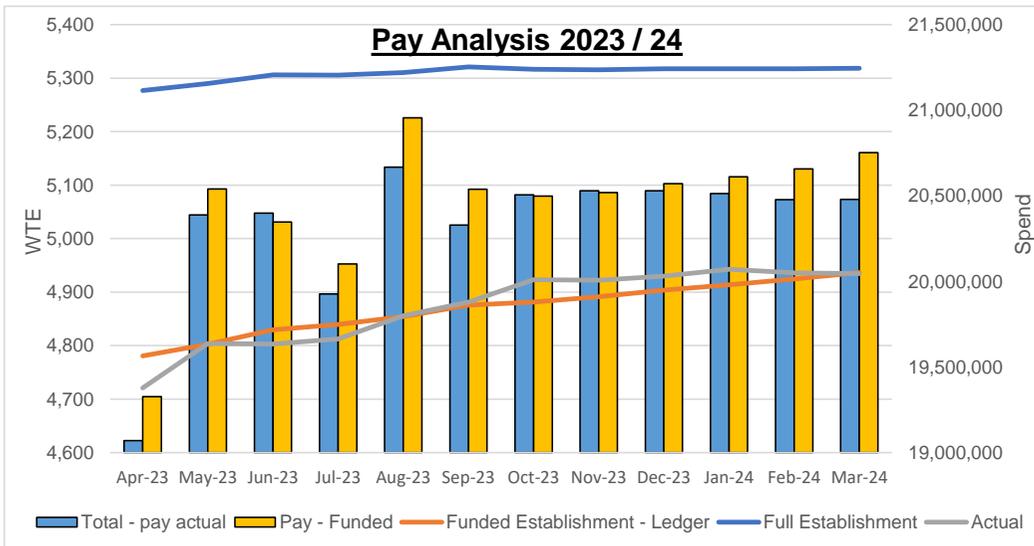
Our workforce is our greatest asset, and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities 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	17,149	18,033	17,939	17,603	18,244	17,826	18,145	18,189	18,191	18,205	18,224	18,220	215,968
Bank & Locum	849	1,355	1,337	1,360	1,481	1,454	1,389	1,390	1,391	1,407	1,399	1,407	16,219
Agency	939	908	1,002	855	810	915	837	823	821	774	727	726	10,137
Total	18,936	20,296	20,277	19,819	20,535	20,194	20,371	20,403	20,403	20,387	20,351	20,353	242,324
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

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Bank as % (in month)	4.5%	6.7%	6.6%	6.9%	7.2%	7.2%	6.8%	6.8%	6.8%	6.9%	6.9%	6.9%	6.7%
Agency as % (in month)	5.0%	4.5%	4.9%	4.3%	3.9%	4.5%	4.1%	4.0%	4.0%	3.8%	3.6%	3.6%	4.2%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,343	4,329	4,312	4,329	4,356	4,367	4,430	4,429	4,437	4,451	4,454	4,451	4,391
Bank & Locum	222	314	326	321	356	369	345	347	347	349	346	347	332
Agency	157	161	164	163	144	145	148	146	146	143	136	136	149
Total	4,721	4,804	4,803	4,812	4,856	4,881	4,923	4,922	4,930	4,943	4,936	4,934	4,872
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

Pay Analysis 2023 / 24

Legend: Total - pay actual; Pay - Funded; Funded Establishment - Ledger; Full Establishment; Actual

Overall pay expenditure remains in line with run rate. Whilst lower than last month this was due to the arrears element of the medic pay award. A similar level of expenditue is forecast for the remainder of the year with a small change from temporary to substantive staffing modelled.

Worked WTE has increased in September by 25 WTE. This was expected due to newly qualified nurse intake and continued international recruitment. This is, however, 37 WTE less than forecast last month which is reflected in the updated forecast. The forecast continues to highlight an additional 53 WTE by March 2024.

This will have an impact on the Trust medium term financial plan modelling.

The impact of recruitment on agency and bank will be seen in future months after initial induction periods of substantive staff.

Agency spend is £915k in September. 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 and the target trajectory is outlined in the graph below.

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.

September 2023 spend is £915k which is an increase on the previous two months and remains higher than plan. The main increase is in nursing (both registered and unregistered) and is within inpatient areas.

The main action remains to reduce the demand for agency staff by continued substantive recruitment. This includes reviewing recruitment, onboarding and induction programmes to ensure this is as efficient as possible. The Trust also continues to support the development of a West Yorkshire Collaborative bank to reduce the demand for agency.

Agency Spend by staff group

- Medical: 693
- Nursing: 917
- Other Clinical: 168
- A & C: 58
- Other: 10

Agency Spend - Monthly profile

Legend: Spend, Forecast, Target, Linear (Spend)
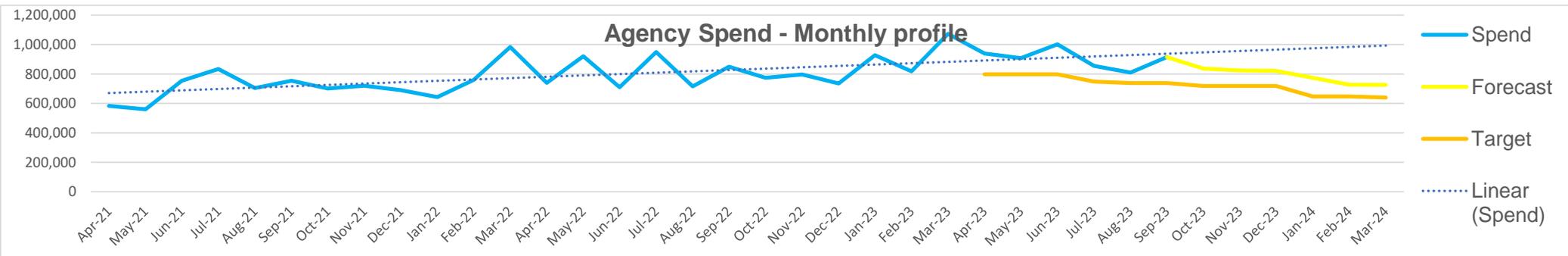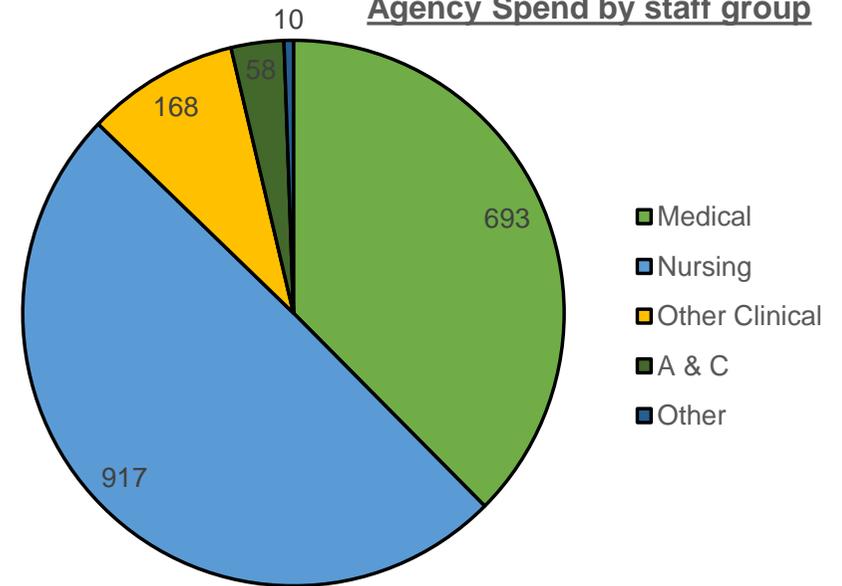
Whilst pay expenditure is the majority of Trust expenditure, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the care groups and corporate services, and excludes capital charges (depreciation and PDC) which are shown separately 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	5,035	4,097	5,016	4,621	4,724	4,852	4,480	4,622	4,659	4,557	4,453	4,516	55,632
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	2,050	1,900	(151)
Establishment	4,401	4,728	328
Lease & Property Rental	4,357	4,231	(126)
Premises (inc. rates)	2,686	2,867	180
Utilities	1,028	1,115	87
Purchase of Healthcare	4,438	4,849	411
Travel & vehicles	2,534	2,478	(56)
Supplies & Services	3,386	3,664	278
Training & Education	948	896	(52)
Clinical Negligence & Insurance	530	532	2
Other non pay	373	1,084	711
Total	26,732	28,345	1,613
Total Excl OOA and Drugs	20,243	21,596	1,353
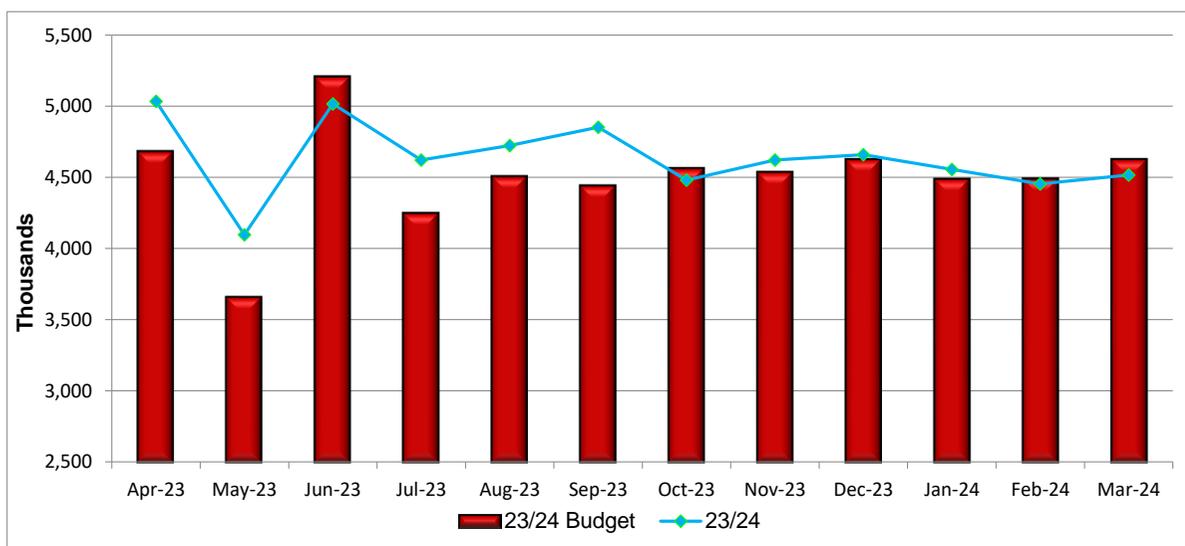
Key Messages

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. Although spend is above plan it remains at a lower level than the prior year.

The non pay review group, and general review of all expenditure, as part of the value for money workstream, continues. This will help to inform the budgets set for 2024 / 25.

Overall the purchase of healthcare, which is traditionally an area of financial pressure and continues to be reported separately, is overspent against plan. Out of area placements (adult and PICU), which forms part of this spend, is currently underspent against plan as highlighted on the focus page of this report.

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	722	1,191	469
PICU	1,911	1,246	(665)
Locked Rehab	1,141	1,340	199
Services - NHS	197	229	32
IAPT	88	250	162
Yorkshire Smokefree	40	15	(25)
Other	339	578	239
Total	**4,438**	**4,849**	**411**

Acute Out of Area placements (Bed days) Trust only

PICU Out of Area placements (Bed days) Trust only

Out of Area Placement costs - trend
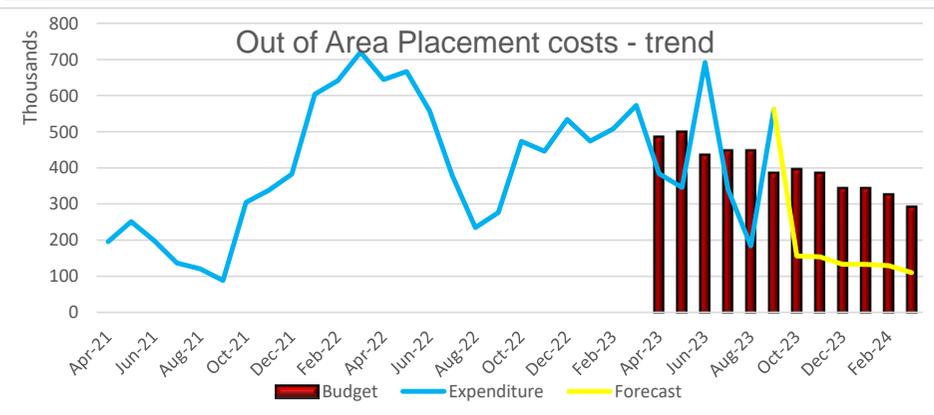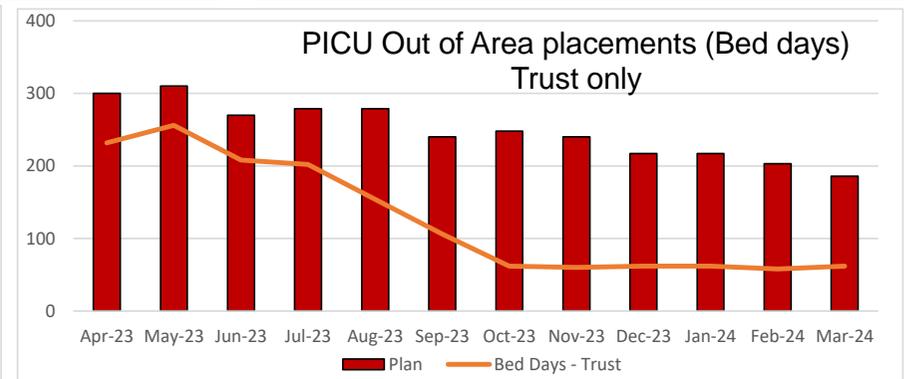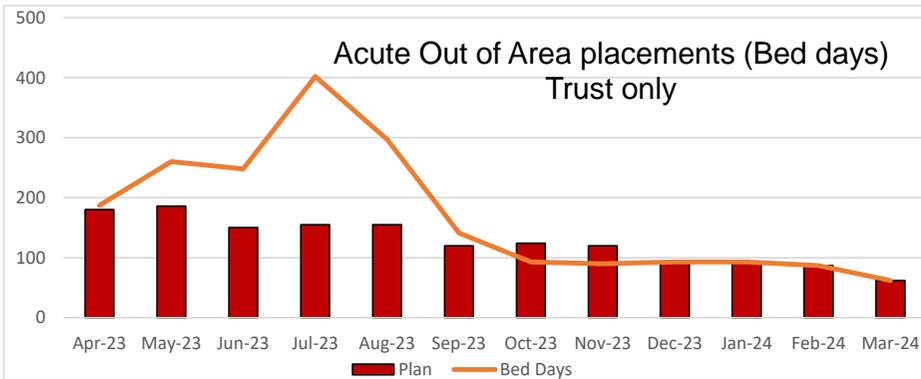
Out of area bed placements continues to be a Trust priority programme to address the operational and financial pressures that this causes.

Progress has been made in month with a continued reduction in both acute and PICU out of area placements. This is reflected in a revised trajectory for the remainder of the year; assuming an ability to maintain current levels of activity (whilst continuing to strive towards nil usage).

Due to the volatility of this area this forecast assumption remains a risk and this is factored into the Trust forecast scenarios.

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.

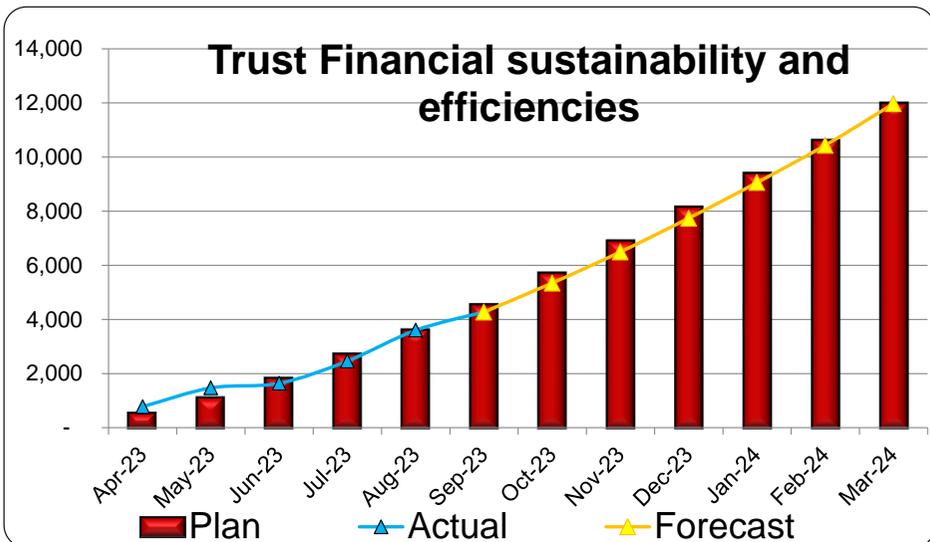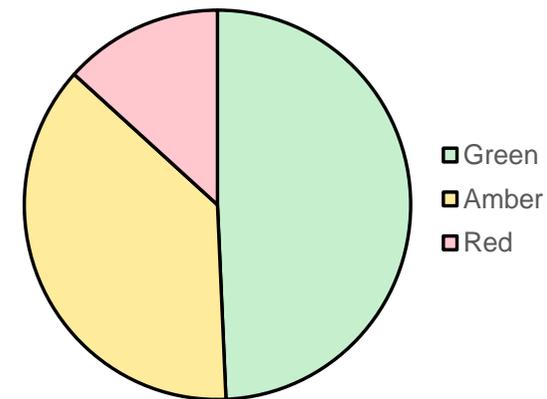| Workstream Categorisation	Breakdown	Year to Date			Forecast			
		Target	Achieved Recurrent	Achieved Non Recurrent	Target	Green	Amber	Red
Out of Area Placements	Pg. 12	1,114	1,297		3,197	1,297	3,353	
Agency & Workforce	Pg. 10	1,405	411	530	4,380	785	574	
Medicines optimisation		200	172		400	172		
Non Pay Review		375	0		1,048		550	1,592
Income contributions		252	119		500	267		
Interest Receivable	Pg. 4	700	1,227		1,400	2,336		
Provider Collaborative	Pg. 5	519	519		1,044	1,044		
Total		**4,565**	**3,744**	**530**	**11,969**	**5,901**	**4,477**	**1,592**
Recurrent		4,160	3,744		10,943	5,901	4,477	
Non Recurrent		405		530	1,026			1,592

□ Green
□ Amber
□ Red

Trust Financial sustainability and efficiencies

■ Plan —▲— Actual —▲— Forecast

Value for money performance for the year to date is £290k 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. Overall there is slippage, both year to date and forecast. There is also slippage on the non pay schemes.

These have been mitigated by better than plan performance on interest receivable, which is forecast to continue, and current out of area placements expenditure. Future months are still reported as amber due to the volatility of this area. Current performance is no guarantee of future performance.

The change in out of area forecast has reduced the outstanding schemes required, and marked as red, by £1.3m to £1.6m.

Balance Sheet / Statement of Financial Position (SOFP)	2022 / 2023 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	165,175	165,502	1
Current Assets			
Inventories & Work in Progress	231	231	
NHS Trade Receivables (Debtors)	1,574	735	
Non NHS Trade Receivables (Debtors)	2,853	2,803	
Prepayments	3,482	4,411	
Accrued Income	9,372	2,039	2
Cash and Cash Equivalents	74,585	78,935	Pg 15
Total Current Assets	**92,097**	**89,155**	
Current Liabilities			
Trade Payables (Creditors)	(6,524)	(8,893)	3
Capital Payables (Creditors)	(739)	(337)	
Tax, NI, Pension Payables, PDC	(7,696)	(8,498)	4
Accruals	(32,952)	(26,565)	4
Deferred Income	(4,172)	(1,772)	
Other Liabilities (IFRS 16 / leases)	(51,979)	(54,356)	1
Total Current Liabilities	**(104,062)**	**(100,420)**	
Net Current Assets/Liabilities	**(11,965)**	**(11,265)**	
Total Assets less Current Liabilities	**153,210**	**154,237**	
Provisions for Liabilities	(4,319)	(4,349)	
Total Net Assets/(Liabilities)	**148,891**	**149,888**	
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	84,984	
Total Taxpayers' Equity	**148,891**	**149,888**	

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, and maintaining at a low level, remains a focus in order to reduce risk and maximise cash balances. This has reduced in month but remains a focus to ensure timely raising of invoices.

3. Trade payables remain high, £2.8m relates to purchase orders receipted but not invoiced. Housekeeping continues for any old orders that need closing. This is a reduction from £3.4m reported at month 5.

4. Accruals remain at a high level, work is ongoing to ensure that invoices are received and processed. NHS accruals have reduced ahead of the month 6 Agreement of Balances exercise as invoices have been received.

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	575	(900)
Seclusion rooms	750	100	22	(78)	750	0
Maintenance (Minor) Capital						
Clinical Improvement	285	165	2	(163)	853	568
Safety inc. ligature & IPC	990	390	419	29	2,282	1,292
Compliance	430	430	0	(430)	300	(130)
Backlog maintenance	510	0	0	0	150	(360)
Sustainability	300	0	8	8	225	(75)
Plant & Equipment	40	40	28	(12)	53	13
Other	1,223	142	754	612	814	(409)
IM & T						
Digital Infrastructure	1,100	500	5	(496)	1,200	100
Digital Care Records	180	30	0	(30)	70	(110)
Digitally Enabled Workforce	815	336	0	(336)	815	1
Digitally Enabling Service Users & Carers	400	100	1	(99)	400	0
IM&T Other	270	120	0	(120)	280	10
TOTALS	**8,768**	**2,353**	**1,238**	**(1,114)**	**8,768**	**0**
Lease Impact (IFRS 16)	5,203	5,203	6,085	882	6,085	882
New lease	303	293	300	7	324	21
TOTALS	**14,274**	**7,849**	**7,623**	**(225)**	**15,176**	**903**

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 current ICB capital allocation so is presented below the line here.

Updated guidance is expected in this area which may have a significant impact on the Trust capital allocation. This risk will be captured once known.

