NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board (business and risk)
Tuesday 30 April 2024 at 9.30am
Small Conference Room, Wellbeing and Development Centre, Fieldhead

AGENDA

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.30	**1. Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
9.31	**2. Declarations of interest**	Chair	**Verbal item**	2	To receive
9.33	**3. Questions from the public** *(received in advance in writing by e:mail to membership@swyt.nhs.uk)*	Chair	**Verbal item**	5	To receive
9.38	**4. Minutes from previous Trust Board meeting held 26 March 2024**	Chair	**Paper**	2	To approve
9.40	**5. Matters arising from previous Trust Board meeting held 26 March 2024 and board action log**	Chair	**Paper**	5	To receive
9.45	**6. Service User / Staff Member / Carer Story**	Chief Operating Officer	**Verbal item**	10	To receive
9.55	**7. Chair's remarks**	Chair	**Verbal item**	3	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.58	**8. Chief Executive's report**	Chief Executive	**Paper**	7	To receive
10.05	**9. Risk and assurance**				
10.05	9.1 Board Assurance Framework	Director of Finance, Estates and Resources	**Paper**	10	To approve
10.15	9.2 Corporate / organisational risk register	Director of Finance, Estates and Resources	**Paper**	10	To approve
10.25	9.3 Draft Annual Governance Statement	Director of Finance, Estates and Resources	**Paper**	5	To receive
10.30	9.4 Quality Account update	Chief Nurse/Director of Quality and Professions	**Paper**	5	To approve
10.35	9.5 Independent review of Greater Manchester Mental Health NHS Foundation Trust	Chief Nurse/Director of Quality and Professions	**Paper**	10	To receive
10.45	9.6 LeDER report	Chief Nurse/Director of Quality and Professions	**Paper**	5	To receive
10.50	9.7 Invited review of autism spectrum disorder service from the royal college of psychiatry outcome and action plan	Chief Medical Officer	**Paper**	8	To receive
10.58	9.8 Older peoples service transformation update	Chief Medical Officer	**Paper**	7	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
11.05	9.9 Assurance and approved minutes from Trust Board committees - Collaborative Committee 2 April 2024 - Audit Committee 9 April 2024 - Quality and Safety Committee 9 April 2024 - Finance, Investment and Performance Committee 22 April 2024	Chairs of committees	**Paper**	5	To receive
11.10	*Break*			*10*	
11.20	**10. Performance**				
11.20	10.1 Integrated Performance Report (IPR) month 12 2023/24	Director of Finance, Estates and Resources	**Paper**	15	To receive
11.35	10.2 Care group performance dashboard (Barnsley physical health)	Chief Operating Officer	**Paper**	10	To receive
11.45	**11. Integrated Care Systems and Partnerships**				
11.45	11.1 South Yorkshire update including and South Yorkshire Integrated Care System (SYICS)	Chief Executive/ Director of Strategy and Change	**Paper**	9	To receive
11.54	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**	8	To receive
12.02	11.3 Provider Collaboratives and Alliances	Director of Finance Estates and	**Paper**	8	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		Resources			
12.10	**12. Governance**				
12.10	12.1 Audit Committee annual report including committee annual reports and terms of reference	Audit Committee Chair	**Paper**	10	To receive
12.20	12.2 Going concern statement	Director of Finance, Estates and Resources	**Paper**	5	To approve
12.25	**13. Strategies and policies**				
12.25	13.1 Policy on policies	Director of Finance, Estates and Resources	**Paper**	5	To receive
12.30	**14. Trust Board work programme**	Chair	**Paper**	5	To receive
12.35	**15. Any other business**	Chair	**Verbal item**	4	To discuss
12.39	**16. Date of next meeting** The next Trust Board meeting held in public will be held on 2 July 2024 (June meeting)	Chair	**Verbal item**	1	To note
12.40	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 26 March 2024
Boardroom, Conference Centre, Kendray 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
	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:	David Webster (DW)	Non-Executive Director
In attendance:	Dawn Lawson (DL)	Director of Strategy and Change
	Lindsay Jensen (LJ)	Interim Chief People Officer
	Andy Lister (AL)	Company Secretary (author)
	Sean Rayner (SR)	Director of Provider Development
	Julie Williams (JW)	Deputy Director of Corporate Governance
Apologies:	Rachel Lee (RL)	Associate Non-Executive Director
Observers:	Paula Gardner	Insight Candidate

TB/24/15 Welcome, introduction and apologies (agenda item 1)

The Chair, Marie Burnham (MBu) welcomed everyone to the meeting. Apologies were noted, 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 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/24/16 Declarations of interest (agenda item 2)

Name	Declaration
Chair	
BURNHAM, Marie	Lay member of the Central Lancashire Integrated Care Partnership Chair of NICE Committee for weight management Chair of Pennine Multi Academy Trust of Schools
Non-Executive Directors	
RAYNER, Mandy Non-Executive Director Deputy Chair/Senior Independent Director	Spouse - works for a global not for profit organisation (HIMSS) selling consultancy services to healthcare bodies. Working within the advisory sector as a private consultant for a number of technology organisations who provide technology to the NHS. Any work that may link to the Trust will be declared at the time any future interest arises. Director/Owner of “Opinicus” providing IT consultancy to organisation/suppliers in healthcare.
FORD, Mike Non-Executive Director	Chair of the Joint Audit Committee for the West Yorkshire Combined Authority and West Yorkshire Police
WEBSTER, David Non-Executive Director	Chief Financial Officer at Red Embedded Consulting Limited (trading as Consultant Red) Director and joint-owner - Tango Residential Ltd Non-executive trustee director - The Mast Academy Trust
MAHMOOD, Erfana Non-Executive Director	Non-Executive Director for Riverside Group. Non-Executive Director for Omega / Plexus part of Mears Group. Sister – Employed by Mind in Bradford.
MCMILLAN, Natalie Non-Executive Director	Director/owner of McMillan and Associates Ltd. Associate - NHS Providers Associate - Audit One who conduct audit work across NHS organisations
QUAIL, Kate Non-Executive Director	Director of The Lunniagh Partnership Ltd, Health and Care Consultancy
Associate Non-Executive Directors	
Dr Rachel Lee Associate Non-Executive Director	Director and owner of North Star Psychology Ltd. Consults and provides therapy for Aspire4you commissioned by NHS England. Associate with Healthy You Ltd funded by individual NHS trusts or NHS England.

Name	Declaration
Chief Executive	
BROOKS, Mark Chief Executive	Trustee for Emmaus (Hull & East Riding) Homelessness Charity Partner member of South Yorkshire Integrated Care Board
Executive Directors	
HARRIS, Carol Chief Operating Officer	Spouse works for an engineering consultancy company specialising in healthcare which has involved work with local NHS Trusts including Mid Yorkshire Hospitals NHS Trust Family members work on Trust bank
JENSEN, Lindsay Interim Chief People Officer	Spouse owns small portable appliance testing company who may occasionally undertake NHS work. Vice president of Health People Management Association (HPMA) Yorkshire and Humber which is a registered charity and has alignments with the NHS
RAYNER, Sean Director of Provider Development	No interests declared.
SNARR, Adrian Director of Finance, Estates and Resources	No interests declared.
THIYAGESH, Dr Subha Chief Medical Officer	Spouse is a Hospital Consultant & Clinical Director at CHFT. Member of the NHS Clinical entrepreneurship strategic board. Honorary Visiting Professor at Huddersfield University.
THOMPSON, Darryl Chief Nurse and Director of Quality and Professions	Member of the Council of the National Mental Health and Learning Disability Nurse Directors Forum.
LAWSON, Dawn Director of Strategy and Change	No interests declared.

It was RESOLVED to NOTE the declarations of interest for the Board.

TB/24/17 Questions from the public (agenda item 3)

No questions were received from the public.

TB/24/18 Minutes from previous Trust Board meeting held 30 January 2024 (agenda item 4)

Mandy Rayner (MR) asked for a slight adjustment on page 6 of the minutes in relation to Band 5 “a lot of work has already taken place”. Andy Lister agreed to amend the minutes to this effect.

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 30 January 2024 as a true and accurate record.

TB/24/19 Matters arising from previous Trust Board meeting held 30 January 2024 and board action log (agenda item 5)

Mike Ford (MF) made the observation about the length of the minutes, in particular service user/staff story where the minutes are almost a transcript rather than a summary.

MBr agreed and added that the staff/carer stories are an important part of board.

Action: Andy Lister

MBu asked for the following action updates to be noted:

TB/24/10a - RIDDOR (reporting of injuries, diseased and dangerous occurrences regulations) incidents - MBu queried if Board members are satisfied with the documented progress against the action.

MBr reported incidents where a member of staff has been harmed or assaulted are raised at executive management team (EMT) meetings through the complex incident report. MBr added there is suitable support available for staff who have been assaulted, and in addition the Trust should seek assurance from affected staff to ensure they feel they have received the appropriate support.

Action: Darryl Thompson/Carol Harris

TB/23/117 - patient and carers' race equality framework. Nat McMillan (NM) advised that this is to come back to Board through the AAA report from the equality, inclusion and involvement committee (EIIC). NM asked that this is explicitly referenced in the AAA report as it is an important question to be addressed.

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

TB/24/20 Service User/Staff Member/Carer story (agenda item 6)

Carol Harris (CH) introduced Donna Markey (DM), the manager for the Podiatry service and highlighted recent improvements in the service including happier staff and a more cohesive team. CH pointed out the levels of skills and expertise within the service, including surgical procedures.

DM gave an overview of a patient's journey through our podiatry service including assessment, diagnosis and treatment. Podiatry is a medical specialty that diagnoses and treats diseases, disorders, deformities and pathologies of the feet and lower limbs. The service has specialists in biomechanics, wound care, nail surgery and high-risk foot care.

DM noted that biomechanics services have been run by John Burston for around 40 years and upon his retirement the dedicated podiatry suite at Kendray will be named after him. DM reported SWYPFT is one of the only trusts in the country that has a biomechanics laboratory based on site, with a great reputation.

DM reported there are challenges filling vacancies as university graduates can earn more money in private practice with perceived less pressure.

DM introduced Trust Board to the "Real Wear" device which is a head worn smart device with a camera that allows staff to observe exactly what the clinician can see during an appointment. The device also has a heat detector which can detect infection. This device is being trialled in the community service and if successful will be rolled out for nurses to be able to share their expertise.

Mandy Rayner (MR) acknowledged the resource issue across the NHS and queried if the Trust have placements in podiatry for students and if the Trust runs apprenticeships.

DM reported that there are currently four final year students within the department who have applied for permanent roles with the Trust. DM confirmed that there is one apprentice with the department at the moment with another due to start at the end of March 2024.

Erfana Mahmood (EM) asked if overseas recruitment could help with staffing issues within the department.

DM advised that podiatry is quite a rare specialty overseas but there are some overseas applicants for the lower banded vacancies.

DM explained that NHS England are involved with promoting the profession as it is now seen as a profession at risk. The number of podiatrists need to increase by 83% by 2034. Students who follow the apprenticeship route are better prepared for working in the NHS.

Sean Rayner (SR) acknowledged the use of technology and the support this can provide and suggested this should be included in the Trust digital strategy.

ST confirmed that this is the case.

MBu thanked DM for today's story.

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

TB/24/21 Chair's remarks (agenda item 7)

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

- Complex Incidents report
- Assurance from Trust Board Committees
- Integrated Partnership Board updates
- Financial operation planning
- Strategic Board reflections

MBu noted the Trust will be recruiting two new non-executive directors (NED's) this year as Kate Quail (KQ) and MR's tenures are coming to an end.

It was RESOLVED to NOTE the Chair's remarks.

TB/24/22 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 Trust's staff survey results have been published and have showed improvement in all nine key themes.
- SWYPFT are the highest scoring trust in Yorkshire and Humber in terms of staff recommending the Trust as a place to work. Leaders within the Trust should be recognised for this.
- Work is required in relation to incidents of racial discrimination, which is being seen nationally. The Trust needs to learn from what went well last year and respond to the areas that need improvement which will be overseen by the people and remuneration committee (PRC).
    - An updated definition of parity of esteem has been provided by the Department of Health and Social Care. It looks to ensure there are equal services for people with

mental illness who require medication or physical health services and equality in terms of access and therapeutic interventions. There is a question about how SWYPFT with partners, promote parity of esteem across all parts of the NHS.

- Final planning guidance has not yet been received.
- A board level competency framework has been issued by NHS England for awareness and needs incorporating into 2023/24 appraisals.
- There has been more industrial action which has been well managed. This takes huge effort and there are always consequences, some clinics will have been cancelled and staff redeployed to provide cover.
- NHS Providers has published the results of its annual state of the provider sector survey. The results of this survey are very helpful for understanding the context in which we are operating.
- There has been a 20% reduction in applications for nursing degrees this year which will impact on the NHS's long term workforce plan.
- The Excellence Awards will be held in May with over 270 nominations to recognise the excellence our staff provide.
- The Trust's submission to showcase improvement work at NHS Providers' annual Quality & Improvement Conference in May has been progressed, which is a real testament to the quality of our submission and our approach to improvement.

MBu highlighted the out of area bed improvement which illustrates how well SWYPFT are performing despite the challenges of high demand.

MR noted the older people's services consultation and the 500+ responses. MR raised the technology fund and advised that funding is being allocated to trusts that are digitally immature, so may be difficult for us to access. MR queried if SWYPFT bid for extra funding for digital improvements.

Adrian Snarr (AS) advised that the Trust are running the new digital strategy in line with the overarching Trust strategy and the clinical strategy, and the Trust does bid for funding opportunities as well as using internal resources.

NM suggested a change in approach to the staff survey to enable the Board to see the key points earlier than we do.

Action: Lindsay Jensen

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

TB/24/23 Performance (agenda item 9)

TB/24/23a Integrated performance report Month 11 2023/24 (agenda item 9.1)

Adrian Snarr (AS) reported that there is one new measure and one revised measure. Oliver McGowan training now being included in the mandatory training list and the metrics for individual placement support (IPS) have been revised.

National Indicators

AS gave an overview of the national indicators:

- Paediatric audiology waits are a challenge for the Trust with improvement and further work needed. Causation impact is being explored in relation to the increased volume of people coming through the service.
- Out of area placements is showing as red in the IPR as the national indicator is 0. The Trust currently has six and low levels do require a lot of management effort. The financial plan for next year has assumed five out of area placements.
- AS highlighted the virtual ward metric has returned to green.

Strategic Objectives

Dawn Lawson (DL) gave an overview of the strategic objectives advising that there are challenges around the recording of some of the protected characteristics data. There are improvements with sexual orientation recording, and further improvement is needed on the recording of disabilities. Training support is being delivered to matrons and nurses across the Trust.
In terms of the up-to-date Equality Impact Assessment metric compliance is now 96%.

Quality
Darryl Thompson highlighted the following points:

- Care planning is on track with over 80% of patients receiving a copy of their care plan and this has been maintained since April 2023.
- There has been a slight reduction in people in the community having a risk assessment within seven days.
- A headline from the quarterly incident report is that 100% of prone restraints have been for three minutes or less. How prone metrics are captured has now changed to be in line with national metrics.
- There have been 20 information governance (IG) breaches in month. This is the highest number of the year. These incidents are mainly information shared in error with no identified themes or concerns with the impact of these breaches.
- There have been two pressure ulcers where lapses in care have been identified with no assumption that the lapse in care had a causal effect on the ulcers. These will be reviewed for any learning to be identified.
- The percentage of complaints responded to within six months remains under the target of 100% with an overall trend in improvement. All complaints that have breached the target have had new response dates agreed.
- All complaints have been acknowledged within the required three days.
- There has been one outbreak of Covid-19 and one outbreak of diarrhea and vomiting.
- There have been two deaths within 28 days of a Covid-19 diagnosis which is in line with national reporting. Both deaths have been reviewed and were not related to the patient's exposure to Covid-19 while in Trust care.

NM suggested complaints are reviewed in quality and safety committee (QSC) to scrutinise improvements and look at what more can be done.

Action: Darryl Thompson

MBr reported the quality of complaint responses is greatly improved and suggested looking at trends on a quarterly basis for a better view as opposed to reacting to one month in isolation.

DT added that the number of complaints being closed now exceeds the number of new complaints.

NM also suggested taking pressure ulcers into QSC for further scrutiny as the complexities and challenges are leading to an increase in pressure ulcers and also look at how achievable a target of zero is.

Action: Darryl Thompson

EM queried what "lapse in care" means.

DT reported that each pressure ulcer incident has a root cause analysis investigation. Where a lapse in care has been identified, this does not mean the pressure ulcer is a direct result of a lapse in care. The lapse in care would be a point of learning, even if it was unrelated to the subsequent pressure ulcer.

EM asked if any of the reported IG breaches were reportable to the ICO and MBr confirmed there were none.

MBr assured the Board there is a Trust focus on IG breaches and they have had the option to reduce the annual training target from 95%, which the Trust have declined to do.

Kate Quail (KQ) queried trends around complaints and asked if trends and themes are presented to Board.

DT confirmed that more detail goes through QSC and advised this detail comes through Board as part of the AAA report. The patient experience annual report also comes to Board which looks at trends and themes.

KQ asked for assurance around the incident report as reporting has increased.

DT confirmed that 96% of incidents are low or no harm and staff are encouraged to report incidents for learning.

Mike Ford (MF) raised the physical restraints table in the IPR and had identified there appeared to be an error in the numbers.

DT reported the number of restraint positions does not have to equate to the number of restraints, as multiple positions can be held, during one restraint.

MF raised the number of incomplete referrals to treatment pathways.

CH explained that these are the 8 musculoskeletal referrals (MSK) and relate to people who have completed treatment and been discharged through the MSK pathways, which will start to present a decrease in numbers.

MBr asked the Board to note that the Trust does not accept the number of days a young person is on an adult ward as “the norm” and this must remain an area of focus. These are the “least worst” scenarios, not a good scenario.

DT added that staff safeguard young people on adult wards with a huge amount of effort going into finding an appropriate space.

People

Lindsay Jensen (LJ) gave an overview of workforce metrics and performance:

- There have been 654.5 starters since the beginning of the year showing that recruitment practices have been working. This represents growth in substantive staffing of 6.95%.
- 86 international nurses have started working for the Trust this year. There have been challenges supporting them working in our services, culture and country, which is being monitored closely. Recruitment for international nurses has now been paused to focus on supporting the nurses we already have. All international nurses now have placements.
- Sickness has reduced to 5% which is the lowest it has been since 2023 and the target is being considered to see if it still appropriate. Hotspots are monitored closely with support offered in relevant areas.
- There has been improvement with appraisals, with more work to do to reach the next target of 90%.
    - Mandatory training is improving with some hotspots identified and focused on, aiming for further improvement.
    - There is a focus on cardiopulmonary resuscitation (CPR) training, ensuring every space on courses is filled.

- SWYPFT continue to benchmark well against like trusts, with the highest stability and lowest turnover within our group.

MBu recognised the challenges within the People Directorate and the hard work going into maintaining work streams.

Mandy Rayner (MR) acknowledged the progress with appraisals and changing the narrative to a 90% target may push staff to improve further.

Care Groups

CH introduced the item and highlighted the following points:

- There is growing pressure in Barnsley community services and children's speech and language therapy which may lead to some waits. The teams are working hard to mitigate some of the expected staffing absences. This care group had significant issues with clinical supervision but has seen recent improvement.
- There are still issues with CAMHS neurodevelopmental services in Kirklees with no agreement yet regarding additional capacity for assessments which was previously in place.
- Access to tier four placements has been escalated to Leeds and York Partnership NHS Foundation Trust as they lead this collaborative.
- ADHD services have had the invited review service report from the Royal College of Psychiatrists with work taking place on the action plan. All of the services metrics are positive with the exception of waiting lists which is testament to the team.
- Learning Disabilities (LD) waits are an area of focus, with a second waiting list report now coming through the Finance, Investment and Performance Committee (FIP) and QSC, as well as EMT.
- Community mental health services - clinically ready for discharge has reduced significantly, however the pressure remains.
- Management training in forensics remains a focus with rostering being used to ensure that there are appropriately training staff in each area, which is particularly relevant in relation to CPR and reducing restrictive physical intervention (RRPI).
- Priestley ward in forensics is a hotspot high sickness and 40% of the staff group on restricted duties. Actions are in place.

NM queried how this data is used within the organisation and how the positives can be used for learning.

CH confirmed the data is used as a starting point and is regularly discussed in the Operational Management Group (OMG), focusing on learning from positive events.

Finance

Adrian Snarr (AS) gave an update on finance including:

- The revenue position is reporting a small surplus, there is confidence the Trust will deliver a £500k surplus for the full year.
- The Trust's run rate is a little more challenging although the Trust is ahead of where we said we would be on all finance key indicators; recurrent pay spend is increasing due to successful recruitment.
- Agency spend is now expected to finish the year favourable to target with significant improvements, predominantly in nursing and unregistered staff. The focus remains on patient safety.
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- The cash position remains strong.
- Capital indicators are green again with confidence that the target will be met for this year.

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

TB/24/23b Care Group Performance Report (agenda item 9.2)

CH gave the highlights from the care group dashboard for the Adult ADHD, ASD and Learning Disabilities services including:

- In terms of appraisals, the LD team are mapping their local database across to the Trust system with around 190 people with appraisals due and expect to meet the target by the end of March.
- ADHD and ASD teams are smaller and continue to meet the appraisal target.
- Sickness is well managed across the services and even though sickness may be low in terms of percentage, when its profession specific, it can have an impact on the wait time of an individual receiving care.
- The Horizon unit is a high reporter of incidents of violence and aggression and their training for RRPI training is currently at 81% with some challenges regarding training capacity, which are being addressed. Rostering is used to maintain a safe environment.
- This care group experiences significant waits compared to other care groups.
- Waiting lists are reported to FIP and the impact of waits is reported through QSC.
- In relation to ADHD, people are prioritised based on clinical need.
- Referral rates are approximately seven times higher than commissioned capacity in Barnsley and Kirklees and 11 times higher than commissioned capacity in Wakefield.
- ST clarified that SWYPFT wait lists are managed in line with NHS England guidance.
- CH explained that Kirklees and Wakefield commissioners have invested in a pilot project which is being worked through, which can signpost service users to other services as appropriate.
- CH added that high referrals and not enough capacity are national issues.
- In relation to autism, Barnsley, Kirklees, and Calderdale referrals are 2.5 times greater than in 2020.
- Learning Disability wait times meet targets for referrals being screened within two weeks, but there are challenges with meeting the 18-week target to meet face to face and commence treatment. This is predominantly due to profession specific vacancies and capacity issues which are reported through QSC.
- Improvement work is underway to revise pathways and create alternative solutions. There are long waits for speech and language therapy with the head of the allied health professionals (AHP) developing training in identifying swallowing difficulties and plans to manage these, which will free up speech and language capacity.
- Unreported waits have been identified and are now being reported.
- On Horizon there are service users who are clinically ready for discharge that are being delayed due to suitable placement for them not being available in the community. A person who is clinically ready for discharge may still have a high demand for need. Discussions are underway in each of our places to identify solutions.
- Further work is required in both services to understand equality data. There is good correlation between population data and service user data in Horizon, but the impact of Leeds and Bradford needs to be factored in as we work across West Yorkshire.
- ADHD and ASD have identified a marked under representation in referrals from people in Asian communities.
- There is ongoing positive work going into recognising health inequalities that people with a learning disability experience, and there is focus on supporting annual health checks and screening.

MBr highlighted the demand for ADHD and ASD is high and we need to ensure it remains a priority regionally and nationally.

CH added that there is no change in diagnostic rate, meaning there are more people with ADHD who will continue to live a chaotic lifestyle, which will have an impact on their mental health.

It was RESOLVED to RECEIVE the report and NOTE comments made.

TB/24/24 Risk and Assurance (agenda item 10)

TB/22/24a Serious Incidents Quarterly report (agenda item 10.1)

DT introduced the item and highlighted the following points:

- There have been almost 3,500 incidents reported in the quarter which remains within expected variation levels.
- The report includes all serious incidents, our learning from incidents, learning from healthcare deaths, and learning from healthcare deaths of people with a learning disability under the LeDeR structure.
- The has been one serious incident reported in Q3 relating to the suicide of a service user on Ashdale.
- There were no homicides or never events in the quarter.
- DT flagged an incident within forensic services where a ward orderly colleague was assaulted by an inpatient. This was investigated and a series of actions have been put in place.

NM reported QSC had asked the question about whether the reduction in serious incidents is a direct result of the learning that takes place. The Committee is assured about the culture and it's always good to see that we have a high level of reporting and that they are low or no harm.

MF noted that the report includes a comment stating that comparisons between care group data should be viewed with caution. MF noted it does look like a couple of the grids have three times the level of the average of the total and queried if this is significant.

DT clarified that it is significant with regard to the type of interventions and the volume of activity within those services which will be driving the different numbers of reporting figures.

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

TB/24/24b Strategic Overview of Business and Associated Risk (agenda item 10.2)

DL introduced the item and highlighted the following points:

- The report is the culmination of discussions at EMT which is a useful framework for supporting the strategy refresh process.

MF commented he was struck by the number of opportunities when looking at the strengths, weaknesses, opportunities and threats (SWOT) analysis which are significant. The Audit Committee is considering management capacity to take advantage of all those opportunities.

MBu agreed there are a lot of opportunities which will need to be viewed with caution as well.

MBu acknowledged that the strategy refresh is very positive and bringing everything together.

It was RESOLVED to RECEIVE the report.

TB/24/24c Review of Risk Appetite Statement (agenda item 10.3)

AS introduced the item and highlighted the following points:

- This is the annual risk appetite review which the executive directors conducted at the beginning of March, following which it was reviewed by non-executive colleagues.
- Changes are mainly presentational.
- Changes are largely restricted to the clinical and quality safety risks and other areas remain as they are.
- There have been debates regarding the environment we operate in and if that should change the risk appetite.

MBu queried how the executive management team challenge each other in relation to risk appetite.

MBr responded with an example. Last week EMT had a decision tree for a potential tender opportunity. The decision tree goes through each of these risk sections and makes an assessment. The decision tree is reviewed every one or two years through FIP. Board members agreed they feel assured about decisions made in EMT using this process.

AL added it is proposed to utilise 360 Assurance, the Trust's internal auditors, every second year to assist with a review of the risk appetite statement, to ensure it is current and that the Trust is benchmarking well against other organisations.

AS reported the Trust has a low-risk appetite and it remains low as a result of these changes.

It was RESOLVED to APPROVE the updates to the Trust's Risk Appetite Statement.

TB/24/24d IPC Board Assurance Framework (agenda item 10.4)

DT introduced the item and highlighted the following points:

- This report is the six-monthly infection, prevention and control board assurance framework which is a self-assessment against national standards.
- The report highlights where the Trust declares compliance, and partial compliance, on criteria six and eight. This relates to fit testing and is where staff are involved in aerosol generating procedures which is more relevant to acute hospitals. This has previously been subcontracted out and we are looking to do this in house.
- There is a particular point about early identification and reporting of an infectious agent and the relevant IT structure to enable this. Planning is in place to address this.

DT explained this report provides assurance of the Trust's self-check against its oversight of infection, prevention, and control practices, and that the Trust is in line with national expectations. It has been to both QSC and EMT prior to submission to Board.

It was RESOLVED to RECEIVE the update.

TB/24/24e CQC Inspection action plan update (agenda item 10.5)

DT introduced the item and highlighted the following points:

- The paper has been to EMT and QSC prior to Board.
- The report shows progress against actions including 'must do' and 'should do' actions.
- Forensic services are approaching their "should do" actions as though they are "must do".
- Each care group is presenting their evidence to support performance to the Quality, Improvement and Assurance Team (QIAT) before declaring the actions complete.
- The QIAT team will continue monitoring and oversight to give confidence that actions have been embedded.

MBr noted that the majority of actions are green and have been discussed at the executive management team. The teams are making good progress, however some of the initial actions are easier to resolve than others, and there may be a risk in future months to be aware of.

MBr emphasised the importance of ensuring that the actions are embedded into the organisation and can be tested. It is helpful that QSC have regular oversight of this, and Board members need good visibility of progress.

MBu reiterated that an organisation should welcome a CQC inspection as it should be an integral part of what we do. MBu stated assurance is gained from this report as it is triangulated and mapped to the other work taking place in forensics.

DT agreed that actions are embedded as part of a broader improvement program within care groups.

MR queried at what point we will see that actions have been embedded.

MBu suggested the report should be presented to Board on a quarterly basis.

Action: Andy Lister

MBu asked DT and CH to pass on thanks from the Board for all the teams' hard work addressing the CQC action plan.

It was RESOLVED to RECEIVE the Care Quality Commission Inspection Reports - Action plan update for Must and Should Do Actions

TB/24/24f Planning update (agenda item 10.6)

AS introduced the item and highlighted the following points:

- The initial financial and operating plan has been submitted to the integrated care board (ICB) on time.
- Nationally and regionally at an ICB level there is still a lot to do as both of our ICBs are projecting a sizeable deficit.
- The national financial position does not look strong and both our ICBs have some way to go to reach a balance position, as does the Trust.
- There is clear evidence that the NHS has grown its workforce significantly and this will need to be explained, along with the benefits we gain from that workforce in terms of productivity.
- Workforce growth has been discussed at EMT looking into 2024/25 and ambitions have been significantly reduced, in part due to over achievement in 2023/24.
- There will be a focus on out of area bed days and agency use, both of which the Trust are performing well on and form part of the efficiency program.
- The final plan will be brough to public board for final sign off in April 2024.

It was RESOLVED to RECEIVE the update.

TB/24/24f Assurance and receipt of minutes from Trust Board Committees and Members' Council (agenda item 10.7)

Collaborative Committee 6 February 2024

MF advised that the minutes will be presented to the private Board and highlighted the following points:

- An assessment against the original objectives in the business case in South Yorkshire has taken place and MF reported that the South Yorkshire Adult Secure Provider Collaborative is delivering against this business case, which is positive.

- There was a paper on provider collaboratives and our assessment against the NHS maturity framework. One area for improvement is contracting and the committee has passed this back to the team to make sure all contracts are in place.

NM queried if the Collaborative Committee carried out an effective survey and AL confirmed that this committee had undertaken an effectiveness review in line with all other committees.

Members' Council 23 February 2024

Mbu asked to take the paper as read, noting it had been a positive meeting with good engagement and inclusive with the governors, making them feel like part of the Trust.

Mental Health Act Committee 5 March 2024

KQ asked to take the report as read and highlighted the following:

- There is a range of assurance from hard data of training which is positive, and audits and reviews including into Section 17 leave and consent to treatment.
- External feedback is sought from multi agency partners and the CQC, as well as hospital managers.
- Work is ongoing with the health inequalities project, particularly in BAME communities.
- There has been a patient experience pilot within forensics which has now been taken up by other trusts.

DL noted the work carried out in forensics and this should now be shared across all wards.

KQ agreed this was the plan and DL agreed to pick up the patient experience pilot and look to roll this out to other wards.

Action: Dawn Lawson

Quality & Safety Committee 12 February/12 March 2024

Nat McMillan (NM) reported the following:

- The independent review of Greater Manchester Mental Health Foundation Trust is now available and will be discussed at committee in April before coming to Board.
- There is an ongoing concern regarding racism that was raised in forensics in October 2023. A review is taking place with an independent expert and will continue to be monitored by the committee until we are assured that concerns have been addressed and the outcomes embedded into the Trust.
- In terms of reducing restrictive physical intervention (RRPI), there have been lots of discussions and committee noted the sustained improvement trends. These will continue to be monitored through the committee.

MBr highlighted the reduction in funding for the Calderdale recovery college which will have an impact on the service provided. This is indicative of the local authority financial environment at the moment.

People and Remuneration Committee 12 March 2024

MR highlighted the following:

- International nurses that have not yet been placed were discussed with some still going through their ready for work processes. LJ assured Board that this is now complete.
- There was an in-depth discussion regarding workforce planning. It was agreed that resource will be re-prioritised to focus on workforce planning, specifically around planning for next year, and being more innovative about how we use our workforce.
- E-rostering was raised, specifically for junior doctors and the difficulty they can have with the system.
- A positive report was received regarding student placements and lots of time and effort is being invested in students within the Trust.

- The committee has gone through its annual self-assessment and agreed to ensure that PRC see staff survey results at the appropriate times, and this will be built into the work program.

Equality, Inclusion and Involvement Committee 13 March 2024
MBu asked to take the update as read.