Capital Programme 2023 / 2024 Cumulative Profile (exc. leases)
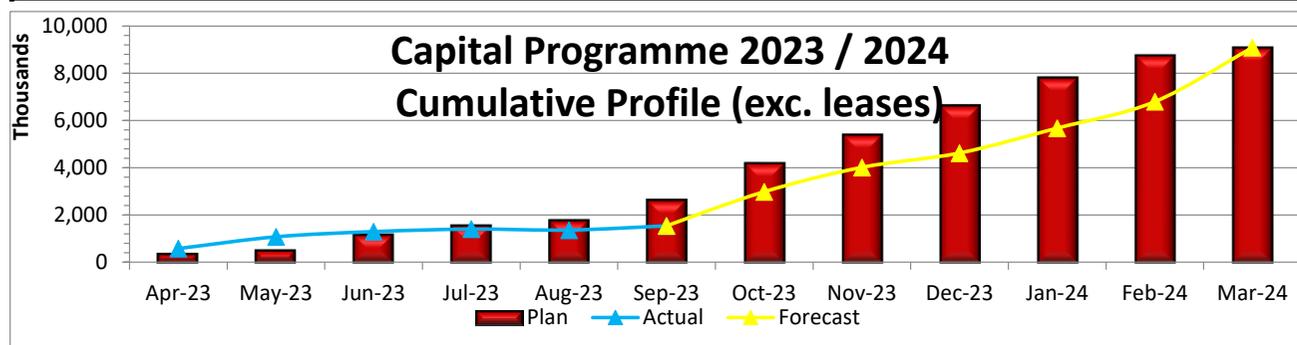
The Trust cash position remains positive.
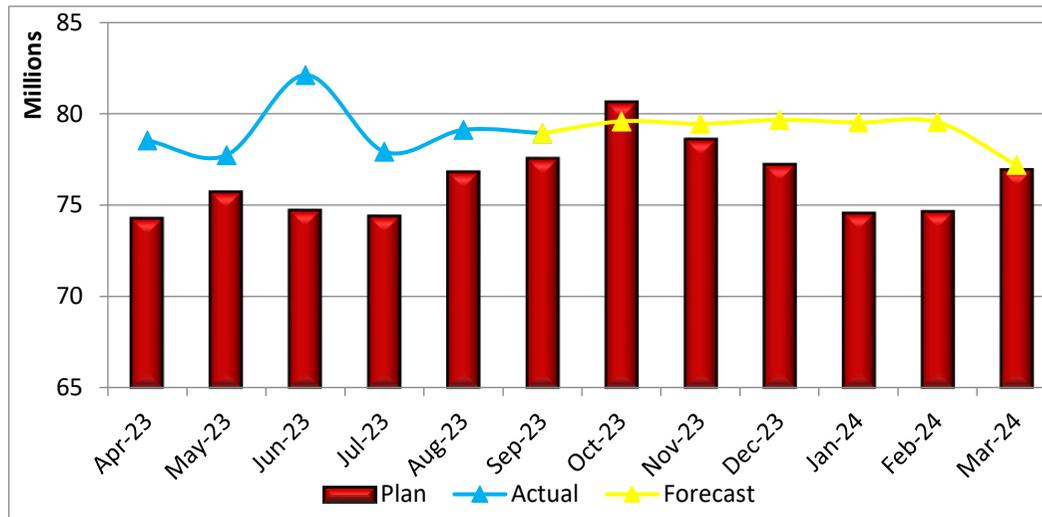
	Plan £k	Actual £k	Variance £k
Opening Balance	74,585	74,585	
Closing Balance	77,549	78,935	1,387

Cash balances remain high as the delays in the capital programme mean less cash than planned has been spent.

The Trust continues to monitor interest rates to assess the optium time to invest.
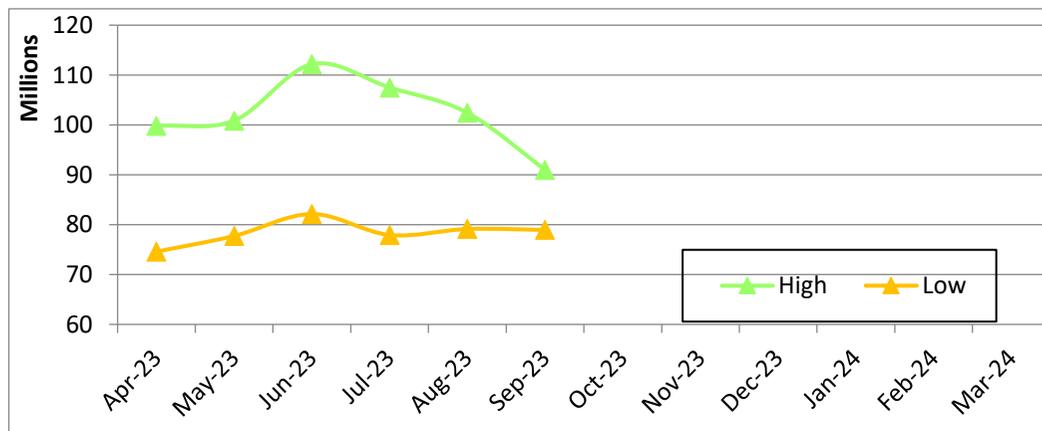
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £91m
The lowest balance is: £78.9m

This reflects cash balances built up from historical surpluses.

	Plan £k	Actual £k	Variance £k	Note
3.3			**Reconciliation of Cashflow to Cashflow Plan**	
Opening Balances	**74,585**	**74,585**	**0**	
Surplus / Deficit (Exc. non-cash items & revaluation)	8,402	7,599	(803)	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(1,747)	6,905	8,652	
Trade Payables (Creditors)	850	(3,619)	(4,469)	
Other Payables (Creditors)	0	0	0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	460	(2,369)	(2,829)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(6,530)	(1,238)	5,292	
Cash receipts from asset sales	0	5	5	
Leases	0	(4,297)	(4,297)	
PDC Dividends paid	0	(691)	(691)	
PDC Dividends received	0		0	
Interest (paid)/ received	1,529	2,056	527	
Closing Balances	**77,549**	**78,935**	**1,387**	

Cash Bridge 2023 / 2024
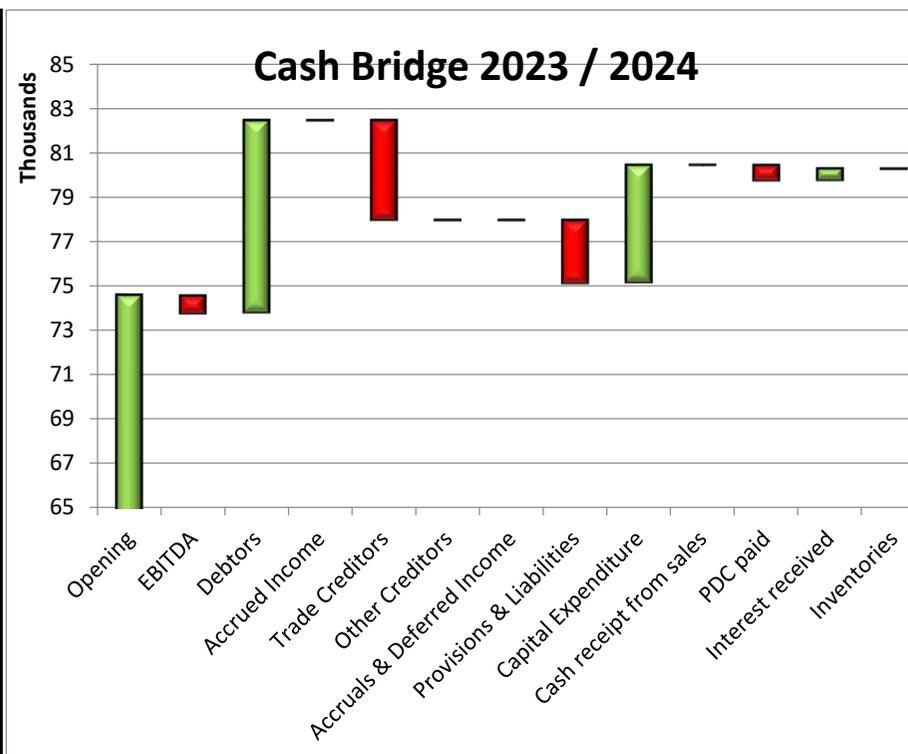
The table above summarises the reasons for the movement in the Trust cash position during 2023 / 2024. This is also presented graphically within the cash bridge.

Cash is £2.3m higher than plan, capital is a driver behind this as we are behind plan and this will continue for the next quarter.

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 continues to be monitored to ensure that recent action to improve performance continues to have a positive effect.

NHS	Number %	Value %
In Month	99%	96%
Cumulative Year to Date	98%	95%

Non NHS	Number %	Value %
In Month	98%	95%
Cumulative Year to Date	97%	96%
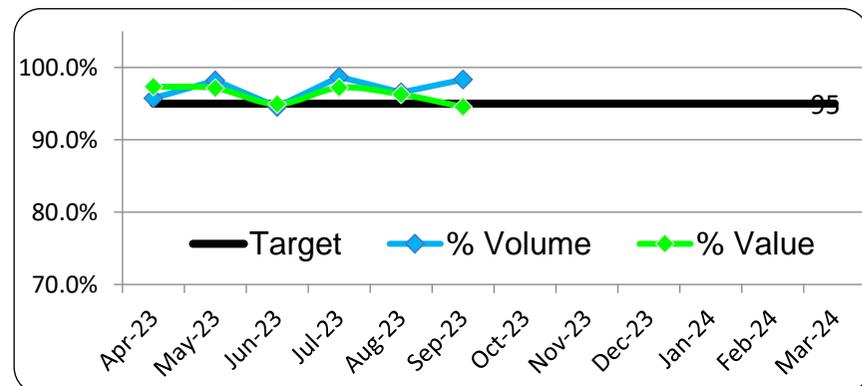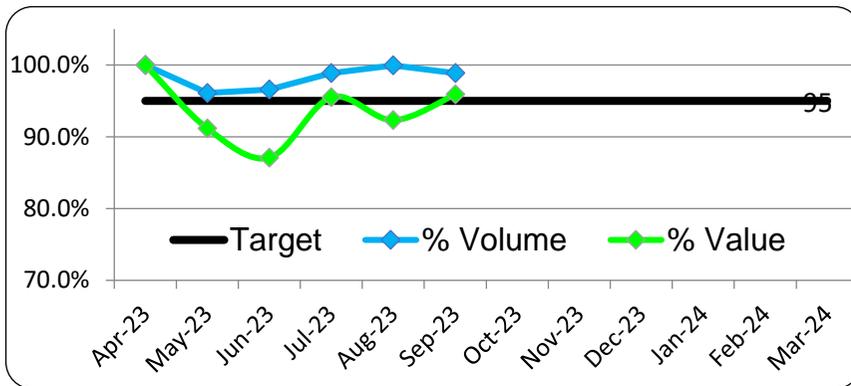
4.1			**Transparency Disclosure**		

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 (£)
26-Sep-23	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	0000000180	1,609,982
27-Sep-23	Staff Recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	1600024487	1,217,951
04-Sep-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5129	800,000
27-Sep-23	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	1000057368	735,182
28-Sep-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1000205	666,894
19-Sep-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS38	544,330
20-Sep-23	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	203579	519,424
27-Sep-23	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	0000000236	319,139
01-Sep-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008272	304,634
19-Sep-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS15	270,000
11-Sep-23	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 276	237,938
08-Sep-23	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber NHS Four	4400000380	230,447
28-Sep-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5175	150,393
01-Sep-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510008268	116,303
12-Sep-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	SYSEC016INV	96,290
06-Sep-23	Computer Licence	Trustwide	Datix Ltd	INRLDUK001333	93,813
27-Sep-23	Drugs	Trustwide	Bradford Teaching Hospitals NHS Foundation Trus	324776	91,180
18-Sep-23	NHS Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710178406	90,465
11-Sep-23	IT Services	Trustwide	Daisy Corporate Services	3I514760	90,250
18-Sep-23	NHS Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710178221	87,514
25-Sep-23	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare NHS Trust	4000000004	82,279
11-Sep-23	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS036SN	74,946
18-Sep-23	External Audit	Trustwide	Deloitte Llp	8003945697	69,816
28-Sep-23	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership NHS Foundation Trust	1000204	64,961
27-Sep-23	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	0000000205	64,703
13-Sep-23	Staff Recharge	Forensic	Wakefield Metropolitan District Council	91314999256	58,691
20-Sep-23	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5148	58,340
20-Sep-23	Utilities	Trustwide	Edf Energy Customers Ltd	000016421040	56,773
27-Sep-23	Purchase of Healthcare	Kirklees	Kirklees Council	8608264389	56,500
23-Sep-23	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	128 11210	56,000
21-Sep-23	Drugs	Trustwide	NHS Business Services Authority	1000078146	54,628

05-Sep-23	Purchase of Healthcare	AS Collaborative	Mersey Care NHS Foundation Trust	72485819	47,313
27-Sep-23	Purchase of Healthcare	AS Collaborative	Sheffield Health & Social Care NHS Foundation Tr	0000000237	46,624
27-Sep-23	NHS Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6027148	45,376
20-Sep-23	Utilities	Trustwide	Edf Energy Customers Ltd	000016581519	44,115
27-Sep-23	Insurance Cost	Trustwide	Willis Ltd	10958GP23000001PRM	40,081
26-Sep-23	Purchase of Healthcare	AS Collaborative	Bradford District Care NHS Foundation Trust	203621	38,038
12-Sep-23	Consultancy	Trustwide	Liaison Financial Services Ltd	34791	36,385
01-Sep-23	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001069EPC	35,280
29-Sep-23	Mobile charges	Trustwide	Vodafone Ltd	104575255	33,986
27-Sep-23	Purchase of Healthcare	Kirklees	Huntercombe Roehampton Hospital Ltd (The)	24309671A	32,595
12-Sep-23	Purchase of Healthcare	Forensic	Humber Teaching NHS Foundation Trust	59893469	30,255
13-Sep-23	Purchase of Healthcare	Calderdale	Cygnet Health Care Ltd	WKE0305866	28,693
01-Sep-23	Purchase of Healthcare	Kirklees	Ieso Digital Health Ltd	UK001359	28,672
05-Sep-23	Purchase of Healthcare	Kirklees	Cheadle Royal Hospital	2900022884	26,955
20-Sep-23	Utilities	Trustwide	Edf Energy Customers Ltd	000016581575	26,211

* 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.

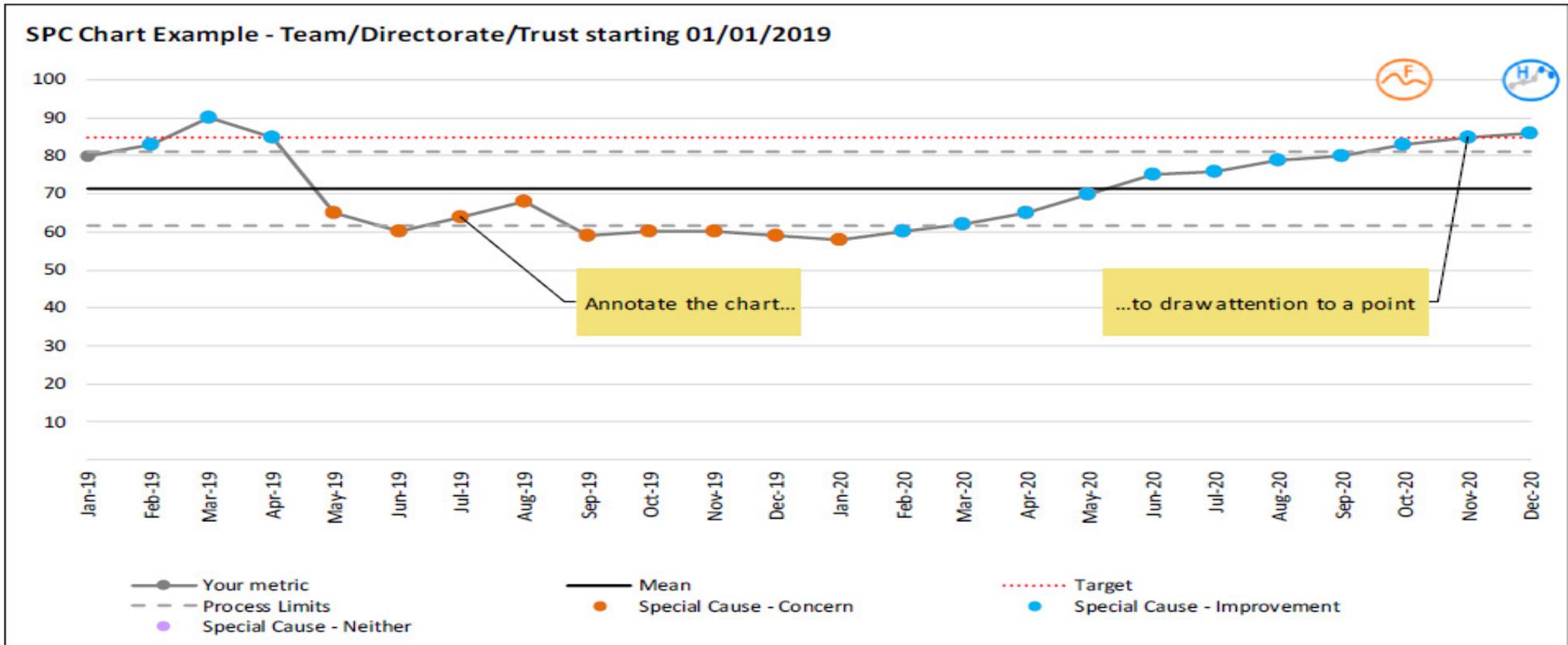## Appendix 2 - Statistical Process Control (SPC) Charts Explained

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	(icon)	?	H	L	H	L	(icon) ?	F	P
SIMPLE ICON	● ● ●	● ?HL ●	● 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

SPC Chart Example - Team/Directorate/Trust starting 01/01/2019

Legend:
- ——●—— Your metric
- — — — Process Limits
- ● Special Cause - Neither
- —— Mean
- ● Special Cause - Concern
- ·········· Target
- ● Special Cause - Improvement

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.

Trust Board 31 October 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 Dawn Lawson – 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):	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 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. 3.1-Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. 3.2-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.

With **all of us** in mind.

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.**

Trust Board 31 October 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 development meeting of 4th October 2023 Key items discussed were: • A focus on quality improvement methodology and the Integrated Care Board's role in improvement. • The financial position across South Yorkshire. • A general update from the Chief Executive, including industrial action and status of the process to agree a new operating model.
Date of next meeting	Next meeting in public is scheduled for 1st November 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 13th September 2023 Key items discussed included: • Lived experience story. • Managing Director report. Key updates included: o Development of an updated national mental health strategy which will follow the existing Long-Term Plan.

<table>
<tr><td></td><td>

- o NHS Confederation Report "The state of integrated care systems 2022/23: Riding the storm".
- o Major Conditions Strategy.
- o Perinatal mental health- there was an opportunity to host six more perinatal beds in the Yorkshire & Humber region. Following NHSE's formal review process the decision was to support the proposal from Leeds and York Partnership NHS Foundation Trust (LYPFT) to site the six additional mother and baby unit (MBU) beds in Leeds as an expansion to the existing MBU service at the Mount Hospital, co-located alongside other specialist Mental Health inpatients wards. Implications for the South Yorkshire population are being considered and partner representatives will be part of the governance structure that is being developed.
- Deliverables for the four objectives
  - o Neurodiversity.
  - o Health based place of safety.
  - o Learning Disabilities – community of practice and stopping over-medication of people with a learning disability, autism, or both (STOMP).
- South Yorkshire (SY) Provider Collaborative Operating Model.
- Future commissioning role for the provider collaborative:
  - o Co-commissioning approach to eating disorders.
  - o Commissioning Hub arrangement.
  - o Longer term development of commissioning.
- ICB Feedback.
- Parity of Esteem.

</td></tr>
<tr><td>**Date of next meeting**</td><td>Next meeting scheduled for 8th November 2023.</td></tr>
</table>

4. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

<table>
<tr><td>**Member**</td><td>Chief Executive and Chair</td></tr>
<tr><td>**Items discussed**</td><td>

Update from meeting on 28th September 2023

Key items discussed included:

- Story from our communities- eating disorders.
- Questions from the public.
- Place Director update and Place achievements.
  - o ICB Running Cost Allowance Programme- the staff consultation has started and aims to conclude by 23rd October 2023.
  - o Maternity Services at Barnsley Hospital were inspected by the CQC recently with the report published in September. The hospital was rated good across the domains of effective, caring, well led and responsive.

</td></tr>
</table>

	o All organisations will have concluded their individual estates plans by the end of Quarter 3. Overall utilisation analysis is underway alongside leasing arrangements. • Feedback from South Yorkshire Integrated Care Partnership Board. • Eating disorders. • Homeless Prevention Strategy. • Transition of Pharmacy, Optometry and Dentistry. • Quality and safety report. • Board assurance framework, risk register and issues log. • Finance update. • Performance dashboard (including SY ICB Performance Report).
Date of next meeting	Next meeting scheduled for 26th October 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 10th October 2023
	
	 Key items discussed included:
	
	 • Draft Housing Strategy.
	     o The draft strategy was shared.
	     o The strategy has 4 pillars: maximising existing housing, supporting strong and resilient communities, supporting people to live healthy and independent lives, and enabling sustainable housing growth to meet need.
	     o Consultation will commence on Monday 16th October for 4 weeks.
	 • Smoking cessation update.
	 • Barnsley Hospital action plan for improving public health and reducing health inequalities update September 2023.
	 • Feedback and reflections from organisational development day.
	 • Escalations from other subgroups.
	 • Escalations for Partnership Board.

Date of next meeting	Next meeting scheduled for 14th November 2023.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair, and Interim Director of Strategy and Change

Items discussed	The Barnsley Community Health and Care Alliance meets bi-monthly. In September, a Development Session was held with focus on neighbourhood working and organisational development.
	
	Update from meeting on 30th August 2023
	
	Agenda items included:
	
	• NHS Joint Forward Plan for South Yorkshire.
	• Learning Disability annual health checks.
	• Severe Mental Illness annual health checks.
	• Frailty & Dementia.
	• Partnership working with social care:
	    o Urgent Response integrated service offer.
	    o Cudworth co-location project.
	• Alliance organisational development – Stage One Report.
	• Key messages for Place Based Delivery Group.
	
	Planned agenda for meeting of 25th October 2023
	
	Agenda items include:
	
	• Frailty and Dementia.
	• Urgent Response Services out of hours integration.
	• Connecting Care approach.
	• Development session update: Ward Alliances and risk management
	• OD update.
	• Key messages for Place Based Delivery Group

Date of next meeting	Next meeting scheduled for 29th November 2023 (Development Session)

Barnsley Health and Wellbeing Board

Invited observer	Interim Director of Strategy and Change
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.

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:	Mark Brooks- Chief Executive Sean Rayner- Director of Provider Development
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning
Mission/values:	The development of joined-up care through Place and system working is central to the Trust's strategy, and is supportive of our mission - to help people reach their potential and live well in their community. The Trust Values are central to our approach to partnership working.
Purpose:	The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership focusing on developments that are of importance or relevance to the Trust. The paper also includes an update on key developments in the three districts in West Yorkshire where the Trust provides services (Calderdale, Wakefield, Kirklees).

Strategic objectives:	Improve Care	√	
	Improve Health	√	
	Improve Resources	√	
	Make this a great place to work		

BAF Risk(s):	1.1- 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.
	1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision.
	3.1-Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively.
	3.2-Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.

With **all of us** in mind.

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:	West Yorkshire Health and Care Partnership is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, hospices, charities and the voluntary, community and social enterprise sector to improve the health and wellbeing of people living in West Yorkshire's five districts. NHS West Yorkshire Integrated Care Board (ICB) became a statutory organisation on the 1 July 2022. The ICB has responsibility to commission the majority of NHS services for the WY population. Each of the five place-based partnerships in WY has an integrated care board committee to make decisions, similar to the NHS West Yorkshire Integrated Care Board. All nomination and appointment processes to the Board include a commitment to improve the diversity of the WY Partnership's leadership and to ensure a spread of representation across places. Work continues in each of the Trust's three districts' partnerships 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 partnership meetings.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the update on the development of Integrated Care Systems and collaborations:** o **West Yorkshire Health and Care Partnership.** o **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.** • **Receive the minutes of relevant partnership boards/committees.**

Trust Board 31 October 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 where the Trust provides services (Calderdale, Wakefield, Kirklees).

West Yorkshire Health and Care Partnership is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, hospices, charities and the voluntary community and social enterprise sector to improve the health and wellbeing of people living in West Yorkshire's five districts.

NHS West Yorkshire Integrated Care Board (ICB) became a statutory organisation on the 1 July 2022. The ICB has responsibility to commission the majority of NHS services for the WY population. Each of the five place-based partnerships in WY has an integrated care board committee to make decisions, similar to the NHS West Yorkshire Integrated Care Board.