Finance, Investment & Performance Committee 18 March 2024
NM highlighted (in DW's absence) the following points:

- The committee recognises it needs greater focus on performance, and progress is being made with this.
- The IPR was discussed, and it was noted it may be worth a future Board discussion to establish if the Board have similar views on the content of the IPR.
- An offer was made for the Board to have a session on patient level information and costing system (PLICS)
- Agency and out of area bed use were both noted in terms of improved performance, and the hard work from the teams who have worked on both of these areas.

MBu noted she was pleased to hear that FIP is enhancing its focus on performance. MBu states she would like to know more about PLICS and would welcome a presentation for Board members.

Action: Adrian Snarr

MBu noted the new committee effectiveness questionnaires that had been utilised this year as part of the Board committee effectiveness reviews.

MBu noted the questionnaires had been updated and improved for this year's process and asked for any feedback on this year's process to be fed back to Andy Lister (AL), company secretary.

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

TB/24/25 Integrated Care Systems and Partnerships (agenda item 11)

TB/24/25a South Yorkshire updated including South Yorkshire Integrated Care System (SYBICS) (agenda item 11.1)
MBr asked to take the paper as read and highlighted the following points:

- Current focus is on the financial operating plan for next year.
- The 2nd meeting of the equality diversity and inclusion group, which DL is a member of, have taken place and the chief executive of the integrated care board, is sponsoring the "call my name right" initiative across South Yorkshire. This is something the Trust might want to consider as well.
- There was an update on industrial action.
- The joint forward plan was published in December 2023 and there is a light touch refresh taking place.
- The mental health learning disability and autism collaborative have been focused on the eating disorders model across South Yorkshire, recognising the collaborative has a role to play in the mental health investment standard, and being assured that money is being spent in the right areas.
- An update was received from the inpatient quality transformation group. The project management office has recruited two members of staff to support programmes of work across they mental health learning disability and autism collaborative.

DL provided an update in respect of Barnsley place and highlighted the following points:

- The place committee was held on the 29 February 2024, and it was identified that A&E waits and ambulance response times are some of the best in South Yorkshire.
- There was a presentation on the day in the life of a paramedic.
- There is a place plan, in terms of efficiencies, and the committee discussed how that looks and feels and particularly how delivery will be achieved to ensure impact is made in the right places.
- Research was on the agenda, with the director of public health in Barnsley, highlighting what research across Barnsley looks like.
- The delivery group that sits underneath the place committee, is attended by Sue Barton, on DL's behalf. We took the Trust strategy refresh discussion to this group and had some interesting feedback about how it feels to work with SWYPFT. This will be built into the Trust strategy refresh.

It was RESOLVED to NOTE the SYB ICS update.

TB/24/25ai South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative revised terms of reference (agenda item 11.1.1)

MBr noted these are updated terms of reference, which clarify the role between the mental health learning disability and autism provider collaborative and the specialist provider collaboratives, such as the adult secure provider collaborative and CAMHS Tier 4 provider collaborative.
MBr added the updates to the terms of reference specifically ensure there is a reporting relationship between the mental health learning disability and autism provider collaborative board and activities in specialist services.

MF reported he will speak to AS and SR to make sure he is clear on governance routes.

It was RESOLVED to APPROVE the terms of reference.

TB/24/25b West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism (MHLDA) Collaborative and place-based partnership update (agenda item 11.2)
SR asked for the paper to be taken as read, highlighting the following points:

- A number of the partnership updates make reference to reactions to the Trust strategy refresh. Various groups have been consulted on the Trust strategy refresh in the last few weeks, and feedback in the main has been very positive.
- The public meetings of the place integrated care board committees are typically moving to a quarterly schedule in 2024-25. This should give committees more time to deal with issues between meetings.

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

TB/24/25bi West Yorkshire Mental Health, Learning Disability & Autism Collaborative Committee in Common terms of reference.

It was RESOLVED to APPROVE the terms of reference.

TB/24/25c Provider Collaboratives and Alliances (agenda item 11.3)
AS presented the item and asked to take the report as read:

- NHS England are running a quality maturity framework. The West Yorkshire adult secure provider collaborative have carried out an assessment and received positive feedback from NHS England. There is still work to be done on contracting.
- South Yorkshire is on a slightly different timeline, and they have not yet received their feedback from NHS England, but the Board will be updated in due course.
- In the West Yorkshire adult secure provider collaborative, they continue to focus on enhancements in pathways, in particular the women's pathway and community pathway. The women's pathway is getting recognition from NHS England, and we are therefore feeding into some of the national work, which is very positive.
- The forensic CAMHS provider collaborative is now live, and the West Yorkshire hub lead on a collaborative level.
- The perinatal pathway, which is not led by the Trust, has been delayed until later in the year. At this time, it is anticipated it will go live in July 2024.
- The West Yorkshire provider collaborative continues to be in a financial surplus, but this masks some challenges that are starting to materialise. We've seen good progress since the collaborative was created in reducing out of area admissions and this is starting to rise slightly in West Yorkshire. Some work is to take place in May 2024 with bed modelling. We have beds available in West Yorkshire, but they are not always in the right pathways for the service users who need them.
- South Yorkshire provider collaborative is currently showing a break-even position.

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

TB/24/26 Governance (agenda item 12)

TB/24/26a Trust Seal (agenda item 12.1)

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

TB/24/26b Internal Governance Framework (agenda item 12.2)

AS introduced the item:

- The internal governance framework is a relatively busy structure, itis reviewed every year and shows any new sub-groups that feed into committees and makes sure that reporting lines are clear.
- Many of the enhancements are presentational, changes have been made to ensure the diagram is as clear as possible.

MBu reported she found the schematic particularly helpful and noted the improvement to ensure governance flows and assurance is fully documented in the framework.

MBr explained he has asked for Julie Williams and Andy Lister to work with executive directors to establish if there is any duplication present within the diagram and to look at alignment. He added that over the coming year financial challenges will increase, and we need to ensure that we are using our resources as efficiently as possible. As presented to the Board today, it is a very thorough document.

Action: Julie Williams/Andy Lister

It was RESOLVED to APPROVE the internal governance framework.

TB/24/27 Strategies and Policies (agenda item 13)

TB/24/27a Estates Strategy Update (agenda item 13.1)

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

- This is the first update to board since the approval of the strategy last year.

- The North Kirklees hub has been carried forward from the previous strategy. The Trust has hubs in other locations such as Wakefield and it can be seen from the narrative there are other external factors which impact our position. The landlord of the building has served notice on it, and we have had to adjust the timelines accordingly. Parking and space utilisation have been issues with hubs that have been created in other areas, and on further investigation it has been identified we are not using our estate to the best outcome.
- Consideration is being given to the renewed lease at Folly Hall in Huddersfield, and we are ensuring that due diligence is taking place.
- Examples are present in the report in relation to the net zero scheme. Although these are not big-ticket schemes, collectively, they start to make a difference.
- This is a 10-year strategy that needs to be dynamic, and we don't know what further opportunities may come to light.
- We are one year into the strategy and already in Barnsley we are looking at a full system wide strategic option. We are working out how this fits with our strategy. We believe there are opportunities. The Trust occupies quite a lot of diverse estate in the Barnsley area in terms of standard, geographical location, and cost.
- The older people's transformation is a pre-commitment on our capital plan for both this year and next year. We have a plan in place which can only be finalised when we reach the end of the public consultation. We need to be ready to make a start so we can spread the cost over two years.

MR queried if we are looking to house services such as the recovery college in areas where the state is not fully utilised to keep costs down.

AS reported the Trust has a number of small leases, these may relate to a room in a building. These are all considered when a lease renewal comes up.

AS noted, part of the challenge is the Trust's geographical spread, and this can create issues for both staff and patients.

MF queried if the strategy will be impacted upon by the recent emergency planning preparedness and resilience (EPPR) assessment.

AS reported, this is a possibility. One of the issues that has presented itself in the EPRR assessment, is a full decant of a hospital site to a like facility. This is in essence suggests building another hospital and keeping it empty in case of emergency.

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

TB/24/28 Trust Board work programme 2022/23 (agenda item 14)

NM noted the safer staffing report needs to be changed to come to Board in June and January. The IPC BAF also needs to be come to Board twice a year.

Action: Andy Lister

It was RESOLVED to NOTE the work programme.

TB/24/29 Date of next meeting (agenda item 15)

The next Trust Board meeting in public will be held on 30 April 2024.

TB/24/30 Any other business (agenda item 16)

STh provided the Board with the following updates for the older people's transformation:

- The consultation closes on 29 March 2024.
- We have received over 1,000 responses to our consultation survey, and we have heard from a diverse range of people across our population and have some extremely valuable insight into our proposals.
- We have had some fantastic, in depth, conversations with staff and members of the public who came to find out more at our consultation events.
- In the coming months we will be looking at what people told us throughout the consultation process to help inform our decision.
- We are working through a timeline for when we hope to make a decision and will keep the Board updated on our progress.
- There have been 972 digital survey responses by Monday 25 March and more paper surveys to input, meaning that we've received above 1,000 responses in total.
- 3,636 website homepage views (between 12 January 2024 and 21 March 2024).
- 721 video / animation views.
- 52,000 people have been reached across the Trust social media accounts with many more across partners social media platforms.
- Further engagement activity has been completed, including public stands in 5 general hospitals and 5 town markets, digital meetings, a Sikh temple visit, and further meetings with interested public groups.
- Analysis shows good response rates across different places and strong representation from those with protected characteristics and groups that have been hard to reach.
- The male response rate has been lower than female and late activity will target males (such as Andy's Man Club).
- Voluntary, community and social enterprises (VCSE) and advocacy work now nearing completion and collected paper surveys are being inputted.
- The feedback from the public consultation and analysis of the results will come to the quality and safety committee, the executive management team, and Trust Board
- the options will then need to be presented to the integrated care board and it will need to be presented again to the system joint oversight and scrutiny committee and other groups final prior to a final decision being reached.
- Some working groups have been established, one of which will look at equality and sustainability, another will look at finance, and another group will look at the outcome of the public consultation.
- The initial analysis needs to be fed back by the end of April and we should have the report back by the end of May.
- this will need to be reported back to various groups within the Trust including the Members' Council
- the options review group and the programme board will delegate a list of appropriate options.

AL asked the Board to note the support provided to the public consultation by the Trust Members' Council. A number of governors have been in attendance at the public events. ST also asked for the support of Non-Executive Directors to be noted as well.

Signature: Date:

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 26 March 2024 – ACTION POINTS

= completed actions

Actions from 26 March 2024

Min reference	Action	Lead	Timescale	Progress
TB/24/19	Mike Ford (MF) made the observation around the length of the minutes, in particular service user/staff story where the minutes are almost a transcript rather than a summary.	Andy Lister	April 2024	March minutes have been written to reflect a summary rather than transcript for review.
TB/24/19	**TB/24/10a -** RIDDOR (reporting of injuries, diseased and dangerous occurrences regulations) incidents - MBu queried if the Board are satisfied with the document progress against the action. MBr noted there is suitable support available for staff who have been assaulted, but the Trust should seek assurance from affected staff to ensure they feel they have received the appropriate support.	Carol Harris/Darryl Thompson	June 2024	
TB/24/22	NM suggested a change in approach to the staff survey to enable the Board to see the key points earlier than we do.	Lindsay Jensen	June 2024	
PS/24/23a	NM suggested complaints are reviewed in quality and safety committee (QSC) to scrutinise improvements and look at what more can be done.	Darryl Thompson	June 2024	

TB/24/23a	NM also suggested taking pressure ulcers into QSC for further scrutiny as the complexities and challenges are leading to an increase in pressure ulcers and also look at how achievable a target of zero is.	Darryl Thompson	June 2024	
TB/24/24e	CQC inspection action plan updates to come to Board on a quarterly basis	Andy Lister	April 2024	Workplan updated.
TB/24/24f	DL agreed to pick up the patient experience pilot that has been utilised within forensic services and roll this out to other wards	Dawn Lawson	June 2024	
TB/24/24f	MBu noted she was pleased to hear that FIP is enhancing its focus on performance. MBu states she would like to know more about patient level information and costing (PLICS) and would welcome a presentation for Board members.	Adrian Snarr	June 2024	
TB/24/26b	Duplication and alignment to be checked in the internal meetings governance framework	Andy Lister/Julie Williams	July 2024	
TB/24/28	NM noted the safer staffing report needs to be changed to come to Board in June and January. The IPC BAF also needs to be come to Board twice a year.	Andy Lister	April 2024	Added to the workplan as requested.

Actions from 30 January 2024

Min reference	Action	Lead	Timescale	Progress
TB/24/08	The latest LeDeR (learning disabilities mortality review) report has been published. This will come to Board once it has been reviewed in detail by the quality and safety committee (QSC).	Darryl Thompson	April 2024	On the April Board agenda.

TB/24/09b	MF asked for a paper on this risk to come to Audit Committee to update the position on risk 1217 - 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 in line with the committees other allocated risks.	Adrian Snarr/Dawn Lawson	July 2024	It is proposed to complete this piece of work once the Trust Strategy Refresh work is completed. The refresh will define our priorities and programs for the next 5 years, so a review of capacity and capability will then be required to ensure we can deliver on our revised strategic priorities.
TB/24/09d	A fundamental review of the safer staffing report is to take place to make sure it is providing Board with the assurance required in preparation for its next publication in June. Clarity is required around the meaning of unfilled shifts and executive trio oversight needs to be included. The report should stipulate if the Trust is safely staffed or not.	Darryl Thompson	June 2024 (date of next report)	
TB/24/09d	PRC should have an agenda item to look at safer staffing and the impact on staff, stress levels and what interventions are available, and the outcome of the forthcoming audit.	Lindsay Jensen	April 2024	This will be picked up as part of the health and wellbeing update due in July at PRC.
TB/24/09f	A discussion followed noting FTSU data should be triangulated with the outcome of the forthcoming staff survey report and pulse surveys.	Darryl Thompson	July 2024 (date of next report)	

TB/24/09g	It was noted that neurodiversity is not a protected characteristic and therefore doesn't fall within the scope of the Equality and Diversity Annual Report. Consideration should be given as to how the Trust reports in relation to neurodiversity.	Dawn Lawson	April 2024	There are 9 protected characteristics, and one of those is disability. Neurodiversity (autism, ADHD, Dyslexia) would be therefore considered as a disability and as such we would make reasonable adjustments based on an individual's needs or requests. We are improving our recording of disability on Sytm1 to enable us to more proactively respond to individual need. We have been delivered training for staff through 'lunch box training' on neurodiversity, in partnership with a service users group, for the last 2 years. Through the EIIC the action plan for 24/25 will put a stronger focus on disability and reasonable adjustments as a key area for improvement. The work on Systm1 will provide the baseline position and will have all reasonable adjustment information in one place and will include access and communications needs. The action plan will be reviewed and overseen by EIIC.
TB/24/09h	ST reported the final report has been received, and the royal college has noted the service has taken an open and positive approach to learning. There are twelve identified areas of improvement and four recommendations. A report is being put together including the context of the invited review and the fact it is quite a niche service, sharing the royal college report and action plan. The quality team are supporting this, and this will go to QSC and will then come to Board.	Subha Thiyagesh	April 2024	On the Board agenda for April Board
TB/24/10b	NM noted the huge improvement in appraisals in the forensic service in a short space of time and asked if any learning could be taken into PRC to review.	Carol Harris	April 2024	All actions are shared regularly through the operational management group and performance is routinely updated in PRC. Improvements relate to increased management focus and data cleansing which is carried out in stages.

Actions from 28 November 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/115	NM queried how the matrons monthly inspections qualitative discussions can be used to inform the patient experience annual report.	Darryl Thompson	June 2024 (date of next report)	
TB/23/117	NM noted the patient and carers race equity framework and queried if this is mandatory? MBr reported there was consultation on the framework, and it was checked against our own equality and inclusion plan. We can now reassess and bring the outcome to the equality inclusion and involvement committee for review, and report to Board through the triple A report.	Dawn Lawson	April 2024	The Patient & Carers Race Equality Framework is a requirement for all organisations is part of the NHS Operating guidance. We are required to submit a report on our progress on the set of metrics we are required to deliver on. This reporting is overseen by EMT and EIIC.
TB/23/119e	AS to take the detail of the EPRR report back to the Audit Committee for further discussion	Adrian Snarr	April 2024	EPPR update was provided to Audit Committee in April.