All nomination and appointment processes to the Board include a commitment to improve the diversity of the WY Partnership's leadership and to ensure a spread of representation across places. Work continues in each of the Trust's three districts' partnerships 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 partnership 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 19th September 2023 Agenda items included: • People at the heart of Integrated Care Board (ICB) decision-making one year review. An update on progress in ensuring that people and communities of West Yorkshire are central to the ICB's decision making. • Focus on the Mental Health, Learning Disabilities and Autism Sector in West Yorkshire. A paper for this item can be found in the meeting papers at agenda item 6. • Chair's report. • Chief Executive's report. • System performance. • Winter planning 2023/24. • Committee 'AAA' reports. • Governance. o West Yorkshire ICB Transformation Committee / Bradford District and Craven ICB Place Committee Terms of Reference. o Governance approach for older people's mental health in-patient reconfiguration across Calderdale, Kirklees & Wakefield Places (agenda item 12 (b)).
Date of next meeting	Next meeting scheduled for 21st November 2023.
Further information:	NHS West Yorkshire ICB Board Meeting - 19 September 2023 :: West Yorkshire Health & Care Partnership

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	Update from meeting of 5th September Agenda items included: • Update from the Partnership Chief Executive Lead. Key updates included: o The government has ordered an independent inquiry into the circumstances behind the events at the Countess of Chester Hospital. An open letter to staff employed by the NHS West Yorkshire ICB has been issued to reinforce the fundamentals of the freedom to speak up. o Industrial action has continued throughout the summer. Doctors in training, consultants and the

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	Society of Radiographers have all taken strike action on a number of periods in June, July and August 2023. A significant amount of work has continued across the whole system to mitigate the impact of strike action and keep people safe, including the running of urgent and emergency care. o Winter planning. • Partnership Agreement between the West Yorkshire Combined Authority and the NHS West Yorkshire Integrated Care Board- members of the Partnership Board were asked to note the final, signed version of the Partnership Agreement • Patient and public voice. • West Yorkshire People Board Update. • Partnership ambitions.
Date of next meeting	Next meeting scheduled for 5th December 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-5-september-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 10th October 2023
	
	Agenda items included:
	
	• Chair's update
	    o Challenges for ICB colleagues currently going through the ICB operating framework staff consultation were acknowledged.
	    o Support was confirmed for Bradford District Care NHS Foundation Trust (BDCT) to coordinate work across West Yorkshire to determine the best use of NHSE funding for mental health services for victims of sexual assault. Scoping work is being undertaken this financial year, and it is proposed that a West Yorkshire service commissioned by BDCT on behalf of the WY partnership will be implemented next financial year.
	    o The issues being presented for Children and Young People's Gender Dysphoria services were acknowledged, and discussions are taking place between ICB and Collaborative partners.

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	o The delay in Strategic Development Funding (SDF) funding becoming 'baselined' was noted, and confirmation from NHSE that mental health and learning disability SDF should still be treated as recurrent funding streams that will eventually become baselined.
	
	• Children and young people's mental health in acute settings - an overview presentation was given, and update on the work relating to training, improvements to resources on wards and the role of Mental Health Champions.
	
	• Children and young people's mental health:
	   o An overview presentation of recent multi-disciplinary crisis events was shared, and reflections on the feedback and learning so far. Two events have been held, with a final event planned for December.
	   o A presentation was shared on the My Needs App. It was agreed to continue work to build the basic prototype and test within a couple of areas, before considering learning and whether there is a viable case to proceed further.
	
	• Community Mental Health Transformation – an update presentation was given.
	
	• Yorkshire Ambulance Service (YAS) - a presentation was shared which included update on the new YAS 2025-2029 strategy development process.
	
	• Older people's mental health.
	
	• Neurodiversity Programme - a presentation was shared. This included a breakdown of NHS provider workforce and the variation between services for children and young people and adults, and considering how new roles might support recruitment to vacancies. Discussions are taking place with primary care regarding how to develop quality assured shared care processes as part of a consistent WY commissioning framework. A summit is planned for 4th December - *Working together to improve access, assessment and support for neurodivergent people.*
	
	• Complex rehabilitation - Enhanced Care Reviews are demonstrating that fewer people require locked rehab than initially thought if they can be well supported by CREST and relevant local options, remaining in the community. A workshop is planned for 6th November.
	
	• Planning and performance.
	
	• AAA reports - these were received for NHS 111 for mental health, Maternal Mental Health (and funding paper for Place 'sign off'), Perinatal Mental Health, Transforming Care Programme, Children and Young People's Mental Health, and Secondary Care Pathways (mental health).

Date of next meeting	Next meeting scheduled for 14th November 2023.

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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 7th September 2023
	
	Key items discussed included:
	
	• Report of the Place Lead. Key updates included:
	    o Launch of the integrated care strategy and joint forward plan - the Five-year Integrated Care Strategy and NHS Joint Forward Plan are now available to view on the Partnership's website https://www.wypartnership.co.uk/publications.
	    o NHS West Yorkshire Integrated Care Board – Freedom to Speak Up. Following the recent Lucy Letby case, Freedom to Speak Up has been highlighted as a way that staff will be heard as part of a culture of positive reporting of incidents and issues.
	    o Anna Hartley, Director of Public Health is due to leave in the autumn to take up a new role. Steve Turnbull has been appointed Interim Director of Public Health for Wakefield District.
	    o The Big Conversation report has now been published.
	    o The Proud to Be You campaign has been developed by the People Alliance's Belonging Group as a toolkit to help all partner organisations explain to colleagues why they should update their equalities information on their HR systems and what this data is used for.
	    o Wakefield District Health and Care Partnership People Plan has been launched.
	    o Wakefield District Safeguarding Adults Board (WDSAB) Annual Report for 2022-23 was shared.
	• Report from the Chair of the Transformation and Delivery Collaborative (formerly Provider Collaborative).
	    o The TDC will oversee the delivery of the 3-year Transformation Delivery Plan on behalf of the Wakefield District Health and Care Partnership Committee.
	    o A number of Alliances and Programmes (including the Mental Health Alliance) have volunteered to test out a new maturity matrix which has been co-designed to support all types and sizes of partnership groups to accelerate

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	the benefits they can deliver for their populations.
	
	 o The latest quarterly figures on maternal smoking released at the end of July show that for this quarter it has fallen to 12.1 per cent.
	
	 • High risk adult update
	    o High-risk adult (HRA) patients are those with a previous hospital admission in the last three years that exceeded 14 days.
	    o There is an opportunity to use data to try and identify the precursors and shift the intervention model further to the 'left'.
	
	 • Older People's Mental Health Inpatient Service transformation – Calderdale Kirklees and Wakefield Joint Committee. The committee endorsed the recommendation to establish a Joint Committee of Calderdale, Kirklees & Wakefield, by the WYICB Board as a decision specific WY ICB Board sub-committee.
	
	 • Winter Resilience 2023 - Four priority areas selected for winter for Wakefield District are frailty, inpatient flow and length of stay (LOS), intermediate care demand, and capacity and single point of access.
	
	 • Summary of 2022/23 quarter 1 quality, safety and experience report.
	
	 • Performance exception report - Autism Spectrum Disorder (ASD) waiting times continue to remain high.
	
	 • Finance update.
	
	 • Wakefield Place risk register.
	
	 <u>Update from joint Development Session Wakefield District Health and Care Partnership Committee and Wakefield Health and Wellbeing Board 19th October 2023</u>
	
	 The focus of the session was on the local voluntary, community and social enterprise sector (VCSE) to promote understanding of the VCSE sector in Wakefield district, its contributions, challenges and opportunities.

Date of next meeting	Next meeting scheduled for 2nd November 2023.
Further information	Meeting papers are available here: <u>Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk)</u> <u>https://www.wakefielddistricthcp.co.uk/wp-content/uploads/2023/08/WDHCP-Committee-7-Sep-23-Meeting-Pack-1.pdf</u>

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Transformation and Delivery Collaborative (formerly Wakefield Provider Collaborative)

Member	General Manager, Wakefield Community Services
Items discussed	There have been two meetings of the Transformation and Delivery Collaborative since the last update to Board. Update from meeting on 26th September 2023 Key items discussed included: • Programme highlight reporting - escalations from alliances/programmes by exception. • Business case overview. • Older people's mental health inpatient transformation. • Business case - adult ADHD. • Business case - dementia. • Business case - end of life. • Business case - bereavement. • Business case - workforce planning tool. • Business case - workforce PMO capacity. • Business case - children's autism pathway. • Items for escalation to Wakefield District Health & Care Partnership Committee. Update from meeting on 17th October 2023 • Key items discussed included: • Programme highlight reporting - escalations from alliances/programmes by exception. • Embedding quality in priority programmes. • NHS Impact Tools. • Children's September Surge. • Transformation Delivery Plan and outcomes framework. • Reducing Healthcare Inequalities Steering Group. • Urgent and Emergency Care redesign model – phase 1 • Items for escalation to Wakefield District Health & Care Partnership Committee.
Date of next meeting	Next meeting scheduled for 21st November 2023.

Wakefield Mental Health Alliance

Member	Director of Provider Development (Chair), with Trust representative as a member.

Items discussed	Update from meeting on 18th October 2023 is as follows:
	
	• Mental Health Alliance performance dashboard.
	• Standing item updates.
	    o Mental Health Emergency Dept Strategy Group.
	    o Older People and Dementia Group.
	    o Community Mental Health Transformation.

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	o NHS 111 roll out. • Mental Health Alliance stakeholder meeting update. • Dementia ready taskforce update. • Proposed Alliance development session. • Review of Mental Health Alliance Partnership Agreement and Terms of Reference. • Long Term Plan review. • Lived experience videos. • 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 15th November 2023.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Provider Development)

Items discussed	Update from meeting on 12th September 2023
	
	Key items discussed included:
	
	• Reducing Health Inequalities.
	    o CORE20PLUS5 update.
	    o The Rosalie Ryrie Foundation.
	• Domestic Abuse
	    o Breakthrough presentation.
	    o Health impact on children.
	    o 0-19 Service.
	    o Focused discussion with partners.
	• Pharmaceutical Needs Assessment.
	• Wakefield Corporate Plan.
	• Wakefield District Adult Safeguarding Board.
	• Annual Report 2022-2023.
	• Strategy 2023-2026.
	• Overview and Scrutiny Committee papers.

Date of next meeting	Next meeting scheduled for 23rd November 2023.
Further information	Papers and draft minutes are available at: Health and Wellbeing Board - Wakefield Council

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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	<u>Update from meeting on 28th September 2023</u> Agenda items included: • Public questions. • Citizen story. • Deep dive on maternity and neo-natal care in Calderdale - an update on maternity services in the Calderdale Place was given highlighting strategic ambitions, how current services are performing, improvement initiatives, challenges, and opportunities for the future. • Talking Therapies Evaluation Report - a report was received following evaluation of the Talking Therapies tender and recommendation to award the contract approved. • Calderdale Delivery Plan Reporting Framework. • Place Lead report. • Quality and safety report. • Place finance report. • Place performance report. • Work plan.
Date of next meeting	Next meeting scheduled for 30th November 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 & Associate Director of Operations, Adults and Older People Mental Health Care Group
Items discussed	<u>Update from meeting on 12th October 2023</u> This session was a development session, focused on Community Health and Wellbeing Workers (CHWW) and the future of this model in Calderdale. The agenda included: A presentation from Imperial College on the evaluation of the use of the CHWW model in Westminster. Some notable improvement in physical health measures such as vaccine and screening uptake has been seen.

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	Presentation from a PHD student from University of Liverpool who is evaluating the different ways the CHWW are being implemented in Westminster, Warrington and Calderdale. The Calderdale model costs £380k, is run by Healthy Minds and has reached about 9% of the target 2000 households. Questions to the presenters and discussions on the tables about how the model connects to existing structures (Primary Care, PCN, social prescribing, community development) and whether the model should be supported and spread, and if so where resources would come from.
Date of next meeting	Next meeting is scheduled for 14th December 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 and Director – Provider Development.
Items discussed	Update from meeting of 13th October 2023 Items discussed included: ○ Starting Well - Maternity and Early Years Strategy 2023 to 2027. ○ Preparing for winter. ○ Health and Wellbeing Board Forward Plan for December 2023.
Date of next meeting	Next meeting is scheduled for 14th December 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 a signed Collaborative Agreement.

The Kirklees Mental Health Alliance continues to meet and progress workstreams. Governance arrangements for the Alliance are aligned to the Kirklees place governance arrangements.

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Kirklees ICB Committee

Member	Chief Executive (deputy – Director of Provider Development)

Items discussed	<u>Update from meeting on 13th September 2023 (and continued into part of the Development Session on 11 October 2023).</u>
	
	Items discussed included:
	
	• People story- this focused on men's mental health.
	• Kirklees Community Services – assessment process outcome and next steps. The recommendation to directly award contract/s, in line with the outcome of the assessment process, to the West Yorkshire ICB Finance, Investment and Performance Committee was agreed subject to a number of actions, including agreement performance metrics and improvement plans. The request for a tender waiver to support the direct award of contract/s was agreed.
	• Home First Discharge - an update was provided on how the model will support more people to go home first alongside providing an optimal temporary community bed base for those in need of further recovery time prior to going home. The Committee supported the repurposing of the existing funding for implementation of the 2023-24 Home First Discharge model.
	• Governance approach for Older People's Mental Health In-Patient Reconfiguration across Calderdale, Kirklees and Wakefield Places. The Committee endorsed the recommendation to establish a Joint Committee of Calderdale, Kirklees and Wakefield, by the WYICB Board as a decision specific WYICB Board sub-committee.
	• Accountable Officer's Report - this focused on a number of areas including:
	   o Integrated Care Board Operating Model and Running Cost Allowance.
	   o Cataract Referral Management Scheme.
	• Kirklees Place Quality Report.
	• Finance update.
	• 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.
	
	<u>Update from Development Session on 11th October</u>
	
	The focus of the session was on:
	• Working with the VCSE in Kirklees- a presentation was shared, followed by discussion on how we work with the VCSE in Kirklees, and future challenges and opportunities.
	• Next steps for ICB Committee development.

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Date of next meeting	Next meeting scheduled for 8th November 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 5th October 2023 Items discussed included: o West Yorkshire Trauma Informed 2030: Adversity, Trauma and Resilience Programme - an update from the WY programme was provided and discussion on how the partnership can be involved with, and support, this work. o Update from Healthwatch Kirklees: Healthwatch Annual Report 2022-23. o Work plan.
Date of next meeting	Next meeting scheduled for 2nd November 2023.

Kirklees Health and Wellbeing Board

Invited Observer	Director of Provider Development
Items discussed	The July and September meetings of the Health and Wellbeing Board were cancelled. 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:

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	o Examples of groups in the community. o Local partner updates to develop range of spaces and activities to promote physical activity and emotional wellbeing. o An example of an affordable food initiative. o 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 23rd November 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 2nd October 2023 Key agenda items included: o Services in the community. o Living Well Programme update. o Health and Care Plan priority - improving access to health and care. o Provider Selection Regime Commissioning Process - this item was deferred to a future meeting.
Date of next meeting	Next meeting scheduled for 6th November 2023.

Kirklees Mental Health Alliance

Member	Director of Provider Development (Co-Chair), with Trust representative as a member.
Items discussed	Update from meeting on 18th September 2023 Agenda items included: • Patient story • Deep Dive – Crisis Transformation

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	• Programme highlight reports (by exception) • CLEAR Working Better Together updates and annual report. • New ICB Operating Model. • Key points for the next meeting. • Future plans. Agenda for upcoming meeting on 30th October 2023 • Patient story. • Deep dive- voluntary sector community offer. • Quality for health. • Kirklees Health and Care Plan. • WY Mental Health, Learning Disability and Autism Partnership Board. • Programme highlight reports (by exception). • New Operating Model.
Date of next meeting	Next meeting scheduled for 11th December 2023.

Recommendations:

Trust Board is asked to:

- **Receive and note the update on the development of Integrated Care Systems and collaborations:**

    o **West Yorkshire Health and Care Partnership;**
    o **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.**

- **Receive the minutes of relevant partnership boards/committees.**

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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):	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 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. 3.1-Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. 3.2-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.		

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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. 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 and the Women's Pathway work continues to be a focus. A workshop was held in October, involving all partners, with focus on the Women's Pathway. • Planning has commenced with Research and Development to understand how the collaborative develop an evidence base for change undertaken through our workstreams. • The collaborative is leading the way in establishing a national women's pathway network with other provider collaboratives. • Development of a performance matrix for forensic community services, to support oversight and monitoring. This has now been approved by the Provider Collaborative Board. • Establishment of an Involvement Steering Group. • Work with the Yorkshire and Humber Involvement Network to develop a clear specification and operating procedure for the network. • Development of a procedure setting out standards and key performance indicators for access assessments, with an annual audit programme planned. • Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow. • Improvements in reporting patients 'Clinically Ready for Discharge'. Opportunities are being reviewed for closer working with community colleagues and place-based commissioners to minimise delays in discharge. • 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. • Work to improve the interface with prisons, improving assessment and transition processes. • Involvement in national work to revise the secure service specifications. • A project to consider how patient reported experience 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.

For the 6 months to September 2023 the collaborative operated with a financial surplus.

The Adult Eating Disorders Provider Collaborative reported a deficit at month 6. A year end deficit position is forecast.

The Children and Young People Mental Health Provider Collaborative reported a deficit position at month 6, largely due to an extraordinary, high cost and complex package 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 Lead 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 has been updated and will be shared with partners for signature once the Lead Provider contract has been agreed. The Hosting Agreement for the SYB Commissioning Hub has been signed by the Trust.

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 Specialised Provider Collaborative Commissioning Hub.

Work has continued by the 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.

An options paper as to how commissioning oversight will be managed going forward has been developed. A workshop is planned between SWYPFT FCAMHS colleagues and the Commissioning Hub to finalise future governance arrangements in November. NHSE have agreed extension of the MOU to support the transition to revised arrangements until end of 31st December 2023.

	In November 2022, NHSE/I published the Perinatal Mental Health (PMH) 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. Following a panel process in April 2023, NHS England confirmed that LYPFT will be the lead provider for the Yorkshire and Humber Perinatal Mental Health Collaborative. A 'go live' date has been confirmed for the PMH Provider Collaborative of 1st April 2024. A mobilisation group has been established, and quality due diligence is due to commence October 2023. A Clinical Director for the PMH Provider Collaborative has been appointed, due to start November 2023. **Risk Appetite** The development and delivery of Provider Collaboratives is in line with the Trust's risk appetite.
Recommendation:	**Trust Board is asked to RECIEVE and NOTE the Specialised NHS-Led Provider Collaboratives update.**

Trust Board 31 October 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.

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3. Phase 1 Provider Collaboratives - West Yorkshire

Recent developments for all West Yorkshire Provider Collaboratives include:

- Production of the first Annual Quality Report for the Phase 1 Provider Collaboratives by the Commissioning Hub.

- Further development of Standard Operating Procedures (SOPs) for all West Yorkshire Provider Collaboratives. This has included approval of 'Managing pathways of concern' SOP by all collaboratives, and development of processes for the Commissioning Hub's management of freedom of information requests.

- Further 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.

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 and the Women's Pathway work continues to be a focus. A workshop was held in October, involving all partners, with focus on the Women's Pathway.
- Development of a West Yorkshire- wide community model, with work now focused on workforce and finance planning to support the proposal.
- Planning has commenced with Research and Development to understand how the collaborative develop an evidence base for change undertaken through our workstreams.
- The collaborative is leading the way in establishing a national women's pathway network with other provider collaboratives.
- Development of a performance matrix for forensic community services, to support oversight and monitoring. This has now been approved by the Provider Collaborative Board.
- Establishment of an Involvement Steering Group.
- Work with the Yorkshire and Humber Involvement Network to develop a clear specification and operating procedure for the network.
- Development of a procedure setting out standards and key performance indicators for access assessments, with an annual audit programme planned.
- Repatriation plans for patients placed out of area (West Yorkshire) and outside of natural clinical flow.
- Improvements in reporting patients 'Clinically Ready for Discharge'. Opportunities are being reviewed for closer working with community colleagues and place-based commissioners to minimise delays in discharge.
- 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.
- Work to improve the interface with prisons, improving assessment and transition processes.
- Involvement in national work to revise the secure service specifications.

- A project to consider how patient reported experience measures are captured across the collaborative, working with the Yorkshire and Humber Involvement Network to strengthen the voice of service users.
- 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.

The Yorkshire and Humber Involvement Network were nominated for a National Service User Award in the category 'Hope and Positivity' for the film they made of 'Welly Fest', attended by services across the three Yorkshire and Humber Provider Collaboratives.

For the 6 months to September 2023 the collaborative operated with a financial surplus of £1,154k. A surplus position of £2,007k is forecast and this will be subject to the collaborative risk/reward share arrangement.

Review of the 2023/24 Lead Provider Contract Variation is complete, and feedback has been provided to NHS England in order that the CV can be prepared for signature. 2022/23 contract variations with in-area partners have now been signed by all partners. 2023/24 contract variations for in area providers have been prepared so that they are ready for signature once the Lead Provider Contract Variation has been signed. A discussion has taken place with NHSE to agree the most efficient approach regarding contracting for out of area providers for 2022/23 and 2023/24, and contract variation templates prepared and issued to providers.

The most recent meeting of the Collaborative Committee of the Trust Board took place on 3rd October 2023, with a further meeting planned for 5th December 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). It has been agreed that primary care partners will host the physical health monitoring and a Service Level Agreement is being developed.

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 6, a deficit position of £230k is reported. This is a deterioration against a break even plan and can be attributed to deficits against the out of area budget (£160k) and the cross flows income target (£99k). There is currently 1 person placed out of area.

The forecast position the 2023/24 financial year is a £428k deficit. The collaborative will investigate ways to increase crossflows income and reduce independent sector placements.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

A year-to-date deficit of £929k is reported for the 2023/24 financial year to September 2023 against a balanced plan. High-cost exceptional packages of care (EPC's) are primarily driving this position. There is one ongoing EPC which is forecast to continue throughout the 2023/24 financial year.

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 Lead 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 has been updated, and will be shared with partners for signature once the Lead Provider contract has been agreed. The Hosting Agreement for the SYB Commissioning Hub has been signed by the Trust.
- Risk share discussions continue between providers.

A year to date deficit of £253k is reported, with forecast deficit of £18k. This is an improvement of the forecast compared to last month. This is due to updated assumptions on an exceptional package of care and the updated timing of the Specialist Community team proposed expansion.

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

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 has continued 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.

An options paper as to how commissioning oversight will be managed going forward has been developed. A workshop is planned between SWYPFT FCAMHS colleagues and the Commissioning Hub to finalise future governance arrangements in November. NHSE have agreed extension of the MOU to support the transition to revised arrangements until end of 31st December 2023.

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 (PMH) services.

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.

West Yorkshire ICB will retain responsibility for commissioning local community specialist PMH services, delivery of access target and joint work to enable a trauma-informed maternity system across WY.

A 'go live' date has been confirmed for the PMH Provider Collaborative of 1st April 2024. A mobilisation group has been established, and quality due diligence is due to commence

October 2023. A Clinical Director for the PMH Provider Collaborative has been appointed, due to start November 2023.

Recommendation:

Trust Board is asked to:

Receive and note the Specialised NHS-Led Provider Collaboratives update.