Actions from 31 October 2023

Min reference	Action	Lead	Timescale	Progress
TB/23/99	CH reported Tracey Smith has just come into role and she will be taking it forward in her new role. DT suggested in 12 months a paper should come to Board to update on progress. CH suggested that interim reports can be provided to the Quality & Safety Committee (QSC) over the 12-month period through the executive trio report. DT suggested a psychological professions update from Tracey Smith would encompass this work.	Darryl Thompson	November 2024 (dated to 12-month update report)	

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
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):	All risks.		
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.		
	Planning guidance for 2024/25 was finally issued on March 28th. Whilst much of the content was already briefed it is helpful to be able to reference all the key points in one paper. There is a more detailed paper on the 2024/25 operating and financial plan within the agenda. Key priorities highlighted in the plan include: • Improving access to community and primary care services, including dentistry. • Improving access to mental health services for patients across all age groups. • Improving staff experience, retention and attendance. • Integrated care boards (ICBs), trusts and primary care providers to work together to plan and deliver a balanced net system financial position. Key areas of focus for mental health services include out of area placements, access (community, children & young people, perinatal), talking therapies, health checks for people with severe mental illness, the mental health investment standard, , flow & length of stay, and inpatient quality improvement **Locally there continues to be intense work and effort on finalising the financial plan for the year**. At the time of writing this report both of our integrated care systems have deficit plans in excess of £100m. It is widely expected that there will be increased pressure to reduce the size of these deficits and there is much-increased focus on productivity and workforce growth. Our submitted plan for the year remains as a deficit of £1.5m.		

	As a Trust and a Board, we need to remain absolutely focused on reducing health inequalities. NHS England has published a helpful guide for Board members, the link for this is provided. The Trust has a wide range of actions in place to support how we can address health inequalities, which are regularly fed back via the Equality, Inclusion, and Involvement Committee. As our own and the national staff survey results have shown we cannot be complacent. The use of this guide and any further actions we need to take can be picked up in the Committee. Reducing health inequalities: A guide for NHS trust board members (nhsproviders.org) **The Trust is delighted to support West Yorkshire's Fellowship Programme which is aimed specifically at colleagues from ethnically diverse backgrounds who are working within the Health and Care system in West Yorkshire**. Miriam Ahmed will be joining our integrated change team for one day a week from NHS England for twelve months to gain senior level experience. **There has been wider profile given to sexual safety for NHS staff**. The publication of the NHS staff survey and the National Education and Training survey results highlight that 58,000 staff reported unwarranted sexual approaches from patients or other members of the public last year, which equates to 1 in every 12 NHS workers. Furthermore, 1 in 26 reported experiencing similar harassment from work colleagues. Our Trust has signed up to the Sexual Safety Charter and the 2024/25 planning guidance sets out a number of actions for trusts to implement to improve sexual safety at work. **The focus of this Trust Board is on risk and assurance.** From a risk perspective the NHS financial position is consuming much time and focus as finances become increasingly challenged across the country, both for NHS organisations and partner public sector bodies. There is an expectation that systems and organisations deliver a break-even position in 2024/25. As the impact becomes clearer the Board will need to understand what the implications of this situation are in terms of achieving our ambitions, delivery of care, and on our workforce. **From a performance perspective** our performance levels are being maintained. Our integrated performance report highlights good performance in many areas. One area requiring continued vigilance is that of children and young people who occupy a bed on an adult ward when no other options are available. Whilst strong safeguarding controls are put in place this is far from an ideal situation, and we continue to work with partners on addressing this issue. The Trust has again achieved its financial targets, delivering a small surplus. This is a solid base from which to work from as the financial situation becomes tighter, but it will require a real shift in mindset and approach for this to continue. In our role as commissioner of adult secure services in South Yorkshire we are aware of financial challenges at Cheswold Park, who are the largest provider of adult secure beds in South Yorkshire. We are working with Cheswold Park, partners at NHS England, and the specialist commissioning hub to develop a sustainable solution. Cheswold's services have previously been rated as inadequate by the CQC.

The consultation on the older people's mental health inpatient services has now ended with over 1,000 responses received. This has been an excellent process with some rich feedback and comment received. This feedback is now being reviewed and will be fully considered as the new model of care is agreed.

The engagement work to refresh our Trust strategy has also completed. Well over 1,000 responses through different forms were received and work is already taking place to review and summarise these. Trust Board will receive detailed feedback in readiness for its strategy board meeting in May and this May meeting will provide protected time to consider the refresh of our Trust strategy.

Our Board papers include several year-end reports including our annual review of Trust Board Committee effectiveness. Each committee has already reported and discussed their effectiveness reviews at the Audit Committee. This is an invaluable exercise that enables strong assurance to be provided, along with an opportunity to consider how we can continually develop and improve. Thanks are given to our corporate governance and finance teams who carry out a great deal of work at this time of year, much of which goes unseen by many.

The recruitment process for our substantive chief people officer has commenced. It is planned to hold the final stages of the process on June 19th and 21st and we are hopeful of a positive response to attract a high calibre candidate.

Carmain Gibson-Holmes's innovative approach to improving quality by engaging with staff has been recognised by an article in the Nursing Times. The article focuses on the 'Tea to Improve Quality' initiative introduced by Carmain and highlights the benefits of fostering an open culture, providing time to reflect, and acting upon issues raised.

Examples of positive achievements and work across the Trust from the past month includes:

- The Trust has been granted the Investors in Volunteers award. This is a great achievement for the Trust, our volunteers, and managers.
- The Trust has achieved the NHS Pastoral Care Quality Award for international nurse recruits.
- Staff at Nostell Ward received some tremendous feedback regarding the care they provided. An excerpt from this feedback is: 'I wanted to take a moment to extend my deepest gratitude to each and every one of you for the outstanding care and support you provided during my time at Fieldhead Hospital Nostell Ward Your dedication, compassion, and professionalism made a significant difference in my journey towards healing and recovery
  I am deeply grateful for the profound impact you have had on my life. You are all true heroes in every sense of the word, and I feel incredibly fortunate to have had the opportunity to be under your care. Your kindness and compassion have made a world of difference, and I will always hold you in the highest regard'.

	• On a similar theme the physical health team & wellbeing team at Kendray led by Hannah Burton received a very complimentary letter regarding the service they provided 'I wish to commend Hannah Burton and her team at Kendray Hospital……Basically, I have had fantastic opportunities from Hannah and her team which keep me well in body and spirit'. **In terms of national developments for our sector the following are worthy of Board note:** • The NHS Confederation has released a major new report in partnership with the Centre for Mental Health and London School of Economics which reveals that mental ill health costs the nation circa £300 billion annually, with these costs spread between individuals, their families, business and government. The Confederation will be using this information to support the development of a long-term society-wide mental health strategy. • On a similar theme official figures show that almost half of working-age adults with a disability now cite mental health as a cause, intensifying anxiety about the growing toll of ill health on the economy. • The Nuffield Trust has warned there must be a "radical rethink" of how autism and ADHD are assessed and treated in England if the NHS is to keep up with demand for services. At our previous Trust Board meeting the gap between demand and capacity for these services was made evident. We will engage in any such work as well as the work taking place locally to identify how pathways can change to improve access. Trust Board members are reminded the Trust's annual excellence awards and long service awards are taking place on Thursday May 2nd. I am sure all Board members are looking forward to celebrating with and thanking our staff for their excellent achievements.
Recommendation:	**Trust Board is asked to:** • **NOTE** the Chief Executive's report.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

28 March 2024

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

Our staff carers network (SCN) received EyUp funding for an overnight retreat at Parceval Hall in Leeds. The retreat offers staff 'time out' from their caring responsibilities in a safe environment. The one night retreat was attended by 15 members of staff who spent their time taking part in meditation, Tai Chi, a mindfulness walk and socialising with other carers. The retreat supported staff carers who might find it a challenge to have a good work life balance alongside their caring responsibilities.

Our priorities for 2023-24

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

Thank you to everyone who gave their views in our **older people's mental health inpatient services consultation** which closes on 29 March. We've had over 1,000 responses. In the coming months we will be looking at all the feedback in partnership with NHS West Yorkshire Integrated Care Board (ICB) and using this to inform our decisions. We are working through a timeline for when we hope to reach a decision and will keep you updated. If you have any questions, drop the team an email at opsconsultation@swyt.nhs.uk

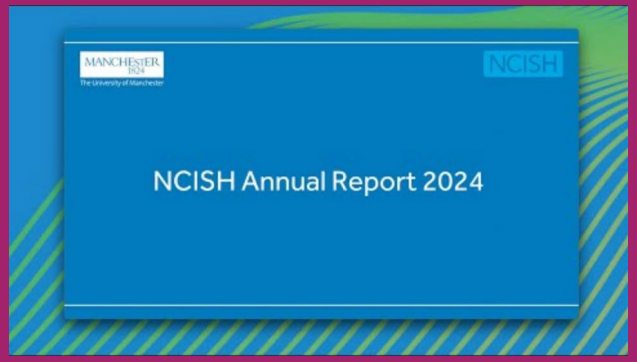
Places are available for managers on the **enhanced equality, diversity, and inclusion training** – health inequalities. The training is essential to job role for all managers. Take a look on the intranet for available dates and locations.

The national, regional and local context

South West Yorkshire Partnership NHS Foundation Trust

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

Watch a two minute video from the national confidential inquiry into **suicide and safety** in mental health (NCISH) 2024. It gives the key stats and information about concerns in suicide prevention and at-risk groups.



'Words can hurt': a language guide for gambling harms is a resource created by the Greater Manchester Combined Authority and partners as part of their work to **prevent and reduce gambling** harms and work independently from the gambling industry. You can use the guide as a tool to double check your language choices.

Local elections are due to take place on Thursday 2 May 2024. We are now in the pre-election period which places specific restrictions on the use of resources and communication activities of public sector organisations, including the NHS. The pre-election period is designed to avoid the actions of public bodies distracting from or having influence on election campaigns. You can read guidance from NHS England online - NHS England » Pre-election guidance for NHS organisations Spring 2024

We have been working with partners in the Barnsley Community Health and Care Alliance to develop a film to encourage people with a learning disability to take up their **annual health check**. You can watch the film, and three social media edits on our YouTube account.

Since the **West Yorkshire Staff Bank** was launched in January over 1300 people have signed on to pick up shifts across the region. The team are working through the local onboarding process. If you are waiting make sure you are fully up to date with your mandatory training, as it is a requirement before onboarding can be completed.

Improving Health
Our performance in February

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **53.9%** of people completing Talking Therapies treatment and moving into recovery
- **100%** of Talking Therapies referrals beginning treatment within 18 weeks. **98.7%** within 6 weeks.
- **91%** of MH service users followed up within 72 hours of discharge from inpatient care
- **90.1%** of people with a risk assessment/staying safe plan in place within 24 hours of admission (for inpatients)
- **74.7%** of people with a risk assessment/staying safe plan in place within 7 days of first contact (for community)
- **88.9%** of people died in a place of their choosing
- **78.8%** in CAMHS services waiting less than 18 weeks for treatment

Our **cardiac and pulmonary rehab service** has been selected to by the National Respiratory Audit Programme to provide a case study due to consistently good practice. They were celebrated for consistently performed very well with care being offered within 90 days of receipt of referral for all people referred with stable COPD, and for showing great improvement with the walking test. All case studies are available online to share learning.

Bookings are now open for our first **research and development conference** on Thursday 9 May 2024. The conference will be a key opportunity to look at new and emerging challenges and start the conversation about solutions in research. Tickets are free, book your place and have a look at the agenda on Eventbrite.

The **community mental health transformation programme** intranet page is now live. Find out the latest information about the community mental health framework that will transform the way mental health care is delivered in our local areas.

With **all of us** in mind.

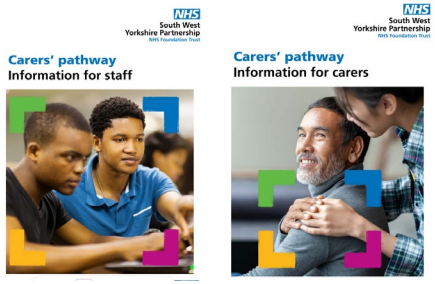
Improving Care
Our performance in February

NHS South West Yorkshire Partnership NHS Foundation Trust

- **74** inappropriate out of area bed days
- **1** child / younger person under 18 in adult inpatient wards
- **81.8%** waiting for referral to assessment within 2 weeks
- **2.9%** of service users clinically ready to discharge
- **88.7%** of service users on CPA offered a copy of their care plan
- **90%** of our service users have their ethnicity equality data recorded, **50%** their disability status, **50%** their sexual orientation, and **90%** deprivation (postcode)

94% of respondents in the friends and family test rated our general community services either good or very good; **89%** in our mental health services, **86%** CAMHS, **100%** for learning disability services, **67%** for ADHD and **67%** for forensic services.

New **carer's pathway** leaflets are available for staff and for carers - Carers pathway leaflets. The leaflets outline how you can identify, recognise and support carers, and helps carers recognise if they are receiving the support they are entitled to.



The **Exchange Recovery College** in Barnsley has received new gym equipment funded by our EyUp! Charity, to help their students and learners improve their mental and physical wellbeing. To find out more about how EyUp funding can help your service area see the intranet or contact the EyUp team direct.

Our facilities support manager **Katie Whittam** has been shortlisted in the Health Estates and Facilities Management Association (HEFMA) awards for her innovative approach to recruiting new estates and facilities staff.

With **all of us** in mind.

Improving Care Incidents in February

NHS South West Yorkshire Partnership NHS Foundation Trust

In February we reported:

- **1,275** incidents – **900** rated green (no/low harm)
- **294 were rated yellow and 72 rated amber**
- **9** rated as red (incident severity is reviewed and may be downgraded)
- **96%** of incidents resulted in no or low **actual** harm, or were external to our care
- **37** patient safety incidents that resulted in moderate or severe harm or patient safety related death.

We had **165** restraint interventions in February. **100%** of prone restraints were 3 minutes or less.

We had **45** falls in February, 3 less than in January. See the falls prevention intranet pages for steps you can take to prevent falls.

We had **49** pressure ulcers which developed under our care in February. **2** of them identified areas for improvement (formerly known as lapse in care).

We are progressing well with Triangle of Care which is about involving carers at all levels of the service user journey. Over 75% of teams have now completed the self-assessment to see how far along they are. We're seeing some good practice to celebrate and share, and working with teams on areas where we could develop more. There's more about Triangle of Care, drop in sessions and the self-assessment on the intranet.

There were 20 **confidentiality breaches** in February. All of us can reduce the number of patient data or sensitive information breaches. See the intranet for our IG campaign.

All staff must also ensure they complete their **information governance mandatory training**.

Think. Check. Share.

Annual **sharps safety awareness** training sessions will be held in March and April. Sharps safety awareness training sessions are available to all clinical staff and held via Microsoft Teams. Dates can be found on the intranet.

Information Governance (IG)

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The Trust has experienced an increase in information disclosures made in error in February. These information governance incidents have reached a significant level and will be thoroughly documented in the next IPR report.

We have identified and addressed the underlying causes of these incidents. Here are some simple tips to follow to help all of us prevent an information disclosure breach:

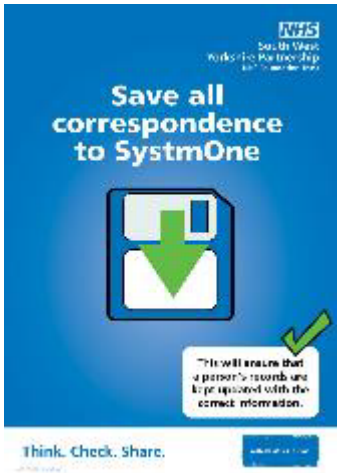
- **Don't forget to blind copy recipients when sending emails** – always double check your emails before hitting send.

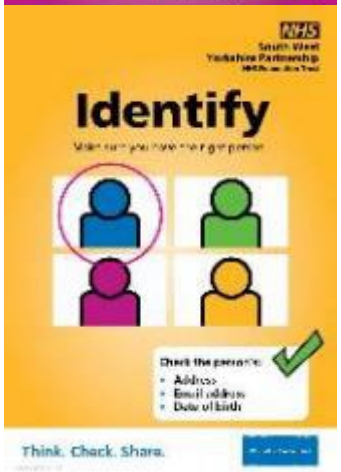
- **Make sure to double check the envelope before sending out any letters to avoid mailing them to the wrong address**. It's also important to update our records when a patient notifies us of a change in their address.

- **Remember to include only one letter per envelope or email attachment**, ensuring each recipient receives the correct correspondence. Use SystmOne letter templates and window envelopes where possible to eliminate errors from happening.

- **Check the information system to verify the correct email address and telephone number** on file to avoid sending emails and text messages to the wrong recipient.

- **Disclosing information with family members** – it's important to check the patient's clinical record to confirm their consent before releasing any information.





If you need any assistance or have any questions, please contact the team on: **Information.Governance@swyt.nhs.uk**

Managing risk

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NHS Foundation Trust

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

Key areas of risk identified in the risk register are:

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

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

Update your Android phone operating system. Outlook and Microsoft Teams will no longer work after the 29 March until you update your phone (you may need to do multiple updates). We recommend you do this when onsite and connected to the Govroam Wi-Fi or at home when connected to your home Wi-Fi, so you're not using the 4G data.

The King's Fund has published a guide illustrating the relationship between **poverty and NHS services**. Remember helpful financial signposting for staff is available on the intranet.

With **all of us** in mind.

Improving resources
Our finances in February

NHS South West Yorkshire Partnership NHS Foundation Trust

Performance Indicator	Year to Date	Forecast 2023/24
Surplus / (Deficit)	£0.6m	£0.5m
Agency Spend	£7.9m	£8.5m
Financial sustainability and efficiencies	£10.8m	£12m
Cash	£74.5m	£71.4m
Capital	£5.1m	£8.3m
Better Payment Practice Code	98%	

A deficit of £398k has been reported in February 2024. The forecast position has been reviewed and revised to a surplus of £0.5m. This is higher than the breakeven target.

Agency spend continued to reduce in February 2024 and is forecast to be under the target of £8.7m spend in year.

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. Year to date is £0.2m ahead of plan.

The Trust cash position remains strong although this is forecast to reduce in March 2024 due to payment of invoices and capital expenditure.

Excluding the impact of the impact of IFRS 16 (leases), year to date capital expenditure is £5.1m (61% of plan). Spend in February was £1.9m. Progress on all schemes has been reviewed and the team are confident that the total allocation of £8.3m will be utilised in full.

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

A great place to work

Our performance in February

- 4.8% sickness rate for the month.
- The rolling 12 months sickness rate is **5%**
- In February we had new **49** starters to the Trust, and **32** leavers
- We currently have **4,574** substantive members of staff
- **82.9%** of staff have a completed annual appraisal

We want all staff to have a high quality **appraisal** and a good conversation with their manager. Our numbers are improving each month. Please continue to make sure they are prioritised.

Find out more about **Ramadan** directly from our Muslim colleagues. Asma's story shares her experiences, goals and what Ramadan means to her.

Please make sure you have the most up to date Trust board and CQC posters on display in your areas. Printed copies will be sent to each service and area across the Trust soon. If you need them to be resent, please email comms@swyt.nhs.uk

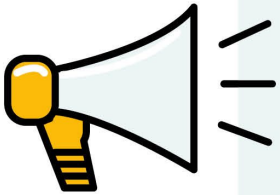
Enter the EyUp! Easter competition - closes Tuesday 2 April at 12pm
Tickets are £1 each. Enter now for your chance to win an Easter egg bundle, Wakefield Trinity RLFC and Huddersfield town tickets, a voucher for the New Inn, Walton and many more prizes.

Thank you to all of you who contributed to our **#allofusconversation**, focused on what we should do as a Trust over the next five years. It will help shape and support the refresh of our Trust's overall strategy, and the development of a new Trust clinical strategy. We will now analyse all the information we have received and will ensure you are kept informed as both strategies are developed.

The contribution the NHS makes to individual's **pensions** is increasing from 1 April. The NHS currently contributes 20.6% to employee's pensions. This is increasing to 23.7% from next month. This high level of employer contributions helps to make the NHS Pension one of the best pension schemes in the country. The contribution staff pay towards their pension is also changing from 1 April and the new rates can be found here.

#allofusimprove and be outstanding

With **all of us** in mind.



A great place to work

NHS staff survey 2023

The survey is carried out every year and was sent out between late September and 24th November

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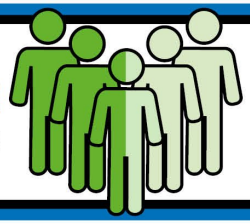
Provides important feedback on your experience of working for the Trust



2,442 responses

51% response rate (up from 50% in 2022)

Theme results	Trust score 0-10	Average
We are compassionate and inclusive	7.7	7.6
We are recognised and rewarded	6.6	6.4
We each have a voice that counts	7.1	7.0
We are safe and healthy	NO DATA	NO DATA
We are always learning	5.9	5.9
We work flexibly	7.0	6.8
We are a team	7.3	7.2
Staff Engagement	7.2	7.1
Morale	6.5	6.2

7 themes

are better than average

1 theme

is average

71% would recommend the Trust as a place to work. An increase from 67% in 2022

72% would recommend the Trust to family and friends as a place to receive care and treatment. This is up from 68% in 2022

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

Developing my potential

65% of staff feel they are supported to develop their potential. *This is above the national average.*

Quality of care

83% of staff say that care of patients and service users is the Trust's top priority. *This is above the national average.*

89% of staff say their role makes a difference to patients and service users. *This is in line with the national average.*

Feeling safe

23% of staff said they had experienced bullying or harassment by service users or relatives. *This is below the national average.*

6% of staff said they had been bullied or harassed by their line manager. *This is below the national average.*

12% of staff said they had been bullied or harassed by their colleagues. *This is below the national average.*

A great place to work
NHS staff survey 2023

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Positive support to keep me fit and well

66% of staff think the Trust takes positive action on **health and wellbeing.**
This is above the national average.

70% of staff feel there are opportunities for **flexible working.**
This is above the national average.

38% of staff say they felt unwell due to **work related stress** *in the last 12 months.*
This is below the national average.

Working in a supportive team

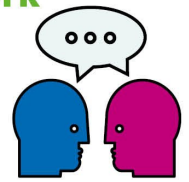
78% of staff say they receive the **respect** they deserve **from colleagues.**
This is above the national average

75% say their line manager takes **effective action** for any problems they face.
This is above the national average.

67% of staff feel they **have a choice in how they do their work.**
This is above the national average.

My Voice Counts

79% of staff feel able to **make suggestions to improve the work of my team or department.**
This is above the national average.



62% of staff feel able to **make improvements at work.**
This is above the national average.

79% of staff feel there are **frequent opportunities to show initiative.**
This is above the national average.

A great place to work
NHS staff survey - next steps

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The staff survey and workforce equality results give us an opportunity to learn about staff experiences and make improvements, alongside other feedback we receive. Below are some of the actions planned or already taking place:

- Review the results in our people committee.
- Work in partnership with staff side representatives to improve our results further.
- Work with our care groups and corporate teams to develop actions which address the local findings of the NHS staff survey. Supporting engagement with colleagues to review the results, recognise strengths and seek further improvements.
- Promoting further our wellbeing at work support offer to colleagues.
- Reviewing our policies to ensure they support all staff.
- Support to our staff networks – REACH, LGBTQ+, disability and carers
- Working with our partners across the ICS' on equality and diversity issues, development opportunities and health and wellbeing initiatives.

With **all of us** in mind.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Safety always comes first. Make sure you do everything you can to keep you and those around you safe.

Book a place at our enhanced equality, diversity and inclusion training courses.

Help raise understanding and awareness by watching the short film on suicide and safety in mental health.

As we are in a pre-election period consider the impact of any external events or public activity.

Discuss our IG guidance in your teams and make sure you have completed your mandatory training.

Discuss the NHS staff survey results in your teams and help identify ways we can improve.

Make sure you and any direct reports have a high quality, up to date appraisal.

Look after yourself and support colleagues during Ramadan.

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

NHS
South West
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NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 9.1

Private/Public paper:	**Public**		
Title:	**Board Assurance Framework (BAF) Quarter 4 – 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 and update Trust Board in relation to the current status of strategic risks including progress on actions.		
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, 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 and comprehensive method for effective and focused management of the risks to meeting the Trust's strategic objectives. The BAF is used by Trust Board to generate the agenda for meetings, provide assurance on the management of strategic risks, and provide assurance against the delivery of the Trust's strategic objectives. The Chief Executive also uses this document to support his mid and full year review meetings with directors to ensure they are delivering against agreed		

objectives, and action plans are in place to address any areas of identified risk. The BAF is also used in the formulation of the Annual Governance Statement.

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

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

As part of the head of internal audit opinion process, the Trust BAF is reviewed by the Trust's internal auditors, 360 Assurance. Their review includes recommendations relating to the clarity of control and assurance statements.

On 4 April 2024, the Executive Management Team (EMT) fully reviewed updates to the BAF for quarter 4 2023/24 to consider current circumstances and the grading of strategic risks. It was acknowledged that the new grading system will be implemented in quarter 1 2024/25 as previously agreed by EMT, Audit Committee and Trust Board.

EMT are recommending, given the proposal for the Trust strategy refresh to be released in July 2024, that strategic risks will remain unchanged for quarter 1 2024/25 and be reviewed following the strategy refresh in time for quarter 2 2024/25 reporting.

EMT discussions in respect of strategic risks considered the external environment in which the Trust operates, including factors such as continued high levels of acuity and complexity in presentation, 2024/25 financial planning arrangements, further instances of industrial action, recent staff survey results, and the recent care quality commission report following the inspection of an independent provider in the South Yorkshire adult secure provider collaborative.

As agreed at Trust Board in April 2023, 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 proposed changes to grading between quarter 3 and quarter 4:

Strategic Risk Ratings	Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24
Red	0	0	0	0
Amber	4	5*	4	4

Yellow	9	9	10	10
Green	0	0	0	0
Ungraded	1	0	0	0

(*2.4 grading was approved by Trust Board in October 2023)

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

Risk 2.3 - Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care. To remain Amber. EMT discussed current levels of demand and complexity in some service lines. For example, demand continues to be high for ADHD and ASD services. Whilst a number of actions have been pursued by both the Trust and commissioners to control and meet demand, it remains significantly higher than capacity. The West Yorkshire integrated care system (ICS) is conducting work on the children's neuro developmental pathway. The local position is reflective of a wider national issue.

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. To remain Amber. In January 2024, EMT discussion noted that actions were being progressed, with further work required. Following the publication of the staff survey results in quarter 4, EMT have agreed that current workstreams need to continue and notable outcomes to be achieved before a reduction in grading can be considered.

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. To remain Yellow. While final planning guidance was ultimately received on 28 March the Trust is still working with the West and South Yorkshire integrated care systems (ICS) to submit a plan that meets system requirements, given the additional financial pressure being placed on the NHS for 2024/25. The grading of this risk will be subject to careful consideration in quarter1 2024-25 following the Trust's plan submission in early May 2024.

Risk 3.2 - Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives. To remain yellow. EMT considered the additional demand placed upon the executive management team, in particular the director of finance, estates and chief nurse/director of quality and professions, to support the South Yorkshire adult secure provider collaborative. This risk will be monitored closely over quarter 1 of 2024/25.

The view of EMT is that the ratings of individual strategic risks for quarter 4 are representative of the operating environment and pressures within our services.

Recommendation:

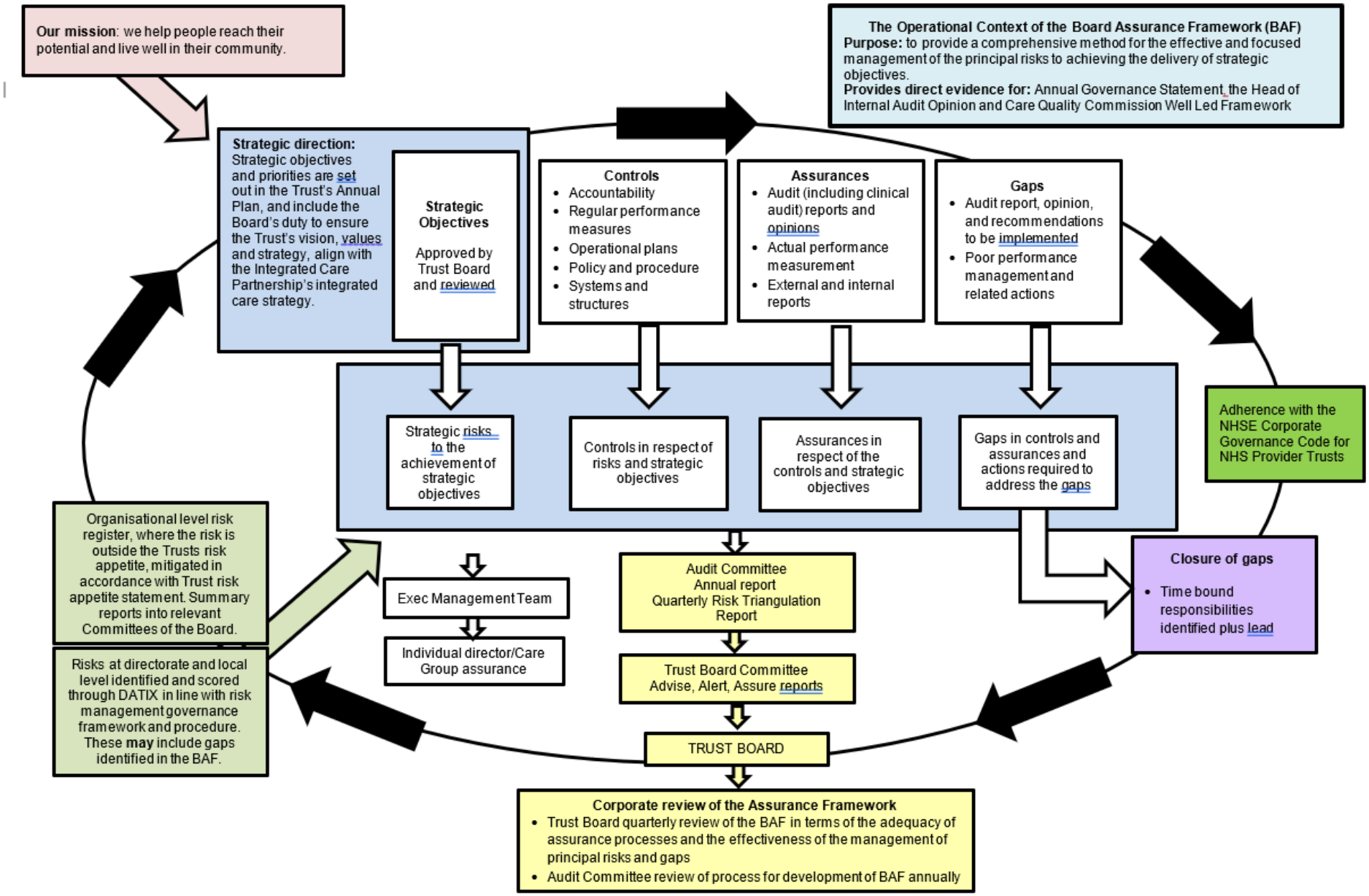
Trust Board is asked to:

- **DISCUSS** this report,
- **APPROVE** the proposed updates to the Board Assurance Framework,

	• **AGREE to** the EMT proposal that strategic risks will remain unchanged for quarter 1 2024/25 and be reviewed following the Trust strategy refresh for quarter 2 2024/25.

BOARD ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

South West Yorkshire Partnership NHS Foundation Trust



Board Assurance Framework (BAF) – 2023/24

Overview of current assurance level:

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

Strategic objective	Strategic risk	Page ref	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	Y	Y
	1.2 Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision		Y	Y	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	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	A	A
Improve care	2.1 The increasing demand for strong analysis based on robust information systems means there is insufficient high-quality management and clinical information to meet all of our strategic objectives		A	A	A	A
	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.		Y	Y	Y	Y
	2.3 Increased demand for services and acuity of service users exceeds supply and resources available leaving to a negative impact on quality of care.		A	A	A	A
	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	A	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	Y	Y
	3.2 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		Y	Y	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	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	Y	Y
	4.2 Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively		Y	Y	Y	Y

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	Y	Y

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

Committees: AC = Audit Committee, 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**	**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 took 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. • The Trust Care Quality Commission (CQC) assessment remains as an overall rating of good. In May 2023 an inspection of forensic and adult mental health inpatient services took place, the outcome of which was requires improvement. In 2019 the CQC conducted a well-led review which contributed to the overall rating of good and partnership working was acknowledged to be strong • Strong and robust partnership working with local partners, working through integrated partnerships in Barnsley, Calderdale, Kirklees and Wakefield (boards and committees). • 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.