Trust Board 31 October 2023
Agenda item 12.1

Private/Public paper:	**Public**
Title:	**Constitution review**
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 Trust Board with an update in relation to the latest constitution review

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 Trusts constitution incorporates the governance structures, which support its contribution to the objectives of the integrated care partnership (ICP), integrated care board (ICB), and place-based partnerships.
Any background papers / previously considered by:	Proposal to update the Trust Constitution (including standing orders), Standing Financial Instructions and Scheme of Delegation – Trust Board January 2023 and Members Council February 2023.
Executive summary:	In January 2023 the Trust undertook a detailed review of the Trust's constitution in readiness for compliance with the revised Code of Governance for NHS provider Trusts, which came into effect on 1 April 2023.

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	In addition, the Trust board workplan details the requirement for an annual review of the constitution each October. The outcome of which is detailed below:
	1. Legal and statutory requirements - the writer has reviewed legal guidance and can confirm that there are no further legal changes required in 2023/24.
	2. Trust review - in recent years the Trust has been unsuccessful in appointing a staff governor to the Members' Council staff constituency for social care workers in integrated teams.
	For point two above, the writer has liaised with the Director of Services for Adult and Older Peoples services, it has been established that the Trust does employ a number of social workers, however they sit outside the integrated team model.
	It is therefore proposed to widen the constituency to include all social workers, to maximise the opportunity to fill the vacancy in the next round of elections, starting January 2024.
	The Trust is required to consult with members council on any proposed changes to the constitution, ahead of presentation to Trust Board. Therefore, a two-week consultation period took place between 14 and 26 October 2023, where governors were asked to respond to the proposal by objection only.
	No responses were received, and it is therefore proposed to the Board that the staff constituency for social care workers in integrated teams is changed to social workers.
	No further changes have been proposed for 2023/24.
Recommendation:	**Trust Board is asked to RECEIVE the update and SUPPORT the recommendation to the Members Council to APPROVE the change of staff governor constituency for social workers in integrated teams to social workers.**

Trust Board 31 October 2023
Agenda item 13.1

Private/Public paper:	Public
Title:	**Digital Strategy 2021-24 – Strategy Progress Report**
Paper presented by:	**Adrian Snarr - Director of Finance, Estates and Resources**
Paper prepared by:	Paul Foster - Assistant Director of IT Services & Systems Development Dr Abida Abbas - Chief Clinical Information Officer
Mission/values:	The Trust continues to embed a culture that embraces digital solutions within our approaches, ensuring this is an integral way of supporting our staff and enabling our service users, carers, and wider communities to achieve their potential and live well based on value, need, risk, choice, and preference. Becoming a digitally mature organisation through embedding a culture of innovation and continuous improvement is a priority for the Trust.
Purpose:	The purpose of this report is to inform the Board of the progress and developments made during the first half of 2023/24 (year 3 of 3) in respect of the Trust's 2021-24 digital strategy

Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	

BAF Risk(s):	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
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Trust's digital strategy remains comprehensively aligned with the digital priorities and objectives of our Integrated Care Systems, Integrated Care Boards and Place-based partnerships across West and South Yorkshire. Good progress is being made as presented in this report which serves to demonstrate our overall improving levels of digital maturity, whilst providing the Trust Board with the assurances that our current digital strategy and plans remain fit for purpose and relevant within local, regional, and national agendas.
Any background papers / previously considered by:	Digital Strategy 2021–24 approved by Board in March 2021 and the last progress update report provided in May 2023, summarising the March 2023 end of year position.
Executive summary:	The purpose of this report is to inform the Board of the Digital Strategy progress to date during the first half of 23/24. Within the Trust we are actively continuing to embed a culture that embraces digital solutions and approaches as an

integral way of supporting our staff and enabling our service users, carers, and wider communities to achieve their potential and live well. Whilst we are witnessing a growing interest in digital health innovations, placing greater emphasis on digitally enabling service users, carers, and staff domains, this is being tempered by operational pressures and capacity.

Summary of progress

The report summarises progress against each digital domain, with notable updates and achievements highlighted recognising the mid-year position for 23/24 (year 3 of 3), with the dashboard outlining the collective picture across the broad spectrum of work in support of the growing digital agenda. Whilst some initiatives have been subject to revised delivery timescales for a variety of reasons, appropriate governance has been followed.

Key risks

The key risks associated with the digital programme are subject to constant review in line with notable progress being made, with mitigating actions put in place, as necessary.

Financial investment

Capital funding of £2.655m has been made available to support digital developments during 23/24, with an additional £0.920m confirmed recently in year following successful bids for external National 23/24 funding.

Digital strategy alignment

The Trust's digital strategy remains comprehensively aligned with the wider agendas and priorities, meaning the Trust remains well positioned in respect of recent developments and our continued digital evolution.

During the remainder of 2023/24, we will be working on revising the Trust's digital strategy, plotting the strategic roadmap for our next phase of digital evolution, building on the foundations set by the current 2021/24 digital strategy. Our approach will ensure that the views and experiences of our staff, our service users and carers remain critical and central in driving forward our digital agenda as their lived-experienced are of paramount importance.

Overall summary rating

This report demonstrates that overall good progress is being made against 2023/24 priorities, placing the Trust in an advantageous position from which to expand our digital capabilities during 23/24 and beyond. The reported position is rated as Green overall.

Recommendation:	**Trust Board is asked to NOTE the achievements made to date in respect of the 2023/24 milestones and COMMENT on the contents of the paper.**

Digital Strategy 2021-24

6-Month Progress Report

Assistant Director of IT Services & Systems Development

Chief Clinical Information Officer

October 2023

www.southwestyorkshire.nhs.uk

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Purpose of report

The purpose of this report is to inform the Board of the progress made during the first half of 2023/24 (year 3 of 3) in respect of the Trust's 2021-24 digital strategy, noting key updates and achievements since the last report in provided in May detailing the 2022/23 end of year position, summarising how we are driving forward the Trust's digital agenda.

Introduction

This report focuses on the progress over the last six months during the first half of 2023/24 regarding the digital priority areas that underpin delivery against the aims and objectives of the 2021-24 digital strategy. This update incorporates new and emerging themes, as well as ongoing programmes of work during 2023/24. All initiatives are incorporated into the milestone delivery plan as detailed in Appendix A.

Developing our digital culture

We continue to embed a culture that embraces digital solutions within our approaches, ensuring this is an integral way of supporting our staff and enabling our service users, carers, and wider communities to achieve their potential and live well based on value, need, risk, choice, and preference. Becoming a digitally mature organisation through embedding a culture of innovation and continuous improvement is a priority for the Trust.

The approach adopted is in line with the Trust change approach and at the heart of this approach is co-production with strong clinical leadership and involvement of service users and carers where relevant. An enabling governance approach has been embedded to ensure that digital opportunities support clinical engagement in appraising innovations and new solutions through the Digital Strategy and Innovation Group.

Our Chief Clinical Information Officer is playing a key role in engaging staff from across the organisation in key improvement and change programmes, such as the implementation of Patients Know Best, key SystmOne initiatives and the procurement phase for a Trust-wide digital dictation solution, ensuring a clinically led focus.

We have developed examples of good practice in implementing digital change programmes with a strong emphasis on continuous improvement to enhance the way in which we work and deliver care as well as join up care with other partners in the community. This continues to build on the learning from Covid-19 and the acceleration of digital ways of working adopted as part of our response. We continue to embed hybrid and new ways of working as part of our approach to delivering our ambitions set out in the Trust and digital strategy.

Our digital priorities serve to deliver the aims and objectives set out in the digital strategic by: -

- Ensuring digital services are accessible anywhere to all who need to use them and be available on demand.

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- Developing high quality digital services so that they are beneficial to all receiving care, centred around the individual, improving the overall experience.

- Ensuring that our service users receive timely responses and feedback in a manner that is preferable to them.

- Providing digital opportunities for service users to influence, co-design, and co-produce care and services.

- Ensuring that digital services are easy to use, intuitive and should be designed from an end user perspective.

- Creating digital intelligence through electronic systems and processing data from multiple sources with minimal manual intervention.

- Ensuring digital intelligence informs improved decision-making capabilities in delivering care to anticipate individual care requirements, as well as predicting future service demands that support design and planning.

- Ensuring digital services are subject to regular enhancements with minimal adverse impact on end user experiences with little or no disruption to service access and availability.

- Ensuring that adoption and uptake of digital innovations will deliver improvements through effective benefits management and realisation underpinned by a quality improvement framework approach.

These are central themes that spans all our digital domains and digital initiatives that are supported through an integrated approach to change.

During 2023/24 we continue to place an emphasis on ensuring that digital as an enabler serves to deliver efficiencies whilst demonstrating best value from the application of available resources.

During the latter half of 2023/24, we are commencing work on revising and refreshing the Trust's digital strategy, plotting the strategic roadmap for our next phase of digital evolution and growing levels of maturity, building on the foundations set by the 2021/24 digital strategy. In developing this subsequent revision, we will continue the ethos that we all have a collective role to play in shaping and influencing our future digital journey. The views and experiences of our staff, our service users and carers remain critical and central in driving forward our digital agenda as their lived-experienced are of paramount importance. We will work with the Involving People team to ensure broad engagement with the myriad of our stakeholders and networks in formulating the strategy.

The 2021-24 digital strategy remains relevant and fully aligned with our vision, mission, strategic objectives, values, and ambitions, which are underpinned by the digital domains and constituent digital initiatives, as depicted in Figure 1 below.
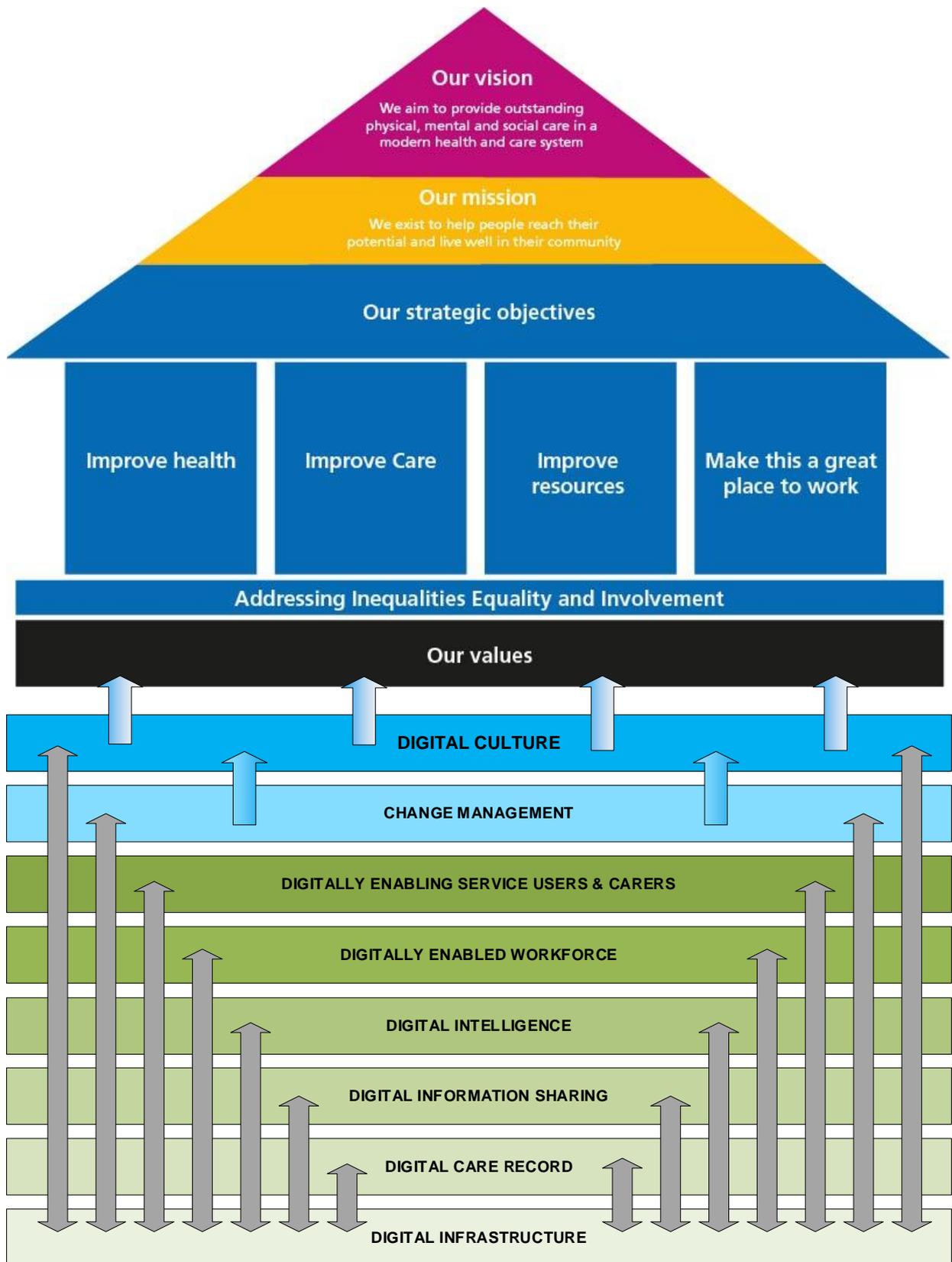
Figure 1

Summary of progress against the 2023-24 digital schemes (October 2023 position)

To support the implementation of the 2021-24 digital strategy, the six digital domains are mapped against the Trust's priorities as shown in the matrix below.

Digital Domains	Improve health	Improve care	Improve resources	Make this a great place to work
Digitally Enabling Services Users & Carers	❖	❖		
Digitally Enabled Workforce		❖	❖	❖
Digital Intelligence	❖	❖	❖	❖
Digital Information Sharing		❖	❖	❖
Digital Care Records		❖	❖	❖
Digital Infrastructure			❖	❖

The accompanying Appendix A document provides additional supporting information detailing the activities and progress against each initiative for the 2023/24 digital programme.

Below is a summary of the main notable achievements in this reporting period by each digital domain.

Digitally Enabling Services Users & Carers	Supports the following Trust Priorities			
	Improve health	Improve care		
To provide our service users and carers with access to services and care that has digital embedded within the service offer that is more in keeping with how they prefer to engage with other services digitally in everyday life. This domain will also be concerned with championing digital inclusion and in addressing digital inequalities in terms of access and capability for our service users, carers, their families, and the wider communities that we serve.				

Key achievements and notable updates

There has been a continued increase in activities under this digital domain during the last six months, with interest in exploring opportunities for digital health innovation that have the potential in adding value to service offers and support improvements to service user and carer experiences.

Digital personal health record: Implementation activities for the introduction of digital solution that enables service users and carers to access their personal digital health record information was completed towards the end of July 2023, following extensive testing and NHS App enablement of the solution across the Trust geography. This initial deployment starts to provide opportunities for

service users and carers to be able to self-manage and engage more readily in their care. Uptake and usage have been encouraging since go live and further developments to enhance the solution are being planned.

Inpatient services food ordering: Collaborative work between the IM&T team and the Catering dept introduced handheld devices (tablets) in June 2023 that allow inpatient service users to order food on wards, promoting choice and improving service user experiences, whilst also aiding order accuracy.

Digital inclusion:
The ability for capturing and recording service user digital preferences within SystmOne has been established as previously reported but further work is required to actively promote and embed the capturing/recording within service users records within SystmOne as uptake has been minimal to date. This work is being championed by the Chief Clinical Information Officer with a task action group being planned to take this forward.

We are also continuing to explore collaboration opportunities with partners across our places and regionally to further reduce barriers to digital inclusion.

Collecting and reporting health outcomes: The training package to support the wider rollout has been completed and this also serves to raise awareness of the importance of recording outcome measures and linking to personalised care plans. Development of the solution to enhance the functionality further and aid the wider rollout are progressing with the next area of focus on Enhanced and Early Intervention teams.

Digital health app – Create & Bloom: The proof-of-concept creativity app to support an individual's health and wellbeing through creative approaches has concluded testing and user feedback activities which is now enabling the opportunity to enhance and develop the app further.

Digital solutions and innovation: Digital health solutions and digital technologies that aim to improve access to services, care provision and access to supportive information continue to be explored via the Digital Strategy & Innovation Group. This remains a growing area of interest and focus within the Trust's digital landscape. However, opportunities from which to take forward and assess the potential for such digital technologies remains impacted by operational service pressures and capacity.

Digitally Enabled Workforce	Supports the following Trust Priorities		
		Improve care	Improve resources	Make this a great place to work
Equipping Trust staff with the requisite digital skills is critical in the full utilisation of digital technologies, systems, and information. By improving such capabilities, all staff are provided with the appropriate digital skills to use current and future digital solutions in line with the changing demands of the organisation and the services we provide. This domain focusses on the Trust's workforce becoming digitally excellent, to be fully conversant, competent, capable, and confident in their use of digital solutions.			

Key achievements and notable updates
Good progress is being made in several areas within this domain. There are capacity limitations impacting digital dictation progress but activities to remedy this are actively being explored as outlined below.

Trust-wide digital dictation solution: The procurement phase of the project has progressed and the Invitation to Tender evaluation activities concluded, with the recommendations proposed approved by EMT. During the standstill period, the Trust received some clarification questions and a challenge from one of the unsuccessful bidders. The standstill period has been put on hold whilst the Trust considers the challenge and responds accordingly following legal advice. Once concluded the Integrated Change-led implementation phase will be able to commence and a project manager has recently been recruited to oversee this work, with an employment start date being finalised. At the end of August, the Trust also bid for National Frontline Digitisation 23/24 underspend monies to support this priority programme for the Trust, which was successful.

Workforce digital confidence and capability: A degree of progress has been made more recently in the collaborative approach between the IM&T and Learning & Development teams regarding exploring ways in which we can conduct a staff digital skills self-assessment to identify digital learning and development requirements, which will help to inform the digital learning offer and influence the planned digital strategy revision. Overall progress continues to be somewhat hampered by the People's directorate re-organisation.

Digital Intelligence	Supports the following Trust Priorities
	Improve health Improve care Improve resources Make this a great place to work
The use of business intelligence tools helps to deliver information in a more standardised and user-friendly way e.g., via dashboards. Such developments increase the use of forecasting, benchmarking, and statistical techniques to deliver information rather than data, whilst also supporting the delivery of care, improving data quality and accuracy. This domain arms the Trust with the capabilities from which to inform future service planning based on the ever-changing needs of the populations we serve, enabling continuous service improvements ensuring that we remain relevant for today and tomorrow.	

Key achievements and notable updates
It is evident from this update that there is a significant amount of work in progress in support of the Trust's performance and business intelligence agenda, spanning new developments and business as usual reporting activities.

Dashboard developments: Further development work to enhance and establish dashboards is continuing into 2023/24.

Waiting list reporting project: The project focused on introducing the use of waiting list functionality available within SystmOne is progressing, with the waiting list analysis report now lie for most services who use SystmOne.

CQUIN developments: Development work to support the proposed CQUIN metrics for 2023/24 was completed in July 2023 as planned.

Datawarehouse developments: Development work is continuing establishing data feeds from other sources of Trust data such as from Tendable, Datix and Health Roster during 2023/24.

Integrated Performance Report (IPR) developments and automation: The work focussing on national metrics has been completed with the next priority area being to ensure all People directorate data is flowing into the data warehouse by the end of January 2024.

National reporting requirements: This forms part of the continuous programme of ongoing developments, where numerous activities are planned, underway or completed, ensuring the Trust complies with national reporting obligations.

Automation: Exploration of automating manual processes to improve efficiency and allow more capacity for data analysis has commenced.

	Supports the following Trust Priorities		
Digital Information Sharing	Improve care	Improve resources	Make this a great place to work
There are numerous information systems both within the Trust and wider within our partner organisations across the geographic footprint that we serve, many of which function in isolation and where staff from different organisations cannot access, where there is a clear need to support direct care. This leads to staff having to adopt time-consuming activities to overcome these obstacles and has the potential to lead to clinical risk and patient safety concerns. This domain will focus on improving the ability to share and access information digitally, where is it clinically appropriate to do so and where there is a legitimate need.			

Key achievements and notable updates
There is a significant amount of work underway within this digital domain. Whilst there continues to be a degree of timeline slippage within specific initiatives, in the main this is due to external factors outside of the Trust's control and down to the complexity of the requisite activities.

Information Governance: The Trust achieved the mandated Information Governance training target which together with other assurances, enabled the organisation to reach continued compliance for the Data Security & Protection toolkit standard.

Yorkshire & Humber care record onboarding: Testing activities were completed within the Trust in June 2023, followed by the progression to go-live production, although a series of issues had to be resolved by Yorkshire & Humber Care Record team to eventually allow access. The final stage of smoke-testing by Chief Clinical Officers at the Trust and YHCR remains subject to scheduling due to competing work demands and annual leave. Once complete the functionality can be rolled out across the Trust.

Electronic Referrals (eReferral Service): The Trust continues to explore the feasibility of introducing the National eReferral Service (formerly Choose & Book) within Mental Health services where appropriate. Discussions are ongoing with NHS England and insight from the experiences of another NHS Trust has been obtained, which highlights the need for significant workarounds to be established. We are maintaining a close watching brief and an evaluation paper considering options and recommendations for Trust consideration will be produced in due course.

Access to partner electronic care record systems (Acute): Access to the Cerner system at CHNFT for a small, designated number of Trust staff has been successfully achieved. Further meetings are being planned to facilitate similar arrangements for our staff in Barnsley in having access to the BHNFT system.

Patient reminder systems review: An evaluation paper assessing both existing systems that are in use for legacy reasons has been drafted for internal (IM&T) review prior to routing through appropriate Trust governance channels.

Digital Care Records	Supports the following Trust Priorities		
		Improve care	Improve resources	Make this a great place to work
Digital care record information systems are the cornerstone of the Trust's digital capabilities which support clinical and operational front-line services in providing high quality care and service provision. Digital care records provide the basis from which to support business intelligence and data analytics, interoperability in the exchange of information and electronic messaging capabilities. This domain focuses on the creation of a comprehensive digital care record and the eradication of paper records where possible.			

Key achievements and notable updates
This update highlights the varied work that has been completed to date, as well as work in progress.

Electronic prescriptions & medicines administration (EPMA): An evaluation of the Mental Health inpatient services deployment phase has been completed, with focus now shifting to planning and prioritisation for Physical Health inpatient services and Mental Health community services.

Clinical Records System: This is a continuous programme of development work that also ensures the potential future opportunities for utilisation of the ever-evolving SystmOne functionality is considered for deployment within the Trust's services. The continued migration of physical health community services into the integrated neighbourhood teams service SystmOne unit and task management implementation focusing on mental health services being the main areas of note within this broad programme of work. All of which contributes to ensuring that SystmOne is used more consistently and effectively and that all services are fully optimised in their usage of SystmOne, in line with the national EPR coverage agenda.

Digital Infrastructure	Supports the following Trust Priorities			
			Improve resources	Make this a great place to work

Ensuring that the Trust has a strategically aligned, resilient and robust digital infrastructure (network/end user computing hardware and software) that guarantees end user accessibility, with enhanced business continuity, disaster recovery measures and safeguards against potential cyber security threats, aiding organisational assurance. This domain provides the foundations from which all other digital domains are built upon.

Key achievements and notable updates
The digital infrastructure provides the solid foundations from which wider digital innovations and opportunities can be built upon. The digital infrastructure work programme incorporates both modernisation initiatives and business as usual activities to maintain a reliable and accessible network.

Microsoft365: The IT team conducted a timely review of the Trust's enterprise-wide agreement for the Microsoft suite of software and products and the renewed agreement took account of the NHS England national NHS contract, completed in June 2023. Whilst Microsoft license costs have increased significantly across the NHS, the NHS England negotiated contract provides a heavily discounted pricing model.

Multi-factor authentication (MFA): The Trust has completed the rollout of the in-scope deployment of MFA, with an alternative solution being explored for specific locations across the Trust that do not allow mobile phones on site (e.g. high secure units).

Email platform accreditation: In August 2023, the IT team working with Daisy undertook the annual email platform standards accreditation that ensures the Trust's Microsoft Office365 email environment remains compliant.

Financial Investment

2023/24 Digital Capital Allocation
To meet the priorities outlined in this report, a capital allocation of £2.655m has been made available to support digital developments. Table 1 below provides a summary of the capital allocation and associated expenditure to date against the digital schemes in 2023/24.

	Digitial Capital Schemes		23/24 (£k)			Scheme Owner	Comments
			Revised	Expenditure / Committed	Variance		
Digital Infrastructure	**Core Network Infrastructure**	Server replacements and enhancements	150	103	(47)	IM&T	Activities in progress in line with plan
		Network hardware replacements & enhancements	100	114	14	IM&T	Activities in progress in line with plan
		Trust Corporate Wi-Fi Programme	100	16	(84)	IM&T	Activities in progress in line with plan
		Partner Wi-Fi Access (Govroam/Eduroam) Programme	50	0	(50)	IM&T	Activities in progress in line with plan
		Virtual Private Network (VPN) Programme	100	0	(100)	IM&T	Activities in progress in line with plan
		Wide Area Network (WAN) enhancements	50	0	(50)	IM&T	Activities in progress in line with plan
	Telephony	Desk Telephony	0	0	0	IM&T	
		Mobile Telephony	0	0	0	IM&T	
		Mobile Device Management Platform	50	0	(50)	IM&T	
	Cyber Security	Cyber Security Enhancements	200	12	(188)	IM&T	
		SIEM & IPS	350	0	(350)	IM&T	Subject to financial prioritisation and EMT approval given significant recurrent revenue implications
	Microsoft	Email enhancements	50	0	(50)	IM&T	
	Digital Infrastructure Sub Total		**1,200**	**245**	**(955)**		
Digital Care Records	**SystmOne**	SystmOne (Mental Health) Development Programme	0	0	0	IM&T	Removed from 23/24 with plans covered in contract
		SystmOne (Physical Health) Development Programme	0	0	0	IM&T	Removed from 23/24 with plans covered in contract
	Electronic Prescribing & Medicines Administration (EPMA)	EPMA community FP10 prescribing	70	0	(70)	Pharmacy	Revised forecast from original £180k
	Digital Care Records Sub Total		**70**	**0**	**(70)**		
Digital Information Sharing	**Shared Care Records & Interoperabilty**	Interoperability & Integration Programme	150	0	(150)	IM&T	Scheme reduced in 23/24
		ICE (Acute partners) integration with SystmOne	0	0	0	IM&T	Year 1 setup costs covered in 22/23
	Digital Information Sharing Sub Total		**150**	**0**	**(150)**		
Digital Intelligence	**Digital Intelligence**	Scanning Bureau	0	0	0	P&I	Scheme deferred to a future financial year
		Reporting Server Upgrades	20	6	(14)	P&I	
	Digital Information Sharing Sub Total		**20**	**6**	**(14)**		
Digitally Enabled Workforce	**SharePoint Developments**	HR & Payroll	20	0	(20)	Payroll	
		Intranet	10	0	(10)	Comms	
		Business & Intelligence Dashboards	10	0	(10)	P&I	
		Supervision Database	10	0	(10)	Nursing	
		Emergency Planning	15	0	(15)	EPRR	
		IM&T Forms & Processes	15	0	(15)	IM&T	
		New SharePoint developments	50	0	(50)		Prioritisation by the SharePoint Development Steering Group
		T&M (Live site enhancements)	0	0	0		
	Digital Developments	eCommunity Resource Scheduling Tool	50	0	(50)	Barnsley CG	Barnsley CG confirmed in May 2023 this scheme would not progress in 23/24
		Genius (NHS Jobs 3 replacement)	35	0	(35)	People	Project initiated
		Digital Training	50	0	(50)	People/IM&T	Plans being worked up
		Trust-wide Digital dictation	500	0	(500)	Integrated Change	Exploring opportunities to divert this funding to other potential initiatives in lieu of frontline digitisation 23/24 underspend funding award.
		Digital Conferencing capabilities	50	0	(50)	IM&T	
	Digital Enabled Workforce Sub Total		**815**	**0**	**(815)**		
Digitally Enabling Service Users & Carers	**Digitally Enabling Service Users & Carers**	Website Re-Development Programme	50	0	(50)	Comms	Plans in place to spend the allocation by end of financial year
		Artificial Intelligence/Remote Monitoring	100	0	(100)	P&I/IM&T	
		Collecting & Reporting Outcome Measures	50	0	(50)	P&I/IM&T	
		eConsultation/Video Consultation	50	0	(50)	IM&T	
		Create & Bloom Creativity app	50	52	2	Integrated Change	
		Digital Health Apps	100	0	(100)		Opportunities to be prioritised by the Digital Strategy & Innovation Group
	Digital Enabled Workforce Sub Total		**400**	**52**	**(348)**		
Contingency		Digital Contingency	0	0	0	IM&T	
Overall Digital Capital Total			**2,655**	**303**	**(2,352)**		**The overall digital capital plan is behind planned expenditure profile as at month 6 with remedial activities in progress to bring back in line with plan**

Additional Capital Schemes (In year)

	Digitial Capital Scheme		23/24 (£k)				Comments
			Agreed Allocation	Expenditure	Variance		
Digitally Enabled Workforce	Digital Developments	Trust-wide Digital Dictation	870	0	(870)		Trust successfully submitted a bid for Frontline Digitisation national 23/24 underspend in August 2023 to support the Trust-wide digital dictation solution implementation
Digitally Enabling Service Users & Carers	Patient Portal Developments	Patients Know Best developments	50	0	(50)		Trust successfully submitted a bid for patient portals national 23/24 funding in August 2023 to support the next phase of planned developments
Current Overall Capital Total			**920**	**0**	**(920)**		

Table 1

Key risks

The provision of digitally enabled services remains vital in enabling Trust staff to deliver safe care. Whilst the progress set out in this report continues to reduce the likelihood of risk associated with digital system failure, the highlighted key risks summarised below in Table 2 require sustained focus and advancement of remedial controls and measures. As such the overall risk appetite is to be considered low with a target score of 1-6.

Risk	Summary	Actions, controls, and measures
Cyber Security. (ORR 1080)	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	Continuation of persistent infrastructure modernisation spanning disaster recovery, network resilience and applicable/systems availability. This work incorporates cyber security enhancements that establish further controls, measures and safeguards that reduce the risk and likelihood associated with the threat of cyber-attacks. A business case recommending the introduction of Security Information and Event Management (SIEM) and Intrusion Prevention System (IPS) to enhance the Trust's current cyber controls and measures and reduce the organisation's risk (1080) score associated to cyber security has been produced and submitted for EMT consideration.
Capacity & capability to deliver on all digital priorities.	Dependency on limited available resources and capacity with suitable project and change management skills within corporate support services to delivery against all digital priorities.	Exploration of options to expand scarce project resources available to the Trust, such as graduate schemes, apprenticeships, internal development opportunities and engagement of 3rd party professional services supplier organisations.
Capacity within Care Group services to consider digital innovation opportunities due to existing service pressures	There is a dependency on operational services staff within Care Groups to collaborate in exploring the potential and participate in deployment opportunities to drive forward frontline digital innovations, which is hampered by existing operational service pressures.	Liaise and work closely with Care Group management regarding timings and scope to ascertain impact to services and further explore avenues that enable consideration of digital innovation opportunities that could present means from which to address capacity, and service efficiencies which could result in quality service improvements.
Ever-increasing demand and reliance upon digital technologies and solutions.	Ability to continue to meet expectations brought about by significantly heightened digital needs and dependencies will require careful balancing of resources and management of expectations.	Careful management of expectations through robust communications and engagement planning, together with horizon scanning to exploit opportunities to source and secure external funding to support digital organizational aspirations.
Lack of clarity for sustainable working arrangements impacting ability plan the digital infrastructure.	Dependency on understanding sustainable working needs which is impacting the ability to plan and prepare the Trust's digital infrastructure and contractual agreements, e.g. desk telephony requirements and wide area network connectivity and capacity across Trust sites.	Ensure digital infrastructure requirements are considered and accounted for as part of the enabling working effectively group activities to take a coordinated and programme approach when adapting to new sustainable models of working, to ensure seamless transition and effective continuity of services.

Increased costs due to current economic climate	As in all walks of life, we are experiencing an increase in costs associated with digital technologies, solutions, and services.	Ensure that opportunities are explored to enable increased cost avoidance. Ensure procurement frameworks and collaborative purchasing arrangements are exploited where possible to enable best value outcomes. Exploit market opportunities to extend current contracts on existing terms where possible and in the best interests of the Trust. Ensure that value for money is clearly demonstrated through benefits realisation, return on investment and associated cost improvements.
<mark>NEW</mark> Potential risks associated with the introduction of digital health apps	Digital apps that are service user focused are considered to be medical devices. Whilst the Trust has robust governance mechanisms in place, there is a need to ensure close alignment of the respective assessment processes and governance arrangements to minimise potential clinical risks.	The Trust has robust procurement, IT, IG, clinical safety, and medical devices governance mechanisms in place, however there is a need to ensure consistent Trust approach and seamless alignment of these governance mechanisms. However, it is proposed to develop a framework that aligns these important dimensions and articulates this process requirement in a standardised manner.

Table 2

Digital Strategy 2021-24 Detailed Dashboard (October 2023 Position)
The key for the digital strategy detailed dashboard (Figure 2) that follows on the next page is provided below for reference.

April 2023 Position		DIGITAL DOMAINS & INITIATIVES	2023/24 - OCTOBER 2023 REPORTED POSITION		
RAG Status	Progress Indicator		RAG Status	Progress Indicator	Key supporting comments by exception
DIGITALLY ENABLING SERVICE USERS & CARERS					
A	↗	Access to Digital Personal Held Care Record	G	↗	Initial phase of the solution providing service users with access to elements of their digital care record went live in July 2023
A	↗	Inpatient Services Food Ordering	C	✓	This project was completed in June 2023.
G	↗	Video Consultation Solution Review	C	✓	
G	↗	Digital Inclusion	A	↗	Further focused work is being planned to raise the importance of capturing this key information within SystmOne.
G	↗	Collecting and Reporting Health Outcomes	G	↗	Initial pilot services deployment. Evaluation planned during 2023/24 to inform Trust-wide rollout.
G	↗	Digital Health App - Create & Bloom	G	↗	
P	→	Digital Remote Monitoring	P	→	
P	→	Website Re-development	G	↗	
DIGITALLY ENABLED WORKFORCE					
G	↗	Microsoft SharePoint365 Developments	G	↗	
G	↗	Trust-wide Digital Dictation Solution Phase 1 - Procurement	A	↗	Standstill period has been put on hold whilst the Trust considers the challenge and responds accordingly following legal advice
G	↗	Trust-wide Digital Dictation Solution Phase 2 - Implementation	P	→	Implementation planning activities to commence once the procurement and commercial dimensions have concluded.
A	↗	Workforce Digital Confidence and Capability	A	↗	Some progress is being made recently in the collaborative approach between the IM&T and Learning & Development teams
P	→	eCommunity Resource Scheduling			Initiative removed from plan as requested by Barnsley Care Group as this work will not
P	→	Recruitment System (NHS Jobs 3 replacement)	G	↗	
DIGITAL INTELLIGENCE					
G	↗	Performance & Business Intelligence	G	↗	Continuation of significant developments in line with the planned programme of work for 2023/24.
DIGITAL INFORMATION SHARING					
A	↗	Yorkshire & Humber Care Record Onboarding	A	↗	Final stage of testing underway to enable live access to YHCR information
G	↗	Electronic Referrals (eReferral Service)	G	↗	
A	↗	Access to ICE	A	↗	Work progressing but delayed due to external factors
A	↗	Access to Partner Electronic Care Record Systems (Acute)	A	↗	Work progressing but delayed due to external factors, with CHFT access for designated SWYPFT staff now provided.
G	↗	Information Goverance	G	↗	
G	↗	Consent to Share Re-engagement	G	→	
P	→	Patient Reminder Systems Review	G	↗	Initial evaluation conducted but further review planned due to changing operational services needs.
P	→	Mental Health APHCs - SystmOne Data Migration	P	→	
DIGITAL CARE RECORDS					
G	↗	Clinical Records System (CRS)	G	↗	Continuation of this significant programme of work.
C	✓	EPMA - Mental Health Inpatient Services Deployment Evaluation	C	✓	The evaluation of the Mental Health services EPMA deployment has been completed as planned
P	↗	EPMA - Physical Health Inpatient Services Deployment	G	↗	
P	↗	EPMA - Mental Health Community Services Deployment	G	↗	
DIGITAL INFRASTRUCTURE					
G	↗	Infrastructure Modernisation	G	↗	
G	↗	Cyber Security & Threat Monitoring	G	↗	
G	↗	Microsoft Office365 Development	G	↗	
G	↗	Multi-Factor Authentication (MFA)	G	↗	
P	→	Email Platform Re-Accreditation	G	↗	
P	→	Telephony (Fixed) Services Review & Contract Re-procurement	G	↗	Contract extended for a further 12 months in 2022/23 to December 2023

Dashboard Key

C	Completed	G	On track	A	Off track but in control	R	Off track major issues impacting overall viability	P	Planned for the future
↗	Improving position	→	No progress	↘	Deteriorating position	✓	Completed activities		

Figure 2

Digital Strategy Progress - metrics

Based on the Trust's priority programmes for 23/24, Table 3 presents the metrics that have been identified to demonstrate how we are moving forward the of use digital approaches to deliver best care and support to service users, carers, staff, and the wider community.

OCTOBER 2023 POSITION		2023/24					
Digital Domain & Initiative	Metric	Q1	Q2	Q3	Q4	Annual Total	Key supporting comments by exception
DIGITAL INFRASTRUCTURE							
Cyber Security & Threat Monitoring	% of NHS Digital high severity CareCert threat notifications acknowledged by the Trust within 48 hours of receipt (Target 100%)	100% (2)	100% (2)				
	% of NHS Digital high severity CareCert threat notifications issued that the Trust has completed remediation for within 14 days (Target 100%)	100% (2)	100% (2)				
Electronic Prescribing & Medicines Administration (EPMA)							100% of Mental Health Inpatient ward beds are live as previously reported. Metrics for the next EPMA phase to be revised to reflect scope.
DIGITAL INFORMATION SHARING							
Yorkshire & Humber Care Record Onboarding	Number of YHCR information requests performed	n/a	n/a	n/a	n/a	n/a	Consumption of YHCR data not yet live, testing in progress. Please refer to update in Appendix A.
DIGITALLY ENABLED WORKFORCE							
Trust-wide Digital Dictation	Number of clinicians able to use Trust-wide digital dictation solution	n/a	n/a	n/a	n/a	n/a	Procurement of a Trust-wide solution commenced during Q4 2022/23 and is in progress. Please refer to update in Appendix A.
DIGITALLY ENABLING SERVICE USERS & CARERS							
Access to Digital Personal Held Care Record	Number of service users registered enabling digital access to personal health records	n/a	5272			5272	Patients Know Best went live on 25 July 2023. Of the total 1903 service users were already registered with PKB as at the point of go live.
Mental Health Annual Physical Health Checks	Number of APHCs undertaken at point of care within the Trust	448	550			998	
Digital Inclusion	Number of service user digital preferences recorded on SystmOne	n/a	n/a	n/a	n/a	n/a	Further work is required to increase uptake of recording this information on SystmOne and reporting mechanisms in development.
Collecting and Reporting Health Outcomes	Number of service user completed digital health outcome questionnaires returned to the Trust.	403	400			803	Please refer to update in Appendix A.

Table 3

Table 4 provides an insight into the IT service operations 'business as usual' quarterly volumetrics that underpin the digital programmes.

OCTOBER 2023 POSITION	2022/23					2023/24				
IT OPERATIONS VOLUMETRICS	Q1	Q2	Q3	Q4	Annual Total	Q1	Q2	Q3	Q4	Annual Total
Total numbers of tickets logged with Service Desk	13,721	12,636	13,050	14,342	53,749	13,468	14,151			27,619
Total tickets emailed to service desk	10,711	10,157	9,813	11,005	41,686	10,530	11,089			21,619
Total tickets phoned to service desk	3,010	2,479	3,237	3,337	12,063	5,736	5,983			11,719
Total phone calls to service desk	6,372	4,990	5,332	5,460	22,154	6,156	5,983			12,139
Number of new registrations on NHS Wi-Fi (Patient Wi-Fi)	1,921	2,194	1,858	1,839	7,812	1,900	2,096			3,996
New network accounts created	480	478	433	604	1,995	472	567			1,039
Number of SystmOne tickets (system requests/amendments)	1,416	976	1,174	1,212	4,778	1,016	1,035			2,051
Number of Smartcard related tickets	1,446	1,681	1,734	1,807	6,668	1,797	2,080			3,877
Number of staff with VPN at present	11,926	12,540	12,886	13,266		13,577	13,922			
Average number of daily VPN connections	3,209	3,589	3,609	3,770		10,511	10,812			
Number of Microsoft Teams 1:1 Calls	34,403	29,673	32,233	32,839	129,148	30,796	28,109			58,905
Number of Microsoft Teams meetings participated in	56,945	52,760	52,781	55,781	218,267	54,779	49,844			104,623
Number of Microsoft Teams Messages (Chat function)	370,913	366,331	400,206	428,651	1,566,101	437,037	400,427			837,464
New/replacement Smartphones provided to end users	205	234	183	151	773	185	158			343
New/replacement voice-only mobile phones provided to end users	185	170	174	149	678	127	134			261

Table 4

Digital Strategy Alignment

Organisational change within our wider care systems continue to influence and shape ICS/ICB digital strategy priorities and plans, incorporating place-based priorities and the annual planning cycle.

Digital Maturity Assessment (DMA)

The national What Good Looks Like (WGLL) digital maturity assessment commissioned in 2022/23 serves to provide all NHS providers and systems across England with access to a consistent digital maturity assessment to help understand their level of maturity with digital technology, whilst allowing comparison with peers and partners across care settings and systems.

The DMA aims to support the strategic objectives of the NHS to improve health and care outcomes through digital transformation, as outlined in Figure 3.
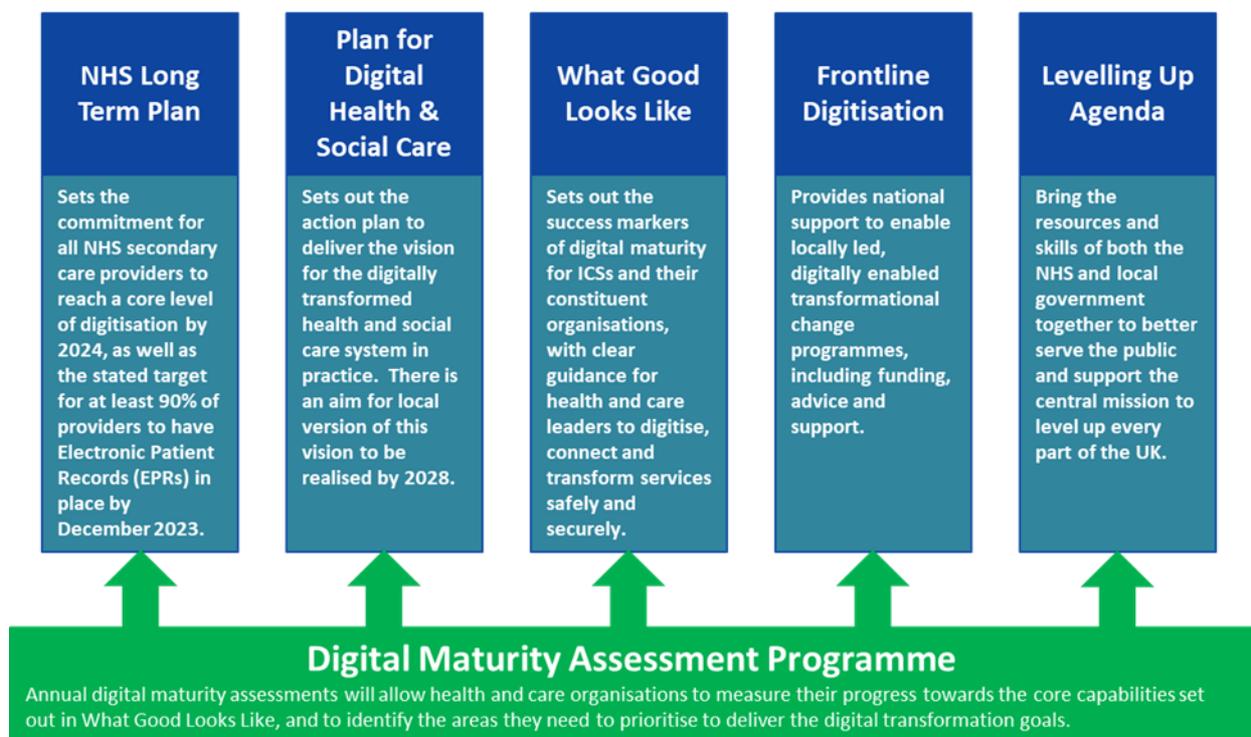
Figure 3

The DMA is defined by a set of questions structured around the pillars of the WGLL framework that gauges how well NHS organisations are making use of digital technologies, whilst identifying strengths and areas for development in the provision of digital services. The DMA consisted of two online surveys, a core survey with 50 questions and a contextual survey with 100 questions, which enabled providers and systems to self-assess their own levels of digital maturity against set criteria for each question. The data and insight from the assessment are considered key to supporting and providing evidence-based planning and investment in digital transformation, in line with the WGLL framework and other national priorities.

Following the initial submission, peer review and ICS workshops a briefing paper was submitted to EMT in May 2023 setting out the Trust position prior to final submission. The insight and findings from the DMA submissions continue to be further analysis at a National and regional level.

NHS Providers - Effectively embedding digital in your Trust
In April 2023, NHS Providers released a guidance document "Effectively embedding digital in your trust", from which a briefing paper summarising where we consider the Trust stands in comparison to the good practice tenets that the guidance promotes. The paper presented to EMT provided assurances regarding the Trust's improving digital maturity journey, whilst highlight some further points for discussion, and making some suggested recommendations for consideration, from which to aid our further evolution as a digitally enabled organisation. This briefing paper compliments the aforementioned digital maturity assessment based on the 'What Good Looks Like' framework.

Organisational Summary
To summarise the Trust's position, the Trust's digital strategy remains comprehensively aligned with National direction and serves to provide the Trust with assurances that our current digital strategy and plans remain fit for purpose and relevant within local and national agendas. However, there is a constant need to develop, enhance and expand our digital landscape further, so to this end we continue to horizon scan and explore potential opportunities for accessing external funding streams to support our digital evolution.

A considerable amount of time continues to be afforded in the planning of activities which has taken account of the annual planning cycle. Whilst some initiatives have been subject to revised delivery timescales for a variety of reasons, appropriate governance has been followed. This means timescales for delivery of such initiatives in this document remain realistic and achievable, subject to allocated/available resources and wider system pressures. Any associated risks are managed with mitigating actions put in place where necessary.

This update is a culmination of the collective work by all involved in continuing to drive forward the Trust's ever-broadening digital agenda in line with the strategy and the organisations increasing levels of digital maturity. Individual contributions are acknowledged in the respective digital initiative profiles listed within the accompanying Appendix A document.