Rationale for current assurance level (strategic objective 1: improve health)
• The Trust has been involved in the development of place-based plans and priority setting. • 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 is in place 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. • The Trust insight report feeds into the Executive Management Team meeting and Equality, Inclusion and Involvement Committee • Integrated Performance Report (IPR) summary metrics month 11 23/24 - out of area beds – red, children and young people accommodated on an adult inpatient ward – red, learning disability referrals with completed assessment, care package and commenced delivery within 18 weeks – 87.5%, clinically ready for discharge (previously delayed transfers of care) – red. • 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, public consultation has received positive feedback with significant engagement and involvement of local communities. Task and finish groups have now been created to look at next steps. • 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. • Chief psychological professional recruited and in place, this role provides leadership and oversight of psychological professions within the Trust. • 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. • Chief Medical Officer in their role as executive sponsor of learning disability takes regular updates into the quality and safety committee which reports through to Trust Board via the triple a report. • Strategy refresh is in progress and an extensive engagement process has taken place with all stakeholders including service users, families, carers, staff and communities.

Strategic objective 2: Improve care	Lead Director(s)	Monitoring and assurance	Overall assurance level							
			2022/23		2023/24					
Links to ORR (risk ID numbers): 275, 773, 905, 1078, 1132, 1159, 1424, 1522, 1530, 1545, 1568, 1649, 1650 1757, 1758,1820	As noted below.	EMT, QSC, WRC, Trust Board	Q4		Q1	Q2	Q3		Q4	
			Y	A	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 is in place to take a lead role in our approach to dysphagia.

Rationale for current assurance level (strategic objective 2: improve care)
• Business intelligence development plan is being aligned to Trust strategic objectives and priority programmes including health intelligence data and reporting. • Trust developing overarching operational data quality improvement plan which will be monitored by Improving Clinical Information Group (ICIG) and Operational Management Group (OMG) • Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 11 23/24 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. This includes any response to CQC actions. • Themes from serious incident investigations, are identified through the patient safety oversight group (formerly 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 to increase the number of responses. Results continue to be triangulated with other feedback, such as the Insight report, and Healthwatch. • Patient Safety Incident Review Framework went live in the Trust on 1 December 2023. PSIRF includes an enhanced analysis of thematic learning as part of the framework. • 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. • 92% compliance with internal audit actions. • The Trust Care Quality Commission (CQC) assessment remains as an overall rating of good. In May 2023 an inspection of forensic and adult mental health inpatient services took place, the outcome of which was requires improvement. In 2019 the CQC conducted a well-led review which contributed to the overall rating of good. • 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 piloting working with identified teams – senior responsible owners are the chief people officer and chief nurse/director of quality and professions. Funding for this work has been agreed for 2024/25. • "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. • Care group performance reports provide additional performance information to the Board and are presented in all public meetings. • Medical workforce race equality standard lead (MWRES) in place to work with the Trust EDI lead to ensure the Trust is in keeping with national race standards and indicators in the medical directorate.

Strategic objective 3: Improve resources	Lead Director(s)	Monitoring and assurance	Overall assurance level				
			2022/23	2023/24			
Links to ORR (risk ID numbers): 275, 812, 852, 905, 1080, 1114, 1217, 1319, 1368, 1432, 1585	As noted below.	EMT, AC, WRC, Trust Board, FIP	Q4	Q1	Q2	Q3	Q4
			Y	Y	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 the process of being secured for 2024/25 and will remain predominantly on a block basis. Longer term planning is underway 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 submitted a break-even plan for 23/24 and is in the process of agreeing a 2024/25 plan. • There is sustained acuity and demand leading to ongoing pressure on beds. However, we have seen a decrease in the use of out of area beds which has been sustained for six months. • 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 reflect the strategic priorities for 23/24. • Cash balance at month 11 of 2023/24 is £ £74.5m.

Rationale for current assurance level (strategic objective 3: improve resources)
• 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 2022. The Trust is coordinating provider for forensic CAMHS for Yorkshire and Humber region which went live on 1 April 2023. • Mental health investment standard and other recent income growth continues to support our financial position. At present, all places continue to invest to a level compliant with MHIS. The Trust is in the process of agreeing final contracts as a provider. • Inflationary pressures are challenging for revenue and capital planning. Reviews are under way to consider mitigating actions. • Updated priority programmes for 2023-24 are aligned to strategic objectives and will be monitored as part of the IPR reporting. • Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. • The Trust has an approved digital strategy, due for renewal in 24/25. • Capacity has been obtained to progress Digital dictation in the Trust and is on track for delivery during 23/24 • Standing financial instructions and scheme of delegation approved by Trust Board (January 2023) and Members Council (February 2023).

Strategic objective 4: Make this a great place to work	Lead Director(s)	Monitoring and assurance	Overall assurance level				
			2022/23	2023/24			
Links to ORR (risk ID numbers): 1151, 1157, 1614, 1729	As noted below.	EMT, WRC, Trust Board	Q4	Q1	Q2	Q3	Q4
			A	Y	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**	Y
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 – vacancy levels across clinical functions • Increased use of bank in preference to agency and use of 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. • The Trust Care Quality Commission (CQC) assessment remains as an overall rating of good. In May 2023 an inspection of forensic and adult mental health inpatient services took place, the outcome of which was requires improvement. In 2019 the CQC conducted a well-led review which contributed to the overall rating of good. • Changes to the Integrated Performance Report (IPR) to improve oversight and of workforce data at both Board and Board Committee level. • Staff survey has been completed for 2023 and the results available from 7 March 2024. The Trust benchmarks well in comparison to similar local organisations and overall shows a positive position. • The exit process for leavers from the Trust has now been revised following an internal audit process. Outcomes of exit interviews are reported into PRC. • The Trust now has a full and substantive board including both executive, and non-executive roles. • The Trust is reviewing its 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 meetings are attended by representatives of the People directorate. • 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 Interim Chief People Officer 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. • Year to date recruitment continues with 654.4 starters since April 2023. • The inclusive leadership programme development was commissioned in May 2023, and a planned event to took place in November with extended EMT. A series of engagement events have now taken place across the Trust with recommendations and actions being formulated for early 2024. • 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. • The appraisal window has been widened to ensure more flexibility for the appraisal process, particularly for those in front line services. • 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.

Rationale for current assurance level (strategic objective 4: make this a great place to work)
• 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 • #allofus conversations are taking place in regard to the Trust strategy refresh including great place to work and engagement with Trust staff

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/DSC	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 in place 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
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 for extensive engagement 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 Mental Health Act Committee , 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 Quality and Safety Committee and 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

Controls (strategic risk 1.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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
C201	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. The changes that have taken place have not impacted on mental health, learning disability and autism commissioning or capacity. To close as the gap no longer remains.	To close	
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 January 2024and April 2024. Work is not progressing at the rate anticipated and is still live. To review further in September 2024	September 2024	DSC/DPD
The Trust continues to embed the approach to the utilisation of health inequalities information to gain insight. Progress has been made and reviewed in January 2024, further work still required, and this will be included and aligned to the forthcoming Trust strategy refresh. Operational equality dashboards are now in place and are being refined and tested and will be used to both inform the strategy refresh and to monitor progress. To review again in July 2024.	July 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.	Unannounced and planned visits as part of our routine CQC interface. Monthly CQC updates are provided to QSC, and an annual report is received. Quality monitoring visits programme in place for 2023/24 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. New schemes for 2024 / 25 are yet to be identified and agreed acknowledging that funding is limited. (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

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

Controls (strategic risk 1.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval, including equality impact assessments. Central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies. (I)	DNQ / DFR	1.1, 1.2, 1.4, 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
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 Mental Health Act Committee, 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 stakeholders, 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
C78	Chief Medical Officer is the senior responsible owner for West Yorkshire ICS Older people mental health workstream which identifies and shares best practice, looks to reduce unwarranted variation in service provision and health inequalities.	CMO	1.2/1.3
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 Quality and Safety Committee and 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. Stakeholder analysis updated November 2023. (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
CXXX	The Trust has implemented a revised care group structure to further reduce service variation across the Trust footprint including a Childrens and Family care group and alignment of Barnsley mental health community services into mental health care group.	COO	1.2

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

Assurance (strategic risk 1.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. (I) (P)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality monitoring structure. Reports on these visits are provided to the EMT, Quality and Safety Committee (QSC), Trust Board and Members' Council.	Unannounced and planned visits as part of our routine CQC interface. Monthly CQC updates are provided to QSC, and an annual report is received. Quality monitoring visits programme in place for 2023/24 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 reports (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 Patient Safety Oversight Group (formerly Clinical Risk Panel) including the undertaking proportionate investigations and dissemination of lessons learnt and good clinical practice across the organisation. PSIRF is in place from 1 December 2023.	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 Trustwide 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.	Quarterly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DPD/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 24/25 is in progress, the Trust is looking at longer term planning into 25/26. This will take into account of 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 Q1 2024/25 to align with the integrated care system, this will be subject to national planning guidance timelines. Review in July 2024.	July 2024	DFR
The new people directorate structure is in place but gaps at a senior level within the people directorate could pose a risk to both achievement of outcome and timescales. New staff started in post during Q2, and they continue to progress through their induction process and forming part of a cohesive leadership team. From January 2024 the Director of Strategy and Change is providing executive support to the People directorate.	July 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
C15	Equality, Involvement, Communication Membership Strategy in place 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
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
C78	Chief Medical Officer is the senior responsible owner for West Yorkshire ICS Older people mental health workstream which identifies and shares best practice, looks to reduce unwarranted variation in service provision and health inequalities.	CMO	1.2/1.3
C124	Enhanced internal monitoring arrangements have been embedded in each place covered by the Trust. Digital and Estates TAG receive quarterly updates. (P) (I)	DFR	1.1, 1,2, 1.3
C127	Communication leads network established in places and across ICSs (P, I, E)	DSC	1.3
C128	Senior level representation at Health & Wellbeing Boards in each place. (P, E)	DSC	1.3
C129	Ongoing meetings with Healthwatch organisations in each place. (P, I, E)	DSC	1.3
C130	Working with partners such as Healthwatch, public sector colleagues and ICSs to collectively capture and share insight and intelligence and avoid duplication. (P, I, E,)	DSC	1.3
C131	Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) process integrated and used at gateways in transformation and change programmes. (P, I)	DSC	1.3
C138	Trust wide Equality Impact Assessment together with the inequalities data developing systemic analysis and plans to address Trust inequality priorities (P, I)	DSC	1.3
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C143	Trustwide Benchmarking Group in place. 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 Quality and Safety Committee and 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
C199	Partnership group in place as part of the improving mental health priority programmes, including representatives from community partners and stakeholders. (E, P, N)	COO	1.3
C203	The process through which the Trust has engaged and consulted internally and external stakeholders and members of the public to inform the older peoples inpatient service transformation programme.	CMO	1.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Data collection in relation to health inequalities is in line with local and regional direction including Core20plus5 and the NHSE toolkit. An equality interactive tool dashboard is now being used and continues to develop insight to ensure improvements and service change are now taking place thorough case studies. Service improvement work continues to use EIA insight to support the approach. Operational teams now have access to the BI intelligence that supports the Trust Dashboard and work continues to evolve.	July 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
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
A91	West Yorkshire older people's mental health work stream steering groups provides updates	Regular updates from the steering are presented to West Yorkshire mental health learning disability and autism board (P/N/E)	CMO	1.3
A92	Older people's mental health service transformation updates as part of priority programmes	Regular priority programme highlight reports into EMT. Updates are also presented to QSC and Trust Board (P, N, I, E)	CMO	1.3

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 Trust is now rolling out the enhanced equality and diversity training to all senior staff identified as essential to job role. This training is in month 6 of a 12 month roll out period. This is being led by the equality and involvement team. Equality impact assessment (EIA) training continues Review further in July 2024.	July 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 in place 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

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data is in place to identify any themes. Assurance via Mental Health Act Committee, 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
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 Quality and Safety Committee and 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
C204	Chief Medical Officer is the executive sponsor of learning disabilities for the Trust	CMO	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. The changes that have taken place have not impacted on mental health, learning disability and autism commissioning or capacity. To close as the gap no longer remains.	To close	
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 and building feedback processes to reflect and improve. In line with gaps in control and assurance for risk 1.3 to review further in July 2024.	July 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.	Quarterly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DPD/DFR	1.2, 1.4, 3.1, 3.2, 3.3
A33	Patient experience (including complaints) reports to Trust Board (annually) and QSC	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.4, 2.3, 2.4
A34	Quality strategy review updates report into QSC 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
A93	CMO is the executive sponsor for learning disabilities for the Trust.	Regular updates go the quality and safety committee which reports through to Trust Board via the AAA report. (P, N, I)	CMO	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. (Upon expiry the digital strategy timeline will be aligned to the Trust Strategy refresh) (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 through the Patient Safety Oversight Group where all red, amber, and incidents related to, staffing, bed management, and protected characteristics, are reviewed (irrespective of grading) for immediate learning. (I)	DNQ / CMO	2.1, 2.3, 2.4, 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
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 in place. 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
C172	Substantive data quality and waiting list lead in post from March 2024 to ensure the continued development and monitoring of waiting list management across the Trust. (I, P)	DFR	2.1

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

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 (as required)	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 EMT and 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 a cyclical approach to care group metrics 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	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 is in place 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, and are included in quarterly and annual incident management reports. (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 Quality and Safety Committee and Trust Board (Trustwide incident management report). (I)	DNQ	2.2
C61	I-hub platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate, and improve. (I)	DSC	2.2
C62	Peer lead worker role in place and training toolkit developed. (I)	DSC	2.2
C139	Process established for the use of improvement case studies which are then shared by the communications team and published on the Trust website. (P, I)	DSC	2.2
C141	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. Objectives set annually for all Directors. Monthly one to one meetings take place between Chief Executive and Directors. (P) (I)	CEO	All
C161	Learning from innovation process through use of SBAR structure to create short learning case studies which are shared with all staff via the Trust headlines (P, I)	DSC	2.2
C173	The use of external experts 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
C205	Patient safety partners are in place. These are volunteer roles to ensure lived experience is part of our learning. (P, N, E)	DNQ	2.2

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

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 Patient Safety Oversight Group (formerly Clinical Risk Panel) including the undertaking proportionate investigations and dissemination of lessons learnt and good clinical practice across the organisation. PSIRF is in place from 1 December 2023.	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 Trustwide Incident Management Report" which includes learning from serious incidents (P, N) (I)	DNQ	1.2, 2.2
A44	Clinical risk scan update into each EMT meeting.	Clinical risk scan update into EMT meeting. (P, N) (I)	DNQ	2.2
A45	Assurance reports to Quality Committee covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place.	Routine report to each Quality and Safety 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 QSC. (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 escalated in governance report to QSC (as required). (P) (I)	COO/DNQ	2.2

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)**
A51	Process in place to review and identify learning from an national investigations or reports.	Reports go into the clinical governance group (CCG), EMT and then QSC	DNQ	2.2
A90	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
A94	Service improvement work is now aligned with inpatient quality transformation programme for Mental Health, Learning Disabilities & Autism transformation.	Reports through priority programmes into EMT monthly (I, E, P, N)	COO	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**
The Quality and Safety Committee (QSC) and the clinical governance group continue to monitor the embedding of learning from SI action plans. The committee monitors the development of reports to evidence the link between the incident and the learning and further review will take place in April 2024. The development work is continuing in line with the patient safety incident response framework (PSIRF). Further update July 2024.	July 2024	DNQ
Impact of information governance (IG) training and action plan on IG hotspots. (Linked to ORR risk 852). Bespoke and ad-hoc training was 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 continuing to address this. Mandatory training standard of 95% was achieved for the submission of the data security and protection toolkit for 30 June 2023, and continues to be monitored (currently 92.7%). As part of the information governance communications campaign stories with associated learning are communicated via the intranet to help all staff understand the real impact of information governance breaches.	July 2024	DFR

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	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 in place 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 through the Patient Safety Oversight Group where all red, amber, and incidents related to, staffing, bed management, and protected characteristics, are reviewed (irrespective of grading) 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	Partnership Meeting includes a group established as part of the improving mental health priority programmes, including representatives from community partners and stakeholders. (E, P, N)	COO	2.3
C64	Care closer to home programme incorporating whole system actions with out of area bed reduction reported against trajectory. (I, E)	COO	2.3, 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	Healthwatch and regulators provide external assurance on standards and quality of care. (E) (P) (N)	DNQ	2.3, 2.4