As this report hopefully demonstrates, continued good overall progress has been made against 2023/24 priorities in the main, which is a great achievement when balanced with working collaboratively and sensitively with frontline services who face challenging operational pressures, and having to flexibility respond to additional urgent/unplanned work. The reported position is rated as **GREEN** overall.

The Board is asked to note this progress to date and will continue to be updated twice a year in respect of progress, with the next update to be provided in April/May 2024, highlighting that this will be the final update against the 2021-24 Digital Strategy.

Digital Strategy 2021-24

Appendix A for the Progress Report

Assistant Director of IT Services & Systems Development

Chief Clinical Information Officer

October 2023

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Appendix A – Digital Initiative Profiles in 23/24 (New & Carried Forward from 22/23)

Digitally Enabling Service Users & Carers

Title	**Access to Digital Personal Held Care Record**					Status	Progress Indicator
Lead	S Pidgeon	*Start Date*	01/04/2022	*End Date*	31/03/2024	**G**	↗

Purpose	Development of a SWYPFT capability that provides service users and carers with access to their own digital care record via a portal solution, utilising the Patients Know Best (PKB) digital platform. Potentially providing opportunities to self-manage and engage more readily in the delivery of their care and that delivers alternative means from which to engage with care professionals offering greater flexibility.
Expected Outcomes	• Improve communication between service users, carers, and care professionals. • Providing service users (and, where appropriate their carers) with online access to relevant parts of the clinical record. • Support self-management using online self-management tools. • Supports recovery through signposting to support and recovery resources. • Improve service user and carer awareness of and engagement with Trust related initiatives, events, research opportunities and Recovery College courses. • Improve the consistency and quality of service user related data collection through direct online input by individuals themselves, saving staff considerable time.

Key Milestones			Completion Dates	
Activity	**Summary**		**Target**	**Actual**
Project mobilisation to support the implementation, and initial deployment	A project has been mobilised chaired by the Director of Nursing, Quality & Professions (Senior Responsible Officer) to oversee and facilitate the introduction, configuration, and development of digital personal health record capabilities for our service users and carers. The project approach is centred around inclusivity, engagement, involvement, and active participation across all stakeholder groups. In scope for this initial deployment will be demographics, appointments, shared correspondence such as letters, care plans, carers passport, mood diaries and consent solution.		Jun 2022	Jun 2022
Equality impact assessment review	As this capability forms a key element of the Trust's Digital Strategy, the equality impact assessment undertaken as part of the digital strategy development is to be reviewed based on the requirements of this initiative.		Jan 2023	Jan 2023
Provision of in scope Trust data to the PKB solution	Whilst technical activities relating to the provision of data from SystmOne to PKB has resulted in the overall project timeline being deferred, good progress is being made from collaborative work between the systems team, Performance & Business Intelligence, PKB and our integration partner Restart Consulting.		~~Feb 2023~~ Apr 2023	Apr 2023
NHS App enablement within PKB	The NHS App has already been enabled in West Yorkshire due to Mid-Yorkshire NHS Foundation Trust already deploying PKB. The enablement of the NHS App for PKB in South Yorkshire is in progress		~~Mar 2023~~ May 2023	Jun 2023
Testing of the SWYPFT PKB solution	Testing activities are dependent upon completion of data provision activities		~~Mar 2023~~ May 2023	Jun 2023
Pre-Go Live engagement	To conduct engagement sessions to showcase the Trust's PKB environment prior to go live.		~~Mar 2023~~ Jun 2023	Jul 2023

| Go live | Live deployment of the Patients Know Best (PKB) digital platform within SWYPFT. | ~~Apr 2023~~ Jun 2023 | Jul 2023 |
| Enhancements to the PKB platform | The next phase of the development plan is in the planning stage and aims to focus on the provision of Mental Health care plans from SystmOne and mood diaries to be made available within PKB | Jun 2024 | |

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Project implementation activities and planned go live timeline potentially impacts frontline service delivery due to competing operational pressures	3	3	9	• Project plans and timelines to be shared with OMG and Care Group management meetings to consider any potential impact on service operations, and to remain subject to regularly review.

Title	Inpatient Services Food Ordering					Status	Progress Indicator
Lead	Heath Haigh	Start Date	01/06/2022	End Date	30/06/2023	C	✔
Purpose	The IT Team are currently working with the Catering Department to introduce handheld devices to allow service users to order food on Inpatient wards.						
Expected Outcomes	• Improves the overall service user experience. • Promotes choice. • Improves order accuracy. • Easier to track patients' meal history. • Improves access to services and supportive information.						

Key Milestones			Completion Dates	
Activity	Summary		Target	Actual
Digital food ordering solution	To liaise with the Catering Department, activities are underway to introduce handheld devices (tablets) to allow service users to order food on inpatient wards. A change to the scope has meant that the timeline for this work has been revised.		~~Mar 2023~~ Jun 2023	Jun 2023

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Video Consultation Solution Review					Status	Progress Indicator
Lead	S Pidgeon	Start Date	01/04/2023	End Date	30/09/2023	C	✔
Purpose	Video consultations are electronic means of establishing consultative communications between clinician-to-clinician either at a provider-to-provider level or in collaboration with patients/service users/carers via video conferencing appropriate solutions.						
Expected Outcomes	• Improves the patient experience. • Improves access to services, engaging information users and further supporting the digitisation agendas in line with wider digital aspirations across West and South Yorkshire.						

Key Milestones			Completion Dates	
Activity	Summary		Target	Actual
Evaluation of video consultation solutions in use	The Trust is to consider its needs for video consultation solutions based on current usage and future requirements, through close collaborative working with clinical services to determine an appropriate and strategic way forward.		Sep 2023	Sep 2023

Microsoft Teams is funded through the Trust's licence agreement with Microsoft, whereas use of AccuRX web is provided free of charge through to 31 March 2024.

The use of Microsoft Teams is the preferred option for Trust staff and their patients for this type of functionality, with the use of AccuRx continuing to be proactively monitored for any potential future charge.

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Continued use of AccuRX may not continue to be free of charge beyond 31 March 2024	3	3	**9**	• The Trust to review its requirements for video consultation solutions based on current and anticipated future usage in conjunction with clinical services. • Collaborate across ICS regions and partners to explore most strategic and financially cost-effective options should additional costs be incurred.

Title		Digital Inclusion				Status	Progress Indicator
Lead	Dr A Abbas V Whyte P Foster	**Start Date**	01/04/2023	**End Date**	31/03/2024	**A**	↗
Purpose		Championing digital inclusion and in addressing digital inequalities in terms of access and capability for our service users, carers, their families, and the wider communities that we serve. Digital inclusion remains a key area of focus within the Trust, across both ICSs and in all our places.					
Expected Outcomes		• Service users and carers are more informed about their care, the options available and what they can expect from accessing services digitally. • Needs, wishes, preferences, and aspirations of our service users are comprehensively considered, and they feel listened to and are actively in control of the care they receive. • Service users and carers can use digital technology available to them to access services and information in ways that are preferable.					

Key Milestones			Completion Dates	
Activity	**Summary**		**Target**	**Actual**
ICS and place-based digital inclusion networks	Active participation in ICS (WY & SY) and constituent place-based digital inclusion forums.		Ongoing	
Digital strategy engagement	Engaged on the development of the Digital Strategy which identified several areas for consideration around digital inclusion, such as: ▪ Asking about digital preferences at every contact would be useful; and ▪ To ensure a more representative view – more work needs to be conducted with all other demographics to gain insight into everyone's preferences for a more responsive solution. ▪ Engagement and participation are a key tenet of the Patients Know Best initiative that will enable access to digital personal held care records.		Ongoing	

	As the current Trust Digital Strategy is to be revised during the latter half of 2023/24, this will involve a significant programme of engagement.		
Capturing & recording of service user digital preferences within SystmOne	The means of capturing/recording service user digital preferences within SystmOne has been established and made live, with further work to actively promote the capturing/recording within service users records within SystmOne and develop reporting mechanisms ongoing. Recording uptake has been minimal so further work is being planned to raise the importance and need for capturing this key information.	~~Mar 2023~~ ~~Sep 2023~~ Jun 2024	
Digital Inclusion equipment initiatives	Equipment loaning scheme: Due to the challenges described below and feedback received it is not feasible to establish a short-term 'loaning' of tablet devices. Work will continue to look at other collaboration initiatives. Re-use of Trust decommissioned IT equipment within our local communities: Work has been undertaken in collaboration with West Yorkshire ICS regarding the feasibility of providing laptop devices that the Trust is decommissioning from operational usage, for potential reuse within our local communities. A briefing paper was presented to EMT for consideration in February 2023. This position remains unchanged. ***In both instances, there are several legal, regulatory, and logistical hurdles and social challenges to overcome that are being worked through to enable these initiatives to move forward, from which this will hopefully provide a blueprint for wider expansion.***	Mar 2024	Sep 2023
Additional digital inclusion collaboration opportunities	We are also searching for additional digital collaboration opportunities with partners within our places as well as exploring opportunities with some of our digital/IT service providers to further reduce barriers to digital inclusion and strengthen our supportive interventions.	Ongoing	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
There are several challenges as outlined above to overcome with regards to loaning and issuing decommissioned Trust owned devices for re-use within our local communities.	3	3	**9**	• Work with WYICS to potentially overcome legal/liability implications regarding re-use of Trust decommissioned devices has determined that Trust liabilities cannot be negated following legal advice. A briefing paper with recommendations has been presented to EMT for consideration. • Exploring opportunities with partners and digital service providers to establish mechanisms to reduce barriers to digital inclusion.

Title	**Collecting and Reporting Health Outcomes**					Status	Progress Indicator
Lead	M Garnham S Pidgeon	*Start Date*	01/04/2022	*End Date*	31/03/2024	**G**	↗

Purpose	Some services such as IAPT, CAMHS and early intervention are required to routinely collect outcome measures. There is no consistent approach to outcome measure collection presently within the Trust. Clinical outcomes can be measured by data such as hospital re-admission rates, or by the five domains set out in The NHS outcomes framework indicators: ➢ Preventing people from dying prematurely. ➢ Enhancing quality of life for people with long-term conditions. ➢ Helping people to recover from episodes of ill health or following injury. ➢ Ensuring that people have a positive experience of care. ➢ Treating and caring for people in a safe environment and protecting them from avoidable harm. Therefore, the Trust has developed a solution to enable collecting and reporting health outcomes digitally.
Expected Outcomes	• Improved efficiency by ensuring the delivery of the appropriate questionnaire, at the right time, to the right patient. • Improved timeliness offering real time insight into patient wellbeing and quality of life, providing quicker decision making and ability to tailor treatment. • Automatic analysis, scoring and reporting in real time at clinical, service, and organisational level. • More personalised care and support through service user identified needs and goals. • Better understanding of clinical need and effectiveness of services.

Key Milestones			*Completion Dates*	
Activity	*Summary*		*Target*	*Actual*
Development and early implementation of a digital outcomes App.	The Trust has engaged with its portal/integration partner Restart Consulting to develop a digital solution to collecting patient reported outcome measures (PROMs). This was signed off at the end of October 2022 and rolled out to 8 early implementor teams across CAMHS and mental health during November 2022, with positive feedback from staff and service users. This was supported by communications including a website page, FAQ, leaflet, and user guide.		Jul 2022	Oct 2022
Development of staff engagement and training package	To support Trust wide roll training. A training package to raise awareness of the importance of outcome measures, linking outcomes with personalised care and support and of how to use the digital outcome app is being developed.		Jul 2023	Aug 2023
Initial wider roll-out of the IMX Digital Outcomes tool with the focus being on Enhanced and Early Intervention teams.	To support achieving CQUIN 15a standards and to align with the personalised care planning agenda, a strategy for wider roll-out has been developed by the CQUIN-15 project group and approved by the Personalised Care and Support Steering Group. Training will be rolled out to all Enhanced and Early Intervention teams through September and October 2023 with the IMX digital outcomes tool being live and SMS outcome messages going to the service users from November 2023.		Nov 2023	
Trust wide roll-out	Trust wide roll-out on a phased approach to be agreed by OMG.		Mar 2024	

Key Risks	*Likelihood*	*Impact*	*Risk Score*	*Actions & Controls*

Title	Digital Health App – Create & Bloom					Status	Progress Indicator
Lead	Vicki Whyte	**Start Date**	01/04/2022	**End Date**	31/012/2023	G	↗
Purpose	To digitally enhance services through the application of digital health apps that improve access to services and supportive information.						
Expected Outcomes	• Improves the overall service user experience. • Improves access to services and supportive information. • Forms part of the wider digitisation of the NHS						

Key Milestones				Completion Dates	
Activity	**Summary**			**Target**	**Actual**
Prototype app development	Proof-of-concept creativity app which will support an individual's health and wellbeing through creative approaches has been developed for IoS and Android. A full evaluation including staff and community testing will now take place before a full working version is commissioned.			Sep 2022	Oct 2022
Testing & user feedback	Testing with an initial cohort of people has commenced for both Apple (iOS) and Android platforms, with positive feedback to date.			~~Dec 2022~~ Jun 2023	Aug 2023
Full app development and rollout	A proposal has been received from the supplier for the development of the full app and wider rollout during 2023/4. Capital funding has been approved to take this initiative forward.			From Dec 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Ability to identify funding for the development of a full working version of Create and Bloom.	1	2	**2**	• Commissioning of a full Create and Bloom app has been incorporated into the capital funding proposals. Other avenues of funding through the Creativity & health programme are also being pursued.
Testing on SWYPFT issued smartphones	3	3	**6**	• Investigation of the technical problem to determine the root cause is underway from which resolution can be established.

Title	Digital Remote Monitoring					Status	Progress Indicator
Lead		**Start Date**	01/04/2022	**End Date**	31/03/2024	P	→
Purpose	This is a joint project within South Yorkshire being led and co-ordinated via Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) following a successful bid for national funding in 21/22. For SWYPFT, the potential focus is within Barnsley CAMHS initially and it is an innovative way forward for children, especially those that struggle to leave their home for assorted reasons such as anxiety but also ASD/GID, etc. It is customisable virtual reality solution, where the clinician supervises remotely, potentially many patients at the same time as they go through their desensitisation programme.						
Expected Outcomes	• Improves the overall service user experience. • Enhancing quality of life for people. • Ensuring that people have a positive experience of care. • Treating and caring for people in a safe environment and protecting them from avoidable harm. • Improves access to services and supportive information.						

		• Forms part of the wider digitisation of the NHS			
	Key Milestones			**Completion Dates**	
Activity	**Summary**			**Target**	**Actual**
South Yorkshire Virtual Reality Project (CAMHS)	The initial deployment within RDaSH will explore wider opportunities for potential clinical application. Progress has been hampered by governance and due diligence requirements. Potential application within SWYPFT (Barnsley CAMHS) to be reassessed following change in service approach.			Mar 2024	
Key Risks	**Likelihood**	**Impact**	**Risk Score**	**Actions & Controls**	

Title	**Website Re-development**					**Status**	**Progress Indicator**
Lead	G Richardson	**Start Date**	01/04/2023	**End Date**	31/03/2024	**G**	↗
Purpose	Redevelop Trust public facing website to improve signposting, functionality and accessibility to stakeholders, staff, and general public: Key focus for improvements: ➢ Content and audience review to enable prioritisation of future development in structure. ➢ Service directory review and development – audit and review and development of the current service directory. ➢ Website structure review. ➢ Microsite review. ➢ Accessibility review against the current WCAG 2.1 AA accessibility standard and public accessibility regulations 2018. ➢ Produce a user centred design plan. ➢ Implement new designs and content management system. ➢ Migration of old content to new site.						
Expected Outcomes	• Maintain and improve the user experience of the website with a focus on putting the user first and digital by default. • Make accessibility improvements so the Trust continues to meet its accessibility obligations. • Improve functionality to enable more digital content in a range of formats is available for services within the organisation to utilise to improve patient outcomes. • Ensure a continuation of the current high standards of data security and IG whilst identifying any current and future risks. • Ensure that the high standards of the NHS and Trust brands are maintained.						

	Key Milestones		**Completion Dates**	
Activity	**Summary**		**Target**	**Actual**
Complete an accessibility audit	• Have a third party complete an accessibility assessment on the current website build by sampling 3 common template pages, assessing the page for accessibility against the upcoming WCAG 2.3 regulations. • Complete an audit check and highlight any content failures. • Produce a report and action list to fix and conform with the standard		Oct 2023	Sep 2023

Defining the development approach	• Define the development approach e.g. stakeholder engagement, co-design, co-production, and user testing.	Dec 2023	
Complete a content website and behaviour analysis on website	• Gain website content and behaviour insight via a website insight tool installed on the current website to gain an accurate picture of where the priority content should sit which will feed into the redesign	Dec 2023	
Gain multiple user insight	• Work with engagement and our local Healthwatch organisations to gather user intelligence on the current website. • Healthwatch organisations have been contacted and we are awaiting feedback	Dec 2023	

Key Risks		Likelihood	Impact	Risk Score	Actions & Controls

Digitally Enabled Workforce

Title	Microsoft SharePoint365 Developments					Status	Progress Indicator
Lead	G Richardson & SharePoint Development Steering Group	**Start Date**	01/04/2023	**End Date**	31/03/2024	**G**	↗

Purpose	Enhancements and new developments to the Trust's Microsoft SharePoint365 environment, which the Trust is dependent upon for the following asset areas: - ➢ Intranet (Communications, Marketing & Engagement) ➢ Payroll forms and processes (People) ➢ Business Intelligence dashboards and performance reporting (Performance & Business Intelligence) ➢ Criteria led discharge dashboard and processes (Integrated Change Team) ➢ Supervision database (Nursing Directorate) ➢ Membership database (Corporate Governance) ➢ Emergency planning (Health & Safety) ➢ IT and systems access (IM&T)
Expected Outcomes	• To continue to improve access to corporate systems and information in a timely and responsive manner. • Ensuring that the Trust corporate assets as listed above are continually developed, maintained and services/information is accessible across the workforce. • Continues to support information asset management, integrity, and confidentiality to comply with GPDR requirements. • Establish a robust and strategic approach for ongoing maintenance & support and continuous development (strategic roadmap) of the SharePoint environment, subject to Trust governance and approvals.

Key Milestones		Completion Dates	
Activity	**Summary**	**Target**	**Actual**
SharePoint development programme	Continued development of the Trust's SharePoint online platform in line with the SWYPFT asset owner requirements and key stakeholders working with Emposo (formerly James Harvard associates). The current and future developments will enhance the existing platform, making best use of available functionality.	~~Dec 2023~~ Mar 2024	

Highlight new work programmes through the SharePoint user group	New functionality has been identified through the SharePoint Development Steering group and has been quoted and planned with Emposo.			Ongoing	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Resilience within key SharePoint asset areas due to organisational reliance on key individuals	3	3	9	• The SharePoint operating model provides for a sustainable and robust operating model to address/lessen the impact on the Trust's business operations due to the reliance on SharePoint assets.
From a strategic and operational perspective there is no overall ownership and accountability of the SharePoint platform within the Trust, a key fundamental role that underpins a robust operating model, from which to support and develop the Trust's SharePoint environment.	3	3	9	• A new SharePoint Services Manager post has been put forward for recurrent funding as part of Phase 2 considerations to EMT, following endorsement by OMG. • SharePoint developments and prioritisation is being overseen by the Trust's established SharePoint Development Steering Group.

Title	Trust-wide Digital Dictation Solution Phase 1 Procurement					Status	Progress Indicator
Lead	P Foster	Start Date	01/01/2023	End Date	31/07/2023	A	↗
Purpose	Procurement for a strategic Trust-wide digital dictation solution informed by the business case approved in October 2021. The procurement activities have been subject to deferment due to capacity limitations. However, a revised approach was presented to EMT and approved to commission a third-party professional services supplier to provide the Trust with the resources and capacity to drive this key initiative forward.						
Expected Outcomes	• To determine a preferred solution/supplier from which to initiate phase 2, the deployment of the chosen solution Trust-wide, offering standardisation. • Supports the paperless agenda. • Improves service effectiveness and efficiencies. • Potential economies of scale						

Key Milestones			Completion Dates	
Activity	Summary		Target	Actual
Procurement exercise	Initiation and completion of a formal procurement exercise for a Trust-wide digital dictation solution/service and identification of preferred single supplier.		Jul 2023	Aug 2023

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Ability to identify internal/external capacity and to recruit & secure the required project resources to provide the necessary capability to support this key initiative.	3	3	9	• Proposal put forward as part of Phase 2 recurrent funding for EMT consideration to establish a Digital Transformation Team within the Trust to provide the capacity and capability from which to drive forward the digital dictation project and other digital

				innovation opportunities. OMG are supportive of this proposal.
Timeline for procurement and deployment of a Trust preferred digital dictation solution remains subject to constant slippage due to existing capacity issues.	2	3	**6**	• Alternative avenues to secure the required capacity to expedite and accelerate bringing this initiative forward during 22/23 explored and approved by EMT for non-recurrent monies to enable this, in lieu of the Phase 2 recurrent resource funding requirements. Overall risk score reduced because of the actions and controls taken.
Procurement outcome challenge by unsuccessful bidder	3	3	**9**	• Standstill period paused as the Trust looks to address the challenges posed and is engaging specialist legal services to advise on response and appropriate course of action in mitigation.

Title	Trust-wide Digital Dictation Solution Phase 2 – Implementation					Status	Progress Indicator
Lead	S Barton V Whyte	**Start Date**	01/11/2023	**End Date**	TBD	**P**	**→**
Purpose	Deployment of the Trust's preferred strategic Trust-wide digital dictation solution following conclusion of the procurement exercise, Trust approval and award of contract.						
Expected Outcomes	• To deployment of the chosen solution Trust-wide, offering standardisation. • Supports the paperless agenda. • Improves service effectiveness and efficiencies. • Potential economies of scale						

Key Milestones			Completion Dates	
Activity	**Summary**		**Target**	**Actual**
Procurement exercise for implementation resources	Initiate and complete formal procurement exercise for external resource to provide project management and change management capacity to support the Trust in implementing the chosen Trust-wide digital dictation solution/service.		Jul 2023	
Deployment of Trust-wide digital dictation Solution	Implementation and deployment of the chosen Trust-wide Digital Dictation Solution.		From Aug 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Ability to identify internal/external capacity and to recruit & secure the required project resources to provide the necessary capability to support this key initiative.	3	3	**9**	• Proposal put forward as part of Phase 2 recurrent funding for EMT consideration to establish a Digital Transformation Team within the Trust to provide the capacity and capability from which to drive forward the digital dictation project and other digital innovation opportunities.

						• Project manager to oversee the implementation successfully appointed with recruitment and onboarding activities underway.

Title	**Workforce Digital Confidence and Capability**					*Status*	*Progress Indicator*
Lead	R Meyers P Foster	*Start Date*	01/07/2022	*End Date*	31/03/2024	**A**	↗
Purpose	Our workforce is our greatest asset and to be truly digitally excellent, our staff need to be fully conversant, competent, capable, and confident in their use of digital solutions which promote high quality care provision. Exhibiting good digital knowledge, skills and capabilities is not about developing technical proficiency but in recognising that when coupled with an assured outlook, it is how digital solutions can be applied during effective care delivery which improves care and creates positive health outcomes. To enable this, when planning for and introducing new and innovative ways of working, this needs to be supported by effective learning, education and training which is tailored to the individual and available through different channels. This requires a cultural shift throughout the Trust's workforce.						
Expected Outcomes	• Supports in making this a great place to work, also improving staff retention. • Enables a digital capable workforce that embraces flexible and adaptable work-life balance. • Improve access, timeliness and availability of training and development opportunities in support of identified needs. • Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience, and capabilities. • Adopting and learning from digital best practices. • Better use of Trust resources. • Helps to nurture a continuously evolving digital culture throughout the organisation.						

Key Milestones			Completion Dates	
Activity	*Summary*		*Target*	*Actual*
Further development of Digital Training Services incorporating a review of the Trust estate to facilitate digital training delivery	Work is ongoing in collaboration between Learning & Development, Estates & Facilities, and IM&T with regards to reviewing and improving digital training delivery capabilities across the Trust. This work will take learning from our recent experiences and across our networks, to improve the digital training offer, where applicable and appropriate. Developing plans for converting a selection of training rooms into digital training suites to reduce the need for large groups in one place, support the Trust's sustainability agenda, and reduce associated costs for travel, etc. This scheme was delayed due to competing priorities.		~~Jun 2022~~ Nov 2022	Nov 2022

Improve the digital skills and competencies of our staff	This will require a quality improvement and programme approach to drive forward digital capabilities of staff through by: -
	    ▪ Exploring ways in which we can determine digital skills self-assessment to identify learning requirements as part of personal development planning cycles. A digital skills self-assessment questionnaire/survey is being prepared to facilitate this.
	    ▪ This will inform our digital training and development programmes, influence methods of learning to improve overall digital literacy of the Trust workforce, adopting/adapting Health Education England's tools and frameworks: -
	        o Digital Champions Programme Toolkits
			~~Mar 2023~~ Mar 2024	

		Digital Literacy Self-Assessment Diagnostic Tool			
		Digital and learning in healthcare.			
		Profession and Service Specific Digital Capabilities			
	Our approach to digital training and skills development will be innovative and cognisant of individual learning styles and learning preferences, especially given the diverse and complex needs of our staff.				
	Whilst some progress has been made, activities have been deferred into 2023/24 due to re-organisation within the People's Directorate.				

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Network stability with increased training delivery with large groups accessing programmes from a blended hybrid working model (home or agile bases).	2	3	6	• Assessment and evaluation of digital technologies and solutions that support digital training delivery will take account of this specifically for the Trust's network. Staff accessing training when working from home or from premises outside of the Trust's network control will need to check/test their connectivity prior to attending training.
Staff resistance to digital education, training, and development service changes and in adopting new ways of learning	3	4	12	• Ensure robust awareness, engagement and consultation approach and communication campaigns across all stakeholder groups, forums and networks in the design and development of digital education and training opportunities. • Establish digital champions and supportive networks with positive attitudes, seeking out appropriate and innovative digital technologies to enhance learning for self and others. • Develop key principles for digital education and training that are built upon ethical, positive, sensitive, and appropriate attitudes and behaviours

Title	eCommunity Resource Scheduling					Status	Progress Indicator
Lead	Paul Hughes	Start Date	01/04/2023	End Date	31/03/2024		
Purpose	To explore the potential for a workforce scheduling digital solution for deployment and utilisation across physical health Neighbourhood Teams services.						

Expected Outcomes	• Improve demand and capacity management. • Improve community resource scheduling capabilities. • Improve co-ordination of community-based visits. • Potential to support lone working security arrangements.		
Key Milestones		**Completion Dates**	
Activity	**Summary**	**Target**	**Actual**
Rapid review	Undertake a review of the District Nursing workforce	**SCHEME REMOVED FROM PLAN IN 23/24 AS REQUESTED BY BARNSLEY CARE GROUP**	
Test the market	Explore potential solutions available in the marketplace and conduct a procurement exercise based on the Trust's requirements		

Title	**Recruitment System (NHS Jobs 3 Replacement)**					Status	Progress Indicator
Lead	R Butterfield	**Start Date**	01/04/2023	**End Date**	31/03/2024	**G**	↗
Purpose	To explore innovative digital solutions to improve the Trust's workforce recruitment processes and candidate experiences by replacing the NHS jobs 3 application tracking system. This is only part of the NHS Jobs 3 solution, the Trust will continue to use the front end of NHS Jobs for job advertisements and initial application.						
Expected Outcomes	• Improve workforce recruitment processes and shorten hire time. • Increase ability to target key areas and monitor KPI performance against data-drive insights. • Improve applicant/candidate experiences. • Allow for bespoke tailoring of the Trusts system requirements.						

Key Milestones		**Completion Dates**	
Activity	**Summary**	**Target**	**Actual**
Evaluation of digital recruitment solutions	Undertaken a review of the digital recruitment solutions available within the marketplace and in existing across the NHS to improve the Trust's recruitment processes.	Mar 2023	Mar 2023
Procurement of preferred ATS system	Genius ATS system procured and implementation timescales, training plan and roll out underway	Mar 2024	
End to end recruitment IT solution	Completion of linkages and end to end recruitment solution from NHS Jobs 3 to Genius ATS and Genius onboarding solutions	Mar 2024	

Key Risks	**Likelihood**	**Impact**	**Risk Score**	**Actions & Controls**
Genius ATS system not implemented	1	1	1	NHS Jobs 3 would continue to be our solution to providing ATS tracking of recruitment activity in the event of Genius not being implemented and this is already in place.

Digital Intelligence

Title	**Performance & Business Intelligence**					Status	Progress Indicator
Lead	M. Wood L Metcalfe	**Start Date**	01/04/2023	**End Date**	31/03/2024	**G**	↗

Purpose	The development of a business intelligence, performance management and reporting capabilities that facilitates the provision of an information hub and dashboards to improve access to business performance information that informs service line reporting through key performance indicators to aid service improvements and delivery.		
Expected Outcomes	• Improve availability of information to support operational services and transformation agendas. • Improve performance reporting. • Improve data quality. • Identification of additional key performance indicators and associated metrics		

Key Milestones		Completion Dates	
Activity	**Summary**	**Target**	**Actual**
Data quality dashboard	Data quality dashboard is being developed to allow monitoring of progress against the Trusts data quality action plan. A suite of data quality reports has been made available on the SWIFT site – this continues to be further developed. The next stage for development will be to review against the data quality workplan. This will be linked to the recruitment of the Performance & Business Intelligence Project Manager role.	Mar 2023 Apr 2024	Apr 2023
Waiting list reporting project	Waiting list reporting from SystmOne incorporating health Intelligence forecasting and demand management. The waiting list analysis report is now live for most services using SystmOne. Delay with learning & development services is linked to service re-design.	~~Sep 2023~~ Dec 2023	
Neighbourhood Teams developments (NTS)	Continued development work to support new ways of working in Barnsley Community Services (NTS) and ensure suitable reporting outputs available. Developments continue in line with implementation.	Mar 2024	
Business As Usual (BAU) Reporting	Ongoing additional reporting and reporting enhancements to support the performance management agenda.	Ongoing	
Team dashboards	Further team dashboards developments, with work ongoing to consider variation internally and potential opportunities for improvement. Further analysis to be undertaken on the Trusts benchmarking and Model Hospital data.	Sep 2023 Mar 2024	Sep 2023

National reporting requirements	Reporting developments to support: -
	▪ Virtual ward submission – reporting developments to meet national reporting requirements.
	▪ Long Covid submission – reporting developments to meet national reporting requirements.
	▪ Reporting developments to support the QUIT service and submission of associated data.
	    • QUIT Barnsley
	    • QUIT vaping pilot (South Yorkshire)
	▪ Readiness for MHSDS (version 6) to meet national standards from April 2024.
	Expansion of MHSDS DQMI reporting to include additional 26 data items.
		
		Apr 2023
		
		Apr 2023
		
		Sep 2023
		Oct 2023
		Apr 2024
		
		Apr 2024
			
			Apr 2023
			
			Apr 2023
			
			Sep 2023

Datawarehouse developments	Datawarehouse development efficiencies, continued work on feeds of data from other Trust sources such as	Ongoing	

	Tendable, Datix, health roster. Exploring automated data feed from Datix. Estimated timeline for feed of data for tendable. Estimated timeline for feed of data from Datix is by end Dec 23. Estimated timeline for feed of data for HealthRoster/People.	Oct 2023 Dec 2023 Jan 2024	
Integrated performance report developments & automation	Review and scope out work plan complete. Work has commenced on a PowerBi version of the IPR. This initially focused on the national metrics, the aim being to complete this by the end of Q1 2023/24. This initial work was completed in August 2023. Next priority area identified was people, the first step for the People directorate is to ensure that all data is flowing into the data warehouse this will be completed by 31 January 2024. Therefore a decision has been made to focus on quality for the next phase of the IPR development. People will be scheduled once the data warehouse implementation is complete. Some dependencies for full completion of quality section linked to feed of data from Datix. Initial focus for quality section will be to automate all non Datix related reporting. Completion of overall project expected by end of the 2023/24 financial year.	Jul 2023 Jan 2024 Apr 2024	Aug 2023
CQUIN developments	Development work to support the proposed CQUIN metrics for 2023/24.	Jul 2023	Jul 2023
Automation	Piece of work to review and automate existing manual processes to improve efficiency and allow more capacity for data analysis.	Mar 2024	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Capacity limitations within the team to continue to provide the necessary capability to support this key Trust programme of work	3	3	9	• One agency and one part-time bank resource currently engaged to provide additional capacity and support to the performance & business intelligence function.
Data quality linked to Neighbourhood team services impact on PLICS	4	4	12	• New data quality reporting has been implemented. • Issues are being highlighted with the service. • Meeting arranged with service to discuss and agree next steps re: further mitigation.
IPR Development – People Directorate – capacity/expertise to support	3	3	9	• Task and finish group to be established to progress this work.

Digital Information Sharing

Title	Yorkshire & Humber Care Record Onboarding (Clinical Portal Development/(PORTIA)					Status	Progress Indicator
Lead	S Pidgeon	Start Date	01/04/2021	End Date	~~31/12/2023~~ 31/03/2024	A	↗

Purpose	Enables the Trust to bring together information from different clinical information systems into a single integrated record view, enhancing the care we provide through improved information accessibility and reducing the time staff spend locating the clinical information they need.
Expected Outcomes	- Enhances integrated holistic patient record view. - Sourcing data from Trust internal systems and externally with partners leveraged via the YHCR. - Supports informed clinical decision making and patient care delivery through access to information in a timelier manner. - The richness of the YHCR will increase as more partner organisations onboard and additional datasets defined and become available. This is a strategic priority across both West Yorkshire & South Yorkshire ICS regions and constituent places.

Key Milestones			Completion Dates	
Activity	Summary		Target	Actual
Onboarding to the Yorkshire & Humber Care Record to consume available data	The Trust are currently engaged in connecting with the Yorkshire & Humber Care Record (YHCR) via the Trust's existing clinical portal solution (Viper360). This activity aims to provide a channel for the Trust to consuming available YHCR datasets. Trust progress has been delayed due to revised YHCR governance processes and re-baselining project activities. Testing activities were completed within the Trust in June 2023 followed by the progression to go-live production, although a series of issues had to be resolved by YHCR to eventually allow access. The final stage of smoke-testing by Chief Clinical Officers from both parties remains subject to scheduling due to competing work demands and annual leave. Once complete the functionality can be rolled out across the Trust.		~~Nov 2022~~ ~~Jun 2023~~ Oct 2023	
Onboarding to the Yorkshire & Humber Care Record to provision SWYPFT data	This activity serves to provision Trust data (via defined datasets) to feed into the YHCR. As at the start of September 2023, TPP will now supply the data direct to YHCR who are ready to test the data feed. Once beta testing by nominated NHS provider organisations has been successfully completed, wider deployment can be planned and scheduled.		~~Sep 2022~~ ~~Dec 2023~~ TBD	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Electronic Referrals (eReferral Service)					Status	Progress Indicator
Lead	S Pidgeon J Hirst	Start Date	01/04/2022	End Date	31/12/2023	G	↗

Purpose	The electronic referral service (e-RS) offers different functionality giving patients a choice of place, date, and time for their first outpatient appointment in a hospital or clinic. Patients can choose the hospital or clinic, and then book their appointment to see a specialist in conjunction with a member of

	the practice team at the GP surgery, or at home by telephone or over the internet at a time more convenient to them. This service was originally designed for acute-based services (e-RS was formerly known as Choose & Book) and has been adopted by some Physical Health Community services within the Trust where appropriate. However, uptake by Mental Health services remains subject to evaluation to determine fitness for purpose for this care setting.
Expected Outcomes	• Enables the Trust to reduce the reliance and flow of paper both internally and externally with our partners in respect of delivering patient care. • Supports the continued drive towards digitisation of the NHS and reducing our paper footprint. • Potential to improve more timely access to appropriate care. • Ability to receive referral correspondence electronically rather than traditional printing/posting channels.

Key Milestones		Completion Dates	
Activity	**Summary**	**Target**	**Actual**

eReferral services in Mental Health	Exploration and deployment of electronic referral capabilities that integrate with SystmOne, via the following referral channels, as deemed suitable and appropriate within Trust services: -
	    - eReferral Service
	    - SystmOne to SystmOne
	    - Self-referrals and referrals from other providers
	
	Discussions with NHS England (formerly NHS Digital) are ongoing to explore ways of making the eReferral Service functionality work for Mental Health Services, together with the Trust contacting other Mental Health organisations who are implementing this capability.
	
	A meeting with Surrey & Borders NHS Foundation Trust was held to understand how they had introduced the e-Referral Service into their services, and it is apparent that their staff must perform significant workarounds to utilise the functionality. It appears that there has been little change to the system since the last appraisal was carried out by the Trust which will be reflected in the evaluation paper.
		Sep 2023	Sep 2023

Evaluation report	Produce an evaluation report together with recommendations for the Trust to consider regarding the adoption and application of eReferral services.	Dec 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	**Access to ICE**					**Status**	**Progress Indicator**
Lead	S Pidgeon	**Start Date**	01/04/2021	**End Date**	~~30/09/2023~~ 31/12/2023	**A**	↗
Purpose	To improve accessibility and arrangements for accessing ICE to request and receive order communications and results reporting information with our acute partners (Mid-Yorkshire NHS Foundation Trust, Calderdale & Huddersfield NHS Foundation Trust, and Barnsley Hospital NHS Foundation Trust.						
Expected Outcomes	• Improved ability to access and make requests e.g., blood test via the ICE systems(s) in place with our acute partners. • Improve timeliness of access to results information electronically. • Ability to update the results directly into the SystmOne record.						

21	• Improve user set up time on the ICE system as we move to a structured process covered by a Service Level Agreement (SLA) • Enabling users to electronically add Pathology test results from within the Trust's Clinical information system (SystmOne) • Reduce the risk of manually adding Pathology test results to the wrong record. • Save clinicians time by not having to log-in to numerous applications. • Improved visibility of all Pathology test results for all three Laboratories in the Trust's area including those submitted by other organisations for a complete diagnostic history

Key Milestones		**Completion Dates**	
Activity	**Summary**	**Target**	**Actual**
ICE integration into SystmOne	Establish ICE integration into SystmOne enabling results to be available within the SystmOne record. Following a change to the registration process by CliniSys (ICE system supplier) in September 2022, a full list of users with either NMC or Smartcard number is required, so each Care Group has been asked to supply this information. Once obtained the appropriate paperwork can be sent to each Acute partner Laboratory Dept. Formal quotations for the costs of introducing and utilising this functionality have been obtained from the three acute provider pathology laboratories that cover our geographical area, and timescales to get this implemented are in the main influenced by our acute partners and the system supplier CliniSys. It was hoped to connect to at least one pathology laboratory (Mid Yorkshire Hospitals NHS Trust) in the third quarter of 2022/23 with the other two in the fourth quarter of 2022/23 (Calderdale Hospital NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust). However, due to changes within CliniSys (ICE system supplier) this has been delayed further. A summary of the current position per pathology laboratory is provided below:- *Mid Yorkshire Hospitals NHS Trust (MYHT)* Paperwork has been completed and we are now waiting for the next steps for the integration to be started. MYHT testing another two new connections to their ICE system in August following which they will commence our testing. *Calderdale & Huddersfield NHS Foundation Trust (CHFT)* A Project kick off meeting for CHFT took place in mid-March following which the CHFT IT section have been configuring the system and creating user accounts. Once the users have been created a test will be done by a Trust user and if successful a full roll out to the other users at The Dales. The activation work by CliniSys was completed in June and the 'Interop Services' have been created to enable us to test the system. Some final small amounts of configuration are needed so that testing can be carried out. *Barnsley Hospitals NHS Foundation Trust (BHFT)*	~~Dec 2022~~ ~~Sep 2023~~ Dec 2023	

	All details submitted to CliniSys and waiting for the startup process and activation work to be completed.				

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Challenges across the wider system impacting the ability to improve access to ICE for requesting/receiving order communications.	4	3	**12**	• Options explored and proposal depicting a way forward approved by the Trust. • Continue to liaise and collaborate with local acute partners and system suppliers. • Arrange appropriate training for staff to use the proposed new functionality.
Dependencies on external parties impacting the ability to move this forward in as timelier manner as the Trust requires	4	3	**12**	• Liaise and collaborate with local acute partners and system suppliers to explore having access to their ICE systems and to work through clinical, operational, and technical challenges for mutual benefits.

Title	**Access to Partner Electronic Care Record Systems (Acute)**					Status	Progress Indicator
Lead	S Pidgeon	**Start Date**	01/11/2021	**End Date**	~~28/02/2023~~ ~~30/06/2023~~ 31/12/2023	**A**	↗

Purpose	To improve accessibility and information sharing capabilities through enabling access to our acute partners electronic care record systems for Trust staff where appropriate. This will be achieved by exploring the options to facilitate and enable appropriate access to partners electronic care record systems for Trust staff where there is a defined operational requirement, in line with information governance compliancy.
Expected Outcomes	• Supports informed clinical decision making and patient care delivery through access to information in a timelier manner. • Reduces the reliance on partner Trust staff obtaining the information. • Will help the Trust to meet reporting requirements.

Key Milestones			Completion Dates	
Activity	**Summary**		**Target**	**Actual**
Enabling access to Mid-Yorkshire care record system	Arrangements in place for the MH Liaison Staff to have access to Mid-Yorkshire care record system.		Dec 2020	Jan 2021
Enabling access to CHFT care record system	Discussions have progressed with CHFT counterparts and configuration of Trust computers has been completed for the identified users. User accounts for Cerner PAS have been created by CHFT and the appropriate access mechanism to their secure network provided. Licences for eight concurrent users with access on Trust computers was agreed and the staff identified by Trust services had additional software added to their computers and access has been successfully achieved.		~~Dec 2022~~ Jun 2023	May 2023
Enabling access to BHNFT care record system	Further meetings to be arranged to facilitate access for both party's access to EPR systems, respectively.		~~Feb 2023~~ Oct 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Challenges across the wider system impacting the ability to drive this forward in a timely manner.	4	3	**12**	• Liaise and collaborate with local acute partners to work through clinical, operational, and technical challenges for mutual benefits. • Arrange appropriate training for staff to use the proposed new functionality.

Title	Information Governance					Status	Progress Indicator
Lead	R Smith	**Start Date**	01/04/2023	**End Date**	30/06/2024	**G**	↗
Purpose	To ensure that the Trust achieves compliance with its information governance responsibilities and statutory obligations.						
Expected Outcomes	• Mandatory IG training target is achieved. • The Data Protection & Security toolkit target of meeting all mandatory standards is maintained. • Ongoing compliance with GDPR is assured and processes established which are reviewed regularly.						

Key Milestones				Completion Dates	
Activity	**Summary**			**Target**	**Actual**
Information Governance Training (2023)	Ensure that the mandated annual information governance training update is maintained. Mandated annual IG training target achieved.			Jun 2023	Jun 2023
Information Governance Training (2024)	Ensure that all staff complete satisfactory data security training whilst transitioning from the previously mandated training package to multiple solutions linked to job roles.			Jun 2024	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Failure to meet the Data Security & Protection Toolkit standards due to low compliance with mandatory information governance training	3	4	12	• New national solution to be developed and implemented. • Organisational, operational, and individual communications. • Classroom session(s) offer available. • Where completion is via e-learning, advice is to screen shot for evidence due to risk that ESR may not update automatically.

Title	Consent to Share Re-Engagement					Status	Progress Indicator
Lead	R Smith	**Start Date**	01/04/2023	**End Date**	31/03/2024	**G**	→
Purpose	To resume a previous project to seek consent to share out from existing patients that focuses on implementing a process for seeking consent to share out from new patients and manage withdrawals of consent whilst embedding this within clinical practice.						
Expected Outcomes	• All existing patients will have been asked if they consent to share out. • All new patients will be asked if they consent to share out. • All patients will be aware that of the right to withdraw consent at any time and how to do so. • All responses are recorded, and system settings amended as required.						

Key Milestones	Completion Dates

Activity	Summary	Target	Actual
Consent to share working party	Prior to the covid-19 pandemic, the Trust commenced a project to seek consent to share out from existing patients, whereby letters were sent to patients to request this. The response rate was approximately 33%. Consent must be a positive action that can be evidenced, and verbal consent is not acceptable in law. The project was put on hold when the control of patient information (COPI) notice was issued.

The Health Secretary issued a COPI notice to permit open sharing of health records to manage and mitigate the pandemic, regardless of any prior sharing preferences that were set at patient level. SystmOne was set to share Trust records with other healthcare providers that use the same system. The notice expired on 30 June 2022 and SystmOne sharing was turned off. Therefore, open sharing ceased, unless patients had previously given explicit consent to share out.

The Trust began planning its response to the expiry of the COPI notice in July 2021. It was agreed by the Executive Management Team that consent would continue to be the lawful basis to share, providing a sensitive approach with patient centredness, due to the high-risk nature of most of the Trust's records. It should be noted that sharing out can be turned on at short notice where another lawful basis applies, e.g.: to protect vital interests, reasons of substantial public interest, etc. so there is no risk attached to patients refusing to share out.

The original project resumed on expiry of the COPI notice and a digital solution for obtaining consent for existing patients is almost ready for implementation. Work to embed seeking consent into clinical practice is ongoing. | Mar 2024 | |

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Failure to meet Trust agreement to give patients choice in sharing their sensitive data	3	2	6	• Working party to agree and plan actions. • Regular updates to the Improving Clinical Information Group (ICIG) for oversight. • Issues identified at ICIG escalated to the EMT.

Title	Patient Reminder Systems Review					Status	Progress Indicator
Lead	M Garnham S Pidgeon	Start Date	01/04/2023	End Date	31/03/2024	G	↗
Purpose	The Trust currently has two patient appointment reminder systems in operation which aim to reduce "did not attend" (DNA) levels across Trust services. This is a legacy arrangement due to different clinical information systems and practices in place previously. This review will look to explore the options and opportunity to rationalise down to a single platform within the Trust.						

Expected Outcomes	• Reduce DNAs by increasing re-use of appointment slots ('fast-track' patients in need of urgent appointment) and in turn reduce costs and waiting times.
	• Improve efficiency of services.
	• Improve quality of services.
	• Improve patient experience.
	• Make best use of Trust resources.

Key Milestones		Completion Dates	
Activity	**Summary**	**Target**	**Actual**
Evaluation of the existing patient appointment reminder systems in use	Produce an evaluation paper which assesses the existing systems in use and consider the options based on advantages/disadvantages of rationalising to a single Trust-wide platform to meet this need. This work was put on hold due to SystmOne Neighbourhood Teams Service work ongoing but is now being recommenced during 2023/24, in recognition of the progress being made in this major SystmOne development initiative. The system constraints on SMS message functionality in SystmOne for the newly formed Neighbourhood Teams Service has had a large impact on the evaluation paper recommendations, which have now been drafted for review internally within IM&T prior to routing through appropriate Trust governance channels.	Dec 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	**Mental Health Annual Physical Health Checks – Data Migration to SystmOne**					Status	Progress Indicator
Lead	S Pidgeon	**Start Date**	01/05/2023	**End Date**	31/12/2023	**P**	➔

Purpose	To ensure that the data captured on the individual annual physical health check (APHC) devices is electronically transferred to SystmOne via secure and encrypted interoperability methods, negating the need for manual data entry by staff.