Controls (strategic risk 2.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C145	Service user survey results reported to Quality and Safety Committee and 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	Operations leadership have implemented frequent inpatient staffing meetings 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
The Trust continues to embed the approach to the utilisation of health inequalities information to gain insight... Progress has been made and reviewed in January 2024, further work still required, and this will be included and aligned to the forthcoming Trust strategy refresh. Operational equality dashboards are now in place and are being refined and tested and will be used to both inform the strategy refresh and monitor progress. To review again in July 2024.	July 2024	DSC/DPD/COO
The Trust currently does not have safer staffing establishments in place for mental health community services, this is being developed as part of the community services transformation programme. The latest safer staffing report was submitted to Board in January 2024. A community safer staffing review will be included in the report presented to QSC and Board in June.	July 2024	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
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.	Unannounced and planned visits as part of our routine CQC interface. Monthly CQC updates are provided to QSC, and an annual report is received. Quality monitoring visits programme in place for 2023/24 are reported into QSC. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A33	Patient experience (including complaints) reports to Trust Board (annually) and QSC	Annual reports to Board / EMT and quarterly into QSC. (P, N) (I)	DNQ	1.4, 2.3, 2.4
A34	Quality strategy review updates report into QSC 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)	DSC	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 oversight group is in place to monitor the improving care priority programmes. The internal oversight group operates within the Trust and reports into EMT, but work is shared with the partnership group for support and challenge with feeds back into the Trust.	This group reports into EMT on a monthly basis (P, N, I)	COO/DNQ	2.3
A95	Care closer to home report	Reported into every EMT meeting (I, E, P, N)	COO	2.3/3.1

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
Calderdale children's ADHD and ASD commissioner have implemented Right to Choose which has resulted in a reduction in referrals for the Trust. In respect of Kirklees at the end of March additional capacity arrangements come to an end. There is no agreed solution at this stage. Commission 43 assessments 125 referrals a month. West Yorkshire ICS are conducting work on the children's neuro developmental pathway, this remains a national issue. Review further in July 2024.	July 2024	COO
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 hosted an autism summit and next steps are being established. Work continues to be led by the West Yorkshire ICS. To review in July 2024.	July 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 in place 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 Mental Health Act Committee, 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 through the Patient Safety Oversight Group where all red, amber, and incidents related to, staffing, bed management, and protected characteristics, are reviewed (irrespective of grading) 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 24/25 building on the leadership through a values-based culture and strengthening delivery of the Trusts strategic objectives (P, I, E)	CPO/CEO	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	Patient Safety Oversight Group (formerly risk panel) (executive trio membership) receive information on all incidents referencing protected characteristics, irrespective of incident 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 (including complaints) reports to Trust Board (annually) 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 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	A working group is in place to look at the experience of international recruitments and take learning and make improvements where required.	Reported into through the 90-day plan to 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)	DSC	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 surveys in place to provide insight into staff experience of inclusion and diversity matters in a timely fashion. Phase 1 of the inclusive leadership programme complete.	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**
The Trust continues to embed the approach to the utilisation of health inequalities information to gain insight... Progress has been made and reviewed in January 2024, further work still required, and this will be included and aligned to the forthcoming Trust strategy refresh. Operational equality dashboards are now in place and are being refined and tested and will be used to both inform the strategy refresh and monitor progress. To review again in July 2024.	July 2024	DSC/DPD/COO
Following WRES and WDES results a clear action plan is needed to address experiences of bullying and harassment by BAME colleagues. Review in July 2024	July 2024	CPO/DSC
Following a meeting between the executive trio and international nurse recruits, it has been identified that more work and support is needed to successfully integrate international nurses into Trust teams and ways of working A new steering group has been established and is joint chaired by the deputy CPO and Director of nursing, quality and professions. The group will meet fortnightly and report into EMT with two key functions – 1. To establish five workstreams and governance arrangements 2. To create a clear journey for each of the international nurses. To review in September 2024.	September 2024	DNQ/CPO
Programme of work to address health inequalities is taking place based on Trust data and national evidence to suggest that minority groups are more likely to enter services via detention under the mental health act than white counterparts. NHS confederation will be supporting the Trust. To review September 2024.	September 2024	CMO
Recommendations from phase 1 of the inclusive leadership programme are now under consideration and engagement is to take place with extended EMT to look at the next phase of work to be undertaken.	July 2024	CPO

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	Patient level costing now in place. First national submission made December 2023 (E, I)	DFR	3.1

Controls (strategic risk 3.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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 operational delivery and finance. (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
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.	DFR	3.1
C206	Monthly meeting between the DOF and COO with all care groups to review finance and performance.	DFR/COO	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 continue to fully develop a CIP plan for 24/25 including QIA and consider the impact of not having enough recurrent schemes in 2024/25. CIP challenge for 24/25 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. FIP review CIPs at every meeting. Review again in July 2024.	July 2024	DFR / COO

Assurance (strategic risk 3.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DSC	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A13	Annual plan, budget and strategic plan approved by Trust Board, following scrutiny by EMT and FIP and, for the annual plan, externally scrutinised by the WY ICS and is open to external scrutiny by NHSE.	Financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England. Trust engaged in development of Integrated Care System (ICS) annual and 5-year plans (P, N) (I).	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Calderdale, Kirklees, and Barnsley for 23-24. (P) (I) (E)	DFR	1.1, 3.1, 3.2
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and Trust Benchmarking Group and any action required identified. (P, N) (I, E)	DFR	1.2, 3.1, 3.2, 3.3
A24	Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity.	Quarterly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DPD/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 and performance issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG).	Standing agenda item for OMG (P, N) (I)	COO	3.1, 3.3
A95	Care closer to home report	Reported into every EMT meeting (I, E, P, N)	COO	2.3/3.1

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
Increasing expenditure on staffing in inpatient wards is resulting in financial spend higher than income. This remains has remained through 23/24 due to the Trust maintaining safety and quality on inpatient wards where acuity and demand remains high. Quality and safety remain priorities in line with Trust values. An establishment review has now been completed and is being considered as part of the 2024/25 planning process. Review in July 2024.	July 2024 2024	DFR

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

Controls (strategic risk 3.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with integrated care boards to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets are 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 operational delivery and finance. (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, 3.2
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's workforce plan remains a gap and is 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 April 2024.The longer-term Trust workforce plan is to follow the Trust strategy refresh and clinical strategy in order for them to inform any future workforce plan.	July 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
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

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)**
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.	Quarterly bids and tenders report to Executive Management Team (EMT) and twice yearly to FIP and Trust Board. (P, N) (I)	DPD/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
C200	Creativity and creative practitioner roles have been implemented in inpatient services with positive initial outcomes. (I, P)	DSC	3.3

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

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 23-24 (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 in place 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
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 through the Patient Safety Oversight Group where all red, amber, and incidents related to, staffing, bed management, and protected characteristics, are reviewed (irrespective of grading) 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, 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 which is currently under review. (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)	DNQ	4.1
C106	Medical leadership programme in place with external facilitation as and when required. (I)	CMO	4.1
C107	Great place to work strategy annual delivery plan approved by PRC (March 2023)	CPO	4.1
C110	Values-based appraisal process in place with revised monitoring arrangements in place and monitored through Key Performance Indicators (KPIs). (I)	CPO	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/CMO	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)**
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 which contributes to the sustainable workforce model. (P, E, I)	CMO	4.1
C178	Agency scrutiny group established which is chaired by the director of finance to ensure agency standards are fully adhered to (P, I)	CPO/DOF	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 24/25 are still be established and may create further pressure. To review further in July 2024.	July 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 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 for 23/24 had a trajectory of 3% across the Trust. The gap remains due to the continuing growth in establishment. At the end of the financial year 6.98% growth was achieved well above target of 3% due to our successful international, local nurse and support worker recruitment initiatives.	July 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)**
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 QSC. (P) (I)	DSC	2.2, 4.1
A66	Annual Mandatory Training report goes to PRC and 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 update report.	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	2.4 4.1, 4.2, 4.3
A78	A working group is in place to look at the experience of international recruitments and take learning and make improvements where required.	Reported into through the 90-day plan to PRC Committee (P, I)	CPO	2.4, 4.1, 4.3
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). The Trust is working with MHLDA group across the West Yorkshire MHLDA programme with a focus on retention. Medical and nursing recruitment has been positive in certain areas of the Trust over the last four quarters; however, severe national and global challenges remain, with increased system financial challenges in future months and years.	July 2024	CPO

Strategic risk 4.2

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

Controls (strategic risk 4.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy in place 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 which is currently under review. (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	2.4 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	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
C159	Leadership and development programme to support talent management approach (I, E, P, N)	CPO	4.2
C167	Insight programme – developing future Board members from diverse backgrounds (P, I, E)	CPO	2.4, 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 24/25(P, N, I, E)	CPO	4.2
C189	Trust Board development programme in place for 24/25 building on the leadership through a values-based culture and strengthening delivery of the Trusts strategic objectives (P, I, E)	CPO/CEO	2.4, 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. Following completion of this work consideration of an LGBT equivalent will take place. Work ongoing review further in July 2024.	July 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	2.4, 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. Issues have arisen in relation to the provider and increased costs for implementation. The business case is currently under review. Further update to be provided in July 2024.	July 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 in place 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
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) I	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
C198	The occupational health service has 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
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 will be completed in April 2024 and the outcomes will be available for July 2024.	July 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	2.4, 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	A working group is in place to look at the experience of international recruitments and take learning and make improvements where required.	Reported into through the 90-day plan to PRC Committee (P, I)	CPO	2.4, 4.1, 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
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
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 will be completed in April 2024 and the outcomes will be available for July 2024.	July 2024	CPO

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 9.2

Private/Public paper:	**Public**		
Title:	**Quarter 4 Corporate / Organisational Risk Register 2023/24**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	Asma Sacha - Corporate Governance Manager		
Purpose:	For the 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. To ensure Trust Board members are aware of and have the opportunity to discuss the current level of risk and emerging 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 Partnerships (ICP), Integrated Care Boards (ICB), and place-based partnerships. The organisational risk register recognises risks that have an impact on partnership working and the objectives of integrated care systems including quality of care, addressing health inequalities and achievement of financial and other performance measures		
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. The executive management team (EMT) reviews the organisational risk register at least once a quarter and factors risk into discussions and decision-making		
Executive summary:	**Corporate / Organisational Risk Register** The Corporate/ Organisational Risk Register (ORR) provides Trust Board with oversight of organisational risks that are significant in nature and have been escalated by the Executive Management Team (EMT). Risks that could have an impact across the Trust are reported to the Executive Management Team (EMT) monthly as per the Risk Management Framework. Risks on the ORR are aligned to the Trust's strategic objectives:		

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

All organisational risks are assigned to relevant Board Committees for discussion and oversight, and they report to Board through the individual committee's triple A report (Alert, Advise, Assure). Risk is a standing agenda item at Trust Board committee meetings.

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 is one emerging risk which will be reviewed and scored in preparation for the Quarter 1 2024/25 risk report.

Emerging risks

Risk ID	Description
Emerging risk	There is a risk of harm to staff during the course of their duties when working alone, particularly in the community, due to the low use of the lone worker devices provided by the Trust which could result in staff not being able to access support should an unexpected incident occur.

Risk level 15+

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.

EMT and the Chief Operating Officer (COO) have reviewed the risk actions and h noted that the data to date has not been suggestive of a consistent rise in demand across all services, but highlights specific service lines e.g. ADHD/ASD, CAMHS, paediatric audiology where numbers of people accessing services have clearly increased significantly.

Risk ID	Risk Owner	Description
1080	Director of finance, estates and resources	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.

This risk has been reviewed by EMT. The risk score continues to be considered taking into account new developments. The Cyber Essentials Plus re-accreditation is now complete as planned.

Risk ID	Risk Owner	Description
275	Director of provider development	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners. This includes the risk of service decommissioning where there is a reduction in Local Authority and ICB budgets.

EMT have reviewed this risk and the risk actions have been updated. The risk description has been reviewed by the Director of Provider Development to include a broader impact. In relation to the update on Kirklees Keep In Mind (services for children and young people): the total expected income represented a shortfall compared to the total cost of the service. ICB commissioners have agreed to fund the identified shortfall. The service impact will be continually reviewed.

Risk level <15 Risks outside the risk appetite

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.

This risk has been reviewed by EMT and there has been some progress on the work of the seclusion rooms. The interim measures to expedite repairs include replacing the wall and floor coverings with painted surfaces. The current trajectory of the repair work is multi-year. The Clinical Environment Safety Group (CESG) will meet to discuss and evidence the frequency of use and how often the seclusion room is out of use to determine if the actions taken to date warrant a reduction in risk score.

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

EMT has reviewed this risk and updated the risk actions. A highlight report was presented to EMT by the Chief Nurse / Executive Director of Quality and Professions, which featured oversight on medical devices in response to actions already undertaken and improvement actions, if still required. It was agreed that the risk score remains the same with further progress required in some services, and will be reviewed again in readiness for the next Board report. A medical devices project lead has been appointed on the Trust Bank for 12 months from April 2024.

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

This risk has been reviewed by EMT and further to discussion in the last Trust Board meeting, it was proposed for this risk to be merged with Risk ID 905 – Description: *Risk of a negative impact on quality of care due to low staffing levels and insufficient access to temporary staffing.*

Risk ID	Risk Owner	Description
1078	Chief Operating Officer	Risk that young people will suffer serious harm as a result of waiting for treatment.

This risk has been reviewed by EMT. The Chief Operating Officer has noted that work with commissioners in relation to the Kirklees Keep in Mind service has led to an agreement to fund the service into schools. The capacity gap for demand in neurodevelopment assessment has not yet been agreed beyond March 2024.

Risk ID	Risk Owner	Description
1132	Chief Operating Officer	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.

EMT have reviewed this risk, and the chief operating officer has updated the risk actions. Improvements in psychological services waits are noted. Concerns remain in relation to ASD/ADHD for children and adults and paediatric audiology.

Risk ID	Risk Owner	Description
1319	Chief Operating Officer	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.~~ therefore they will need to be admitted to an out of area bed or remain in an unsuitable environment (such as an acute hospital) until a bed is available. The distance from home or from the appropriate team will mean that their quality of care will be compromised.

EMT have reviewed this risk. The risk actions have been reviewed by the chief operating officer and remain appropriate, but as the focus remains intense, they are not yet considered embedded control measures. The risk description has been updated to include the potential for someone to wait in an inappropriate setting prior to admission to a mental health bed.

Organisational level risks within the risk appetite

Risk ID	Risk Owner	Description
1840	Chief People Officer	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.

The current data shows staff appraisal at 85.3% and an appraisal task and finish group has been established. EMT are proposing a reduction in likelihood from 4 likely to 3 possible, with a reduction in risk score from 12 (amber) to 9 (amber).

Risk ID	Risk Owner	Description
773	Director of strategy and change	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.

This risk has been reviewed by EMT. Work is ongoing to seek engagement with all communities and partners to seek external views. There will be a clear analysis following this engagement period and the potential to review the risk score in Quarter 2, 2024/25.

Risk ID	Risk Owner	Description
1649	Chief Nurse and Director of Quality and Professions	The current inconsistency in Speech and Language Therapist (SALT) provision could compromise the quality of care available in response to choking incident.

EMT have reviewed this risk. The Chief Nurse / Director of Quality and Professions notes the business case for substantive Trust wide SALT service was developed, presented and funded by commissioners in all four places associated with the Trust. Barnsley place have agreed to fund the service using non-recurrent funds until the end of the 2024/25 financial year. This non-recurrent funding is being used to commission a private Speech and Language Therapy provider to provide an additional day support focussed project on the Barnsley wards. The control measures have been updated.

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 this risk and the Director of Strategy and Change will review this risk in Quarter 1 2024/25 with a possibility of increasing the likelihood from 3 possible to 4 likely due to additional requirement for resources and cost implications. Areas of focus will be monitored and resources will need to be prioritised r. Discussions have taken place in each place in the Integrated Care System to review opportunities for transfer of capacity.

Risk ID	Risk Owner	Description
1624	Chief Operating Officer	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.