Expected Outcomes	• Data recorded can be uploaded automatically and stored within a service user's SystmOne care record and their comprehensive care plan.
	• Supports contemporaneous record keeping.
	• This encourages partnership working with the patient's registered GP and the MH team.

Key Milestones		Completion Dates	
Activity	**Summary**	**Target**	**Actual**
Integration of APHC device with SystmOne	Work to be undertaken to liaise with APHC device supplier (Roche) and SystmOne (TPP) to technically integrate the devices to update SystmOne.	Dec 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Inability to integrate the APHC devices and SystmOne	3	3	**9**	• Trust to broker technical discussions and liaise with the respective suppliers to enable technical integration of the APHC devices and SystmOne.

Digital Care Records

Title	**Clinical Records System (CRS)**					Status	Progress Indicator
Lead	S Pidgeon L Maden	*Start Date*	01/04/2023	*End Date*	31/03/2024	**G**	↗
Purpose	SystmOne is the Trust's main electronic clinical record system spanning both mental health and physical health services. This programme of work ensures that the Trust continues to use SystmOne to its full potential, improving how services work both now and in the future, presenting opportunities and challenges faced by an ageing population with changing health needs, linked long-term conditions and those triggered by lifestyle choices. Supported through constantly adapting and enhancing integrated care pathways.						
Expected Outcomes	- SystmOne is used more consistently and effectively. - Processes and workflows that help staff and improve outcomes for our service users. - Supports the development of new integrated models of care. - Contribute to the drive towards digitisation of the NHS. - Ensures continuity of care with key clinical documentation re-designed to meet service needs and providing easier access to clinical information. - To ensure that all services are fully optimised in their usage of SystmOne.						

Key Milestones			Completion Dates	
Activity	**Summary**		**Target**	**Actual**
Trust wide developments	▪ SystmOne eLearning training development: Tailored and bespoke training materials and course packages being created specific to services, teams, and roles.		Ongoing	
	▪ Data quality initiatives: The Systems and Performance & Information teams are working jointly to improve correct recording of outcomes on SystmOne and introduction of waiting list SystmOne functionality.		Ongoing	
	▪ eObservations (SystmOne Brigid) technical evaluation: The product has been downloaded on to tablet devices and testing has begun on the Stroke Unit at Kendray. The NEWS2 and Waterlow assessments have been configured plus the recording of fluid observations. The staff welcomed this new way of working with open arms. Recording this data at the service user's bedside is a big advantage and will save time and effort going forward. A further device is being configured and will be used by staff on Crofton Ward as part of the trial. Testing will continue as new functionality is added and if appropriate will be assessed by the staff on the ward. An evaluation of the benefits will be conducted in due course.		~~Jun 2023~~ Dec 2023	
	▪ Virtual Smartcards: Evaluate the potential for the application of virtual smartcards considering available solution options, the respective advantages/disadvantages and associated financial implications to the Trust. Current NHS England requirements stipulating multi-factor authentication including a Smartphone would mean all Trust staff having a Smartphone which is not the mobile phone strategy of the Trust. This item will be re-evaluated if the Trust strategy or the authentication process changes. A subsequent proposal paper for		~~Dec 2023~~ TBD	

	consideration of virtual smartcard functionality will go through appropriate internal governance at an applicable time.		
	▪ eObservations (SystmOne Brigid) deployment: As a follow on from the technical evaluation and trialing mentioned above, the Systems team are also engaging with the Matron team looking at a standardised template for use Trust-wide for the Pre/Post Leave Risk Assessment, to be completed via tablet devices on the ward whilst with the service user is on the Ward. Once the proposed standardised template has been agreed, it is planned for it to be added to SystmOne as a questionnaire for use via SystmOne Brigid. This may subsequently lead to other forms in use being setup in a similar manner in close collaboration with the Matron team.	Mar 2024	
	▪ Assessment of potential future TPP enhancements: Functionality in the development pipeline including but not limited to communication annex, URL launcher, remote appointment booking and allocate integration, expansion of Visualisations.	Mar 2024	
Mental Health Service developments	▪ Task management implementation: live services include Barnsley Memory Services, Mental Health Dietitians, ADHD/ASD Service, Wakefield Rapid Access Team CAMHS service and Barnsley Clozapine team. ▪ Implementation is progressing with South Yorkshire Liaison and Diversion service, Calderdale and Kirklees Older People's services and Wakefield Intensive Home-Based Treatment Team (IHBTT). ▪ The Trust CCIO is also working with members of the Systems development team regarding the introduction of task management within Inpatient Services.	Mar 2024	
	▪ SystmOne Template Pathway (OneNavigation): To help staff navigate around the key areas of SystmOne a template pathway was developed and fully deployed. This functionality has been further enhanced and it is intended to be eventually rolled out across all the Mental Health units, with the aim of this being completed by March 2024.	Mar 2024	
Physical Health Service developments	▪ Integrated Neighbourhood Teams Service: The Parkinson's Specialist Nursing team is the only service that has been migrated in the reporting period. ▪ Work continues behind the scenes on the new Holistic Core Assessment which will be piloted in the unit once approval has been given by Clinical Safety Design Group. ▪ The Falls Assessment, the Falls Screening Tool and the Osteoporosis Screening Tool have also been amended to improve patient care and safety. Multiple dashboards on the unit have been re-designed for consistency across the services. Developing a single integrated SystmOne unit comprising Physical Health services across Barnsley, migrating each separate service unit into the established integrated model.	~~Mar 2024~~ Jun 2024	

	This work commenced prior to the pandemic, and it is now planned to complete this work by Q1 24/25 at the latest. In addition, two further Trusts have approached the Systems team to discuss the work we have undertaken, with a view to understanding the work being conducted. Within Barnsley Community services there are teams who have used SystmOne for several years and during this time the service provision or patient demographic has changed requiring service re-design and providing opportunities to adopt smarter ways of using SystmOne. The Systems Development team are currently working with the following services: - ▪ Podiatry ▪ HIT & TB ▪ Dietetics and Tier 3 Weight Management ▪ <u>BCBIRT</u>: The Barnsley Community Brain Injury Rehab Team currently record their activity in the Stroke & Neuro unit. Work has commenced to move this service to the more suitable unit of Neuro Rehab. For consistency, the Neuro Rehab staff have been trained to adopt a new way of working, meaning both services will work consistently when migration has taken place.		
Inpatients Developments	▪ <u>Countersigning Tasks:</u> to help with system performance and to ensure system entries are countersigned in a timely manner, we have collaborated and fast tracked the training of staff in the Forensics and Inpatients units in managing their countersigning tasks. The Systems Team will monitor the figures to ensure the good work continues.	Oct 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Risk that the SystmOne training leads to inconsistencies in usage, impacting data quality	3	3	**9**	• Comprehensive assessment of training needs conducted during service deployment and introduction of new functionality has training, learning and development aspects incorporated into the approach. Adopts a co-design, co-produced approach following best practice in the development of bespoke training programmes, materials in collaboration with services leads to aid successful uptake, improved data quality and optimal system usage. • The introduction of eLearning capabilities has improved training access equity across the Trust and virtual short courses serve to aid good practice and message reinforcement, especially where

				areas requiring data quality improvement are highlighted.
Risk that data quality is impacted through ineffective use of the system and application of available functionality	3	3	**9**	• As well as improved and appropriate systems training for staff, several additional initiatives are pursuing improvements in data quality, specifically relating to correctly recording outcomes on SystmOne, the waiting lists project and other targeted interventions.

Title	EPMA – Evaluation of Mental Health Inpatient Services Deployment					Status	Progress Indicator
Lead	K Dewhirst	**Start Date**	01/04/2023	**End Date**	30/06/2023	**C**	✓

Purpose	Conduct an evaluation of this initial phase of the project, undertake benefits realisation activities and establish business as usual arrangements that support EPMA adoption of the new ways of working within Mental Health Inpatient Services across the organisation.
Expected Outcomes	• Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve. • Reduce risks associated with medicines administration. • This provides the opportunity for shared learning and development, for SWYPFT to provide systems leadership and work with partners to influence national changes required within the digital solution. • Improves the Trust's overall digital maturity.

Key Milestones			Completion Dates	
Activity	**Summary**		**Target**	**Actual**
Evaluation of the EPMA deployment into Mental Health Inpatient Wards	An evaluation of this phase of the project has been undertaken with the project closure report completed. Benefits realisation work has commenced, with some result to be reviewed 12 months post implementation. Business as usual arrangements established.		Jun 2023	Jun 2023

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Establishment of BAU arrangements and resilience of EPMA team. System manager is the only dedicated EPMA resource	3	3	**9**	• EPMA training resource absorbed within the System Development team within IM&T to provide additional resilience. Some system training undertaken by pharmacy technician

Title	EPMA - Physical Health Inpatient Services Deployment					Status	Progress Indicator
Lead	K Dewhirst	**Start Date**	01/04/2023	**End Date**	30/12/2023	**G**	↗
Purpose	Electronic Prescribing and Administration of Medications (EPMA) is a key development which is designed to improve patient safety, efficiency in service delivery, quality of data and deliver financial benefits for the organisation. It converts the traditional paper prescription and administration card into an electronic record accessible by an authorised user from any device with the requisite software. This approach is being taken by many trusts. This initial phase of the project is focussed on deploying EPMA functionality and ways of working within Inpatient Services across the organisation.						

Expected Outcomes	• Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve. • Reduce risks associated with medicines administration. • This provides the opportunity for shared learning and development, for SWYPFT to provide systems leadership and work with partners to influence national changes required within the digital solution. • Improves the Trust's overall digital maturity.				

Key Milestones				Completion Dates	
Activity	**Summary**			**Target**	**Actual**
ePrescribing/EPMA deployment planning into Physical Health Inpatient Wards	▪ Planning to commence with a view to deploying EPMA functionality within Physical Health inpatient ward areas, following completion of the Mental Health Inpatient wards deployment. Target completion date has been amended as this is to be incorporated into options appraisal for community services as operational directors have noted other competing priorities.			~~Jun 2023~~ Oct 2023	
ePrescribing/EPMA deployment into Physical Health Inpatient Wards	▪ Commence deployment following on from completion of rollout of EPMA into the Mental Health inpatient wards areas. This deployment will focus on Physical Health inpatient ward areas namely Neuro-Rehabilitation Unit (NRU) and Stroke Rehabilitation Unit (SRU).			Dec 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Establishment of BAU arrangements and resilience of EPMA team. System manager is the only dedicated EPMA resource	3	3	**9**	• EPMA training resource absorbed within the System Development team within IM&T to provide additional resilience. Some system training undertaken by pharmacy technician

Title	**EPMA - Mental Health Community Services Deployment**					Status	Progress Indicator
Lead	K Dewhirst	**Start Date**	01/04/2023	**End Date**	31/03/2025	**G**	↗
Purpose	Electronic Prescribing and Administration of Medications (EPMA) is a key development which is designed to improve patient safety, efficiency in service delivery, quality of data and deliver financial benefits for the organisation. It converts the traditional paper prescription and administration card into an electronic record accessible by an authorised user from any device with the requisite software. This approach is being taken by many trusts. This phase of the project is focussed on deploying EPMA functionality and ways of working within Mental Health Community Services across the organisation.						
Expected Outcomes	• Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve. • Reduce risks associated with medicines prescribing and dispensing. • This provides the opportunity for shared learning and development, for SWYPFT to provide systems leadership and work with partners to influence national changes required within the digital solution. • Improves the Trust's overall digital maturity. • Increases efficiency as prescriptions can arrive at the nominated pharmacy instantly after being digitally signed. • Enables service user choice and improves the service user experience.						

Key Milestones				Completion Dates	
Activity	**Summary**			**Target**	**Actual**
Options appraisal for next steps of implementation to	A variety of services could benefit from electronic prescribing, such as Intensive Home-Based Treatment Team (IHBTT), Barnsley Virtual wards, clozapine and depot clinics			Jun 2023	Aug 2023

determine organisation priorities	and mental health outpatients. Initial appraisal presented to OMG.		
Stakeholder events/discussions	Meetings held with stakeholders to determine order of priority.	Sep 2023	Sep 2023
Programme Manager recruited	Programme Manager to lead this next phase of the project has been successfully recruited and set to commence role in October 2023.	Oct 2023	
Preparation and planning for EPMA deployment within Mental Health Community Services	Preparation and planning to determine the revised approach for deploying EPMA into Mental Health Community Services across the Trust taking learning and experiences from the Inpatient Services deployment. The target date for this activity has been revised to account for stakeholder engagement.	~~Jun 2023~~ Oct 2023	
ePrescribing/EPMA Deployment into Mental Health Community Services	Deployment of EPMA functionality within Mental Health Community Services and General community services.	Mar 2025	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Recruitment & retention of additional project staff to facilitate the implementation and deployment of EPMA. SystmOne capabilities within Community Services impacting the ability to maintain the timely progress made to date. Competing priorities and capacity of EPMA team	3	3	9	• Case for additional project resources being readied for Trust consideration. • Following approval, ensure options to recruit appropriate staff in as timelier manner as possible. • EPMA training resource absorbed within the System Development team within IM&T to provide additional resilience. • Options appraisal for organisational prioritisation

Digital Infrastructure

Title	Infrastructure Modernisation 23/24					Status	Progress Indicator
Lead	Chris Crocker	Start Date	01/04/2023	End Date	31/03/2024	G	↗
Purpose	Continuous programme of replacement, modernisation, and enhancement of the Trust's IT infrastructure. The purpose being to ensure the Trust has a strategic, robust, and secure IT environment which is maintained, providing the necessary assurances of business resilience and disaster recovery capabilities to support the digital footprint now and in the future.						
Expected Outcomes	• Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from one data centre to another in the event of a disaster (e.g., from Fieldhead to Kendray). • A more readily scalable infrastructure that can flex to meet changing demands. • No requirement for major short-term investment in event of a disaster. • Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licences (potentially reducing costs). • Proven disaster recovery position with confirmed recovery points and associated timelines. • Enhanced cyber security position would bring about improved resilience and reduce the risk from cyber-attack, malicious or otherwise.						

Key Milestones				Completion Dates	
Activity	**Summary**			**Target**	**Actual**
Digital infrastructure capital programme	Detailed programme planning, and mobilisation of planned 2023/24 capital expenditure focusing on: - ▪ Server and network hardware enhancements and replacements. ▪ Corporate Wi-Fi modernisation programme replacing end of life approaching Wi-Fi controllers and access points. ▪ Partner Wi-Fi access (Govroam/Eduroam) upgrades ▪ Virtual Private Network (VPN) enhancements ▪ Local area network (LAN) and wide area network (WAN) enhancements.			Mar 2024	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Potential for delays in future hardware deliveries	1	3	**3**	• Currently reviewing lead times and roadmap of known requirements, noting that some equipment now has a 12months+ lead time. • Orders placed and equipment delivered during 2022/23 in readiness for some planned 2023/24 schemes. • Risk score reduced as lead times are typically now reducing across wider supply chain.

Title	Cyber Security & Threat Monitoring 23/24					Status	Progress Indicator
Lead	C Crocker	**Start Date**	01/04/2023	**End Date**	31/03/2024	**G**	↗
Purpose	Given that the threat of a cyber-attack remains constant, the Trust continues to take such threats extremely seriously and has established several steps to safeguard against the likelihood, impact, and considers cyber security in all aspects of the digital agenda.						
Expected Outcomes	• Continued vigilance and awareness of the threat of cyber-attack. • Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats. • Adoption of industry standard best practices, as appropriate. • Improve the defences against a cyber-attack.						

Key Milestones				Completion Dates	
Activity	**Summary**			**Target**	**Actual**
Implementation of SIEM/IPS	Implementation of SIEM/IPS following EMT consideration and approval of the business case presented to EMT in January 2023, proposing the introduction of Security Information and Event Management (SIEM) and Intrusion Prevention System (IPS) which would enhance the Trust's current cyber controls and measures to further bolster its current protection levels and reduce the organisation's risk (1080) score associated to cyber security. Pending agreement of funding.			TBD	
Cyber security communications plan	Undertake a review of the cyber security communications plan in collaboration with the Trust's Communications team to improve awareness of cyber phishing.			Aug 2023	Aug 2023

Cyber security survey	An annual phishing survey to further gauge staff awareness, and understanding, to determine if vigilance is improving. The results of the survey will inform an action plan.	Jan 2024	Aug 2023
Cyber tabletop exercise	Annual cyber security tabletop exercise to be scheduled early 2023 in line with the cyber programme.	Nov 2023	
Penetration testing	The Trust undertakes an independent annual infrastructure, server, and client penetration (PEN) test to ensure and provide further assurances that the services being provided are being proactively managed.	Feb 2024	
Cyber security survey findings action plan	To develop and deliver a programme of guidance and communications to set out how to identify a phishing email, and what staff should (and should not) do if they receive them.	Mar 2024	
Cyber Essentials Plus reaccreditation compliance	Annual review of the Trust's cyber security measures and controls to ensure continued accreditation compliance.	Mar 2024	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Please refer to risk 1080 in the organisation's risk register				

Title	Microsoft Office365 Development 23/24					Status	Progress Indicator
Lead	C Crocker	Start Date	01/04/2023	End Date	31/03/2024	G	↗
Purpose	To ensure that the Trust make optimal use of existing and future Microsoft products available via the Trust's enterprise-wide agreement with Microsoft.						
Achieved Outcomes	• Ensuring that the Trust makes best use of the available Microsoft products and functionality, in the most appropriate and cost-effective strategic way forward to support the wider digital agenda.						

Key Milestones			Completion Dates	
Activity	Summary		Target	Actual
Renewal of the Trust's Enterprise-Wide Agreement with Microsoft	Review the Trust's requirements and complete the timely renewal of the organisation's enterprise-wide agreement for the Microsoft suite of software and products. The revised agreement to take account of and be based on the NHS England nationally negotiated contract with Microsoft.		Jun 2023	June 2023
O365 Email Platform enhancements	Evaluate and consider opportunities to further enhance the Trust's Microsoft Office365 email platform.		TBC	
Mobile Device Management Platform enhancements	Evaluate and consider opportunities to further enhance the Trust's Microsoft Intune mobile device management platform.		TBC	
Review national O365 roadmap	Review of NHS England roadmap Microsoft O365 developments and national recommendations to inform the Trust's 23/24 plans, when information becomes available. Pending further roadmap information from NHS England.		TBC	
OneDrive File Shares	Reviewing options for adoption of OneDrive to enable external file shares		TBC	
OneDrive Folders	Exploring technical feasibility for introduction of OneDrive storage for network home drive folders		TBC	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Multi-Factor Authentication (MFA)					Status	Progress Indicator
Lead	H Haigh	**Start Date**	01/04/2023	**End Date**	30/09/2023	**G**	↗

Purpose	Multi-factor authentication (MFA) is the name for an authentication method that relies on more than one factor when determining whether to grant access to a computer user. It has become an increasingly important means of proving identity and securing information. MFA allows organisations to harden and secure access to their systems, helps prevent brute force attacks taking place and supports heading off threats from phishing attacks. If an attacker obtains login credentials, they can try to access a corporate network and will typically be successful, but with MFA in place they are not typically able to succeed as they do not have the second level of information required. MFA requires end users to have two verification methods when logging onto a device or software application. Instead of just having a username and password they would also have an additional verification method. MFA works by requiring additional verification information to log into the network and access Trust applications.
Expected Outcomes	• Help minimise the risk of successful cyber-attack such as a brute force attacks as well as phishing supported activity. • Recognised as another industry-standard measure of good practice which is widely being adopted across the NHS.

Key Milestones			Completion Dates	
Activity	**Summary**		**Target**	**Actual**
Wider deployment of MFA	The deployment of MFA to most in-scope Trust staff was completed in 2022/23. However, work is ongoing to deploy into remaining service areas in a controlled and sensitive manner to ensure that there are no adverse implications to frontline operational service ways of working.		Sep 2023	Sep 2023
Investigating an alternative solution for areas that do not allow mobiles	Specific locations around the Trust such as high secure units do not allow mobile phones on site, so an alternative solution to achieve two-factor authentication is being investigated.		Dec 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Email Platform Re-accreditation					Status	Progress Indicator
Lead	R Tyas	**Start Date**	01/06/2023	**End Date**	31/08/2023	**G**	↗

Purpose	To oversee the re-accreditation and compliance with NHS Digital's advanced security protocols meaning that emails can then be sent and received containing sensitive/confidential information using the Trust's Microsoft Office365 email platform. The Trust achieved accreditation status in August 2021 which enabled the decommissioning of NHSMail (NHS.Net) email accounts that were in use across the Trust. The Trust subsequently achieved re-accreditation status in August 2022.
Achieved Outcomes	• Staff can use their Trust's Microsoft Office365 email accounts to send and receive emails containing sensitive and confidential information. The sending of sensitive and confidential information via this means to external third parties, requires the organisation in question to confirm that their email platform complies with the requirement of DCB 1596 Secure Email Standards and Transport Layer Security (TLS) encryption. • Removes the need for Trust staff to use multiple email platforms for Trust business purposes. Please note that there will be a requirement for a small number of Trust staff to retain their NHSMail email accounts for specific external correspondence purposes.

Key Milestones			Completion Dates	
Activity	**Summary**		**Target**	**Actual**
Email platform compliancy	The Trust's Microsoft Office365 email environment complies with the NHS Digital standards. Confirmation of re-accreditation achievement provided by NHS Digital.		Aug 2023	Aug 2023
Remediation Activities	A few non-critical enhancement suggestions by NHS England are current being implemented by the Trust's IT Service provider.		Dec 2023	
Email platform enhancements	Compliance work will provide a roadmap for the next 12 months to further enhance the platform		Mar 2024	
Key Risks	**Likelihood**	**Impact**	**Risk Score**	**Actions & Controls**

Title	**Telephony (Fixed) Services Review & Contract Re-procurement**					**Status**	**Progress Indicator**
Lead	C Crocker	**Start Date**	01/07/2023	**End Date**	31/12/2023	**G**	↗
Purpose	To ensure that the Trust has a resilient and robust desk telephony platform which is flexible and scalable in line with current and future business requirements.						
Expected Outcomes	• Ensures the Trust has a stable and resilient corporate telephony and mobile platform which is cost effective and makes best use of available resources.						

Key Milestones			Completion Dates	
Activity	**Summary**		**Target**	**Actual**
Desk telephony services	Undertake a review of the current provision of desk telephony services, future requirements, and potential options in marketplace for the future provision of desk telephony services ahead of the expiry of the existing contract with Virgin Media Business. This has been concluded and is pending contract signature. Further work has been undertaken and is ongoing to review the number of devices being used, which will inform the wider long term desk telephony requirement of the Trust.		Dec 2023	
Key Risks	**Likelihood**	**Impact**	**Risk Score**	**Actions & Controls**
Due to ongoing changes in ways of working due to COVID-19 the Trust does not fully understand its long-term telephony requirements	3	3	**9**	• Potential for shorter term contract extensions to avoid committing to long term high value contracts

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								✖				

Trust Board work programme 2022/23

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)			✖									

Trust Board work programme 2022/23

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**						✖						

Trust Board work programme 2022/23

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 *(September 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)*