This risk has been reviewed by EMT. The chief operating officer has reviewed the intention to close the risk and although the controls are effective, pressures on 136 and inpatient beds remain. EMT is proposing for the risk to remain on the organisational risk register for a further 3 months following another review. This action was supported by Quality and Safety Committee in February 2024.

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 April 2024. The risk score shows the current figures for April 2024 and the projection if the proposals are accepted by Trust Board.

A summary of findings are below:

- The number of risks has reduced from Quarter 3 2023/24 by one risk, bringing the total amount of risks from **37** to **36.**
- 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 is currently **one red risk** aligned to Trust objectives **Improving Health, Improving Care and Improving Resources.**
- There are **no** red risks aligned to Trust objective **Making this a great place to work.**
- The current accumulative risk score is **382** and this will reduce to **367** if the proposals are accepted, which is a reduction of 15.

• The current average risk score is **10.3 (amber**). If the proposed changes are accepted, then the average risk score will be **10.1 (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. • **APPROVE** the new risk description for risk ID 275. • **APPROVE** to merge workforce risk ID 1614 with risk ID 905. • **APPROVE** the new risk description for risk ID 1319. • **APPROVE** the reduction in risk score for risk ID 1840.

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk appetite:
Clinical risks (1-6): Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks.
Business risks (8-12): Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as inability to recruit or retain an appropriately skilled workforce, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.
Compliance risks (1-6): Failure to comply with its licence, CQC registration standards or failure to meet statutory duties, such as compliance with health and safety legislation.
Financial risks (1-6): Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.
Strategic risks (8-12): Risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans.

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

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

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

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

KEY:
CE = Chief Executive
DFR = Executive director of Finance, estates and resources
CPO = Chief People Officer
DNQ = Chief nurse and director of quality and professions
CMO = Chief medical officer
DS = Executive director of strategy and change
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

Committee in bold / blue font = Lead Committee/ Lead director
Committee in standard / black font = Oversight Committee/ director

Corporate/ Organisational Risk Register - Quarter 4, 2023/24

Trust Board meeting: 30 April 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk level 15+

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
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	• Actions to manage the impact of demand are identified within other risk actions, specifically: 1614 and 906 (staffing) 1338 and 1319 (inpatient bed for child and adult) 1078 and 1132 (waiting lists child and adult) 1649 (access and demand for Speech and Language Therapy (SALT). • The operational management group will review refreshed demand data and make a recommendation the executive management group on the future management of this risk (COO 31 May 2024) • Quality and Safety Committee will receive a presentation of the demand data and future actions to manage the risk in May 2024 (COO, May 2024)	31 June 2024	QSC Executive Management Team (EMT) (monthly) Operational Management Group (OMG) Trust Board	4	BAF ref SO 2 Note: Data to date has not been suggestive of an overall rise in demand, but highlights specific areas (ADHD/ASD, CAMHS, paediatric audiology) that are managed separately.	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
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 with Advanced Threat Protection (ATP) • The Trust's computer estate remains comprehensively maintained and supported • Comprehensive security patching regime in place • Annual penetration testing in place • Appropriately skilled and experienced staff in post • Disaster recovery and business continuity plans annually tested. • NHS Digital Care Cert obligations fully met. • Information Governance training includes cyber security dimensions. • Key messages are communicated to • Data Security and Protection Toolkit (DSPT) Cyber and Information Governance standards met • Cyber Essentials Plus re-accreditation completed in 2023 • IT Service performance actively monitored and tightly controlled • Immutable backup functionality implemented. • Data retention policy in place • Annual cyber table top exercise • Multi-Factor Authentication (MFA)	5 Catastrophic	3 Possible	15	8-12 Strategic risk	• Business continuity plans reviewed as planned as part of an EPRR table top exercise in November 2023. A follow-on exercise is to be run in 2024/25 with more of an operational perspective.(DFR) • 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 staff awareness communications schedule remains in place(DFR, ongoing) • Phishing campaign to be scheduled to raise/monitor staff awareness, yearly (DFR, ongoing) • Testing of Windows 11 completed ahead of Windows 10 going End of Life in 2025. (DFR, 2025) • Annual penetration testing in progress as planned (DFR).	30 November 2024	IM&T Managers Meeting (Monthly) Digital TAG (Quarterly) Executive Management Team (EMT) AC (Monthly) IT Services Department service management meetings (Trust / Daisy) (Monthly) Trust Board	10	BAF Ref, SO 2 & 3 Note: The overall risk score can potentially be reduced once the cyber security phase 2 enhancements to support the move towards advanced monitoring capabilities business case is presented to EMT. This has been agreed to put on hold until 2024/25 until the plans are developed and agreed.	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				implemented across the Trust • Digital Technology Assessment Criteria (DTAC) requirements incorporated into procurement of digital/IT solutions and services. • Deputy Senior Information Risk Owner (SIRO) now in place. • Cyber Essentials Plus re-accreditation complete as planned											
275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners. This includes the risk of service decommissioning where there is a reduction in Local Authority and ICB budgets.	**DPD** **DS** **COO** **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 Executive Management Team (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	4 Major	4 likely	16	1-6 Clinical risk	• To work with partners in all places to address in year specific financial challenges (DFR/ DPD/DS Quarterly reviews during (31/05/24) • To work with partners in Kirklees specifically to mitigate the impact of council funding for children and young people's mental health services (DPD, May 2024) • Review stakeholder plan and map to clarify communication arrangements of any future proposals from Local Authorities (DPD/DS, review May 2024). • Short term regular internal meeting established to coordinate discussions re Council cost savings (DPD, review May 2024).	31 May 2024	QSC Care Group (monthly) Executive Management Team (monthly) Operational Management Group (regular) 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:** Update to the risk description. Kirklees Keep In Mind update: As at start of 2024/25, the total expected income represented a shortfall compared to the total cost of the service. ICB commissioners have agreed to fund the total and the risk of the shortfall mitigated. Service	May 2024

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
				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. • Clinical and quality Trust representation now established in all place based quality committees • Review of Local Authority Cabinet papers and minutes.								impact to be continually reviewed. Quarterly reviews have been arranged to review Local Authority actions on reducing their spend (either generally or in respect of any contracts with the Trust), and the associated impact. If any serious risks are identified, the Trust can review and consider what mitigations can be put in place. Given the significant financial challenges in local authorities these are not guaranteed to address risk of deterioration.	

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

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
1368	Risk that given demand and capacity issues across South and 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 cared 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.	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) • 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 • Collaborative development day took place in December 2023. • Director of Children and Families oversight of the pathway working arrangements.	3 Moderate	4 Likely	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 May 2024) • The executive TRIO ensure appropriate escalation to partners where an appropriate solution for a child is not available (Lead: COO, TRIO, ongoing review • Participation in the collaborative work continues. (COO, review May 2024) • The newly established Director of Services for Children and Families will review the Trust's arrangements for working in the collaborative (May 2024, COO)	30 June 2024	QSC Executive Management Team (EMT) (monthly) Operational Management Team (OMG) Trust Board	4	BAF ref: SO 3	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
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. • Interim measures to speed repairs include replacing wall and floor coverings with painted surfaces.	4 Major	3 Possible	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, review May 2024)	Review 31 May 2024	QSC Executive Management Team monthly Operational Management Group (regular updates) Clinical Environment, clinical safety group Trust Board	4	BAF Ref SO 2 Note: Whilst no incidents have been reported recently, the likelihood of the risk occurring remains the same, particularly whilst building work is taking place and the decant facility of Gaskell is in use. The scores are expected to remain until building work is complete. This will be reviewed again in May 2024.	May 2024
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 Trust 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~~	~~4 Major~~	~~3 possible~~	~~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 February 2024)~~ ~~• The focus on recruitment to inpatient areas continues (CPO, review monthly, Ongoing 2024)~~ ~~• A full review of inpatient ward establishments is nearing completion and reporting through the inpatient service improvement programme and will be presented to EMT by February 2024 (DNQ, February 2024)Working with partners across Integrated Care System and the region continues as part of the inpatient service~~	~~29 March 2024~~	~~Executive Management Group (EMT) (monthly)~~ ~~Operational Management Group (OMG)~~ ~~Safer staffing inpatient and community group~~ ~~QSC~~ ~~Trust Board~~	~~6~~	**Note for Trust Board:** It is proposed to merge risk 905 with workforce risk ID 1614. ~~BAF Ref, SO 2 & 3~~	~~February 2024~~

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
				~~occasions where newly qualified nurses undergoing preceptorship are asked to take charge of a shift.~~ • ~~Care Group meetings review safer staffing~~ • ~~Staff redeployment process in place~~ • ~~Overtime is available as part of a range of temporary staffing options~~ • ~~Bank recruitment now embedded~~ • ~~New roles group leads on the development of a range of options including ACP (Advanced Clinical Practitioner)~~					~~improvement programme (COO/ CPO, to review February 2024May 2024)~~ • ~~The focus on recruitment to inpatient areas continues (CPO, review monthly, Ongoing 2024)~~ • ~~A full review of inpatient ward establishments has been completed with recommendations being reviewed by the executive management team (April 2024, COO) is nearing completion and reporting through the inpatient service improvement programme and will be presented to EMT by February 2024 (DNQ, February 2024)~~ • ~~Actions specifically to support internationally recruited nurses to undertake a full registered nurse role in the establishment is led by the chief nurse and director of quality and professions (DNQ, May 2024)~~					
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 (ICSs). • 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	3 Moderate	3 Possible	9	1-6 Financial risk	• Draft longer-term financial sustainability plan in line with the ICB and to be presented to Board in 2024/25 for formal sign off in Quarter 2 2024/25 (DFR) • Reinstatement of efficiency delivery and monitoring. (DFR, Ongoing review via Operational Management Group monthly) • Implement patient level costing for use by Directorates (DFR, review May 2024) • Implementation of Integrated Care Board (ICB) level cost controls are in place but will require further review in 2024/25 to confirm effectiveness (DFR, Ongoing through 2024/25) • Ongoing staff engagement still required to further develop efficiency ideas to be recorded on i-hub (to be evaluated in Q1, DFR)	Review 31 May 2024	Executive Management Team (monthly) FIP (monthly) Operational Management Group Trust Board (quarterly)	4	BAF Ref, SO 3	May 2024

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
				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 2024 • 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) • Implementation of Integrated Care Board (ICB) level cost controls are in place										
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**	• Data is reviewed monthly by the Assistant Director of Nursing, Quality and Professions. This is then shared with the Medical Devices TAG. Monthly updates to be provided to identified leads in each Care Group with a request for their action plan to improve. • The Electrical Biomedical Medical Engineering (EBME) equipment / infection prevention and EBME contract has been reviewed and awarded, part of the new contract. • Equipment register in place • Purchasing process • Partnership working with Mid Yorkshire NHS Trust	4 major	3 possible	12	Clinical risk 1 – 6	• Monthly updates to be provided to identified leads in each Care Group with a request for their action plan to improve (DNQ June 2024). • Quarterly update to be provided to OMG and EMT (DNQ ongoing). • Continuing to review the Electrical Biomedical Medical Engineering / Equipment (EBME) list, ongoing review fortnightly, (DNQ and DFR) • 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) (A monthly report is produced and a quarterly report goes to medical devices, and safety alert sub group) • 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 as part of usual business	30 September 2024	Clinical governance / care group clinical governance QSC Safety and resilience Task Action Group Operational Management Group (OMG) Medical Devices Task Action Group Executive Manageme	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)	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• A blue light alert was shared across the organisation in July 2023. • Medical devices and safety alert group monitor EBME compliance figures quarterly. • 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 • Medical Devices Policy approved in November 2023 and staff notified via Trust communications. • Medical devices project lead has been appointed on Trust Bank for 12 months from April 2024.					• Annual report to be submitted by the Assistant Director of Nursing, Quality and Professions, to show level of assurance with regards to medical devices oversight in response to actions already undertaken, and improvement actions still required. A report was produced in Jan 2024, the next report will be produced for the end of April 2024 (DNQ, end of April 2024) • The Medical devices Trust intranet page is being updated with relevant information (DNQ, August 2024)		nt Team (EMT) Trust Board			
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.	**CPO** COO CMO DNQ	**PRC** QSC	• 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	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, Ongoing, review May 2024) • The supervision database is now working. Some anomalies are still being addressed to ensure all clinical colleagues are included (DNQ, Review, November 2024) • Continuing to progress the complaints improvement programme and developing metrics of performance and quality (DNQ, September 2024) • Inclusive culture and management engagement sessions to enable a plan to be developed (CPO, June 2024) • Developing an approach and policy to adopt just and learning principles across our employee relations, with	30 November 2024	Operational Management Group Executive Management Team Clinical Governance Group QSC PRC Trust Board	3	BAF Ref SO 2 Metrics have been developed and shared with EMT and will inform future reporting into committee. Note: In line with policy, a review of clinical supervision for 1 hour every 8 weeks (6 hours per year). This will be	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• 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 • An agency scrutiny group meet to look at reducing agency workers and increase bank recruitment. • Review of themes from complaints • Strengthening the induction process about values and expected code of conduct • Work is complete on practice and reporting of supervision • Recommendations from the Quality and Safety within Mental Health, Learning Disability and Autism Inpatient services report are now incorporated into broader improvement plans.					the new Head of People Experience (CPO review June 2024) • To explore new and innovative ways to deliver learning and development to enable staff to be released in shorter periods (Ongoing, CPO)				reviewed in OMG.	
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	**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.	3 Moderate	3 possible	9	1-6 Compliance risk	• Local action plans in relation to 2022/23 staff survey results are being implemented and a review of actions undertaken and shared with teams in advance of the 2023 staff survey (CPO review July 2024) • To develop a task and finish group to focus on high areas of sickness including the new People Business Partners (CPO, July 2024) • Supporting internal audit on management of sickness absence in two high areas of sickness, to be	31 July 2024	Safer staffing reports (monthly) Moving forward group PRC EIIC	9	BAF Ref: SO 4	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
	and / or breaches in regulations.			• 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 • The majority of Wellbeing champions appointed in each of the clinical areas					delivered by the end of Q4 (CPO, end of Q4)		Operational Management Group Executive Management Team Trust Board			
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**	**PRC** QSC	• 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 • 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	4 Major	3 possible	12	1-6 Compliance risk	• New roles processes are being explored across the West Yorkshire Mental Health Collaborative (DNQ, review May 2024) • Safecare is being rolled out in the Dales, Ward 18 and Lyndhurst (DNQ Review Ongoing, 2023/2024) • Roll out of Safe care ongoing during 2024/25 including review of effectiveness (DNQ/ CPO July 2024 • Working with partners across Integrated Care System and the region continues as part of the quality and safety of inpatient care service improvement programme (COO/ CPO, to review May 2024) • A full review of inpatient ward establishments has been completed with recommendations being reviewed by the executive management team (end of April 2024, COO) • Actions specifically to support internationally recruited nurses to undertake a full registered nurse role in the establishment is led by the chief nurse and director of quality and professions (DNQ, May 2024)	31 July 2024	Operational Management Group Executive Management Team Trust Board QSC PRC Safer staffing inpatient and community group	6	BAF Ref SO 4 **Note to Trust Board:** This risk has been merged with risk 905: Risk of a negative impact on quality of care due to low staffing levels and insufficient access to temporary staffing. Improvements in impatient recruitment have been noted, although further work is required to support internationally recruited nurses to work as registered nurses in the	May 2024

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
				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 • Recruitment and retention plan agreed • Monthly safer staffing reports to Trust 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. • Staff redeployment process in place • Overtime is available as part of a range of temporary staffing options • Bank recruitment now embedded • New roles group leads on the development of a range of options including ACP (Advanced Clinical Practitioner)								ward establishment Update: Tenable roll out - this has not been rolled out in forensics as it was a limited pilot for adult acute.	

ORGANISATIONAL LEVEL RISK REPORT

NHS South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
1689	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.	DS	EIIC	• Integrated strategy and associated annual action plans • Equality Impact Assessments (EIA) including action tracker in place • SystmOne equality data accessible via the Intranet • Annual Equality Report • Equality Involvement and Inclusion Committee and sub-committee • Internal audit and assurance • Equality dashboard • Making Data Count approach established e.g. waiting list report • Improving access to care priority programme established • 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 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 themed development	3 Moderate	3 possible	9	1-6 Compliance risk	• 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 May 2024) • Involvement in place- based meeting arrangements but need to review Kirklees input. (DS) • Embed the EIIC and inequalities priorities within workplans for care group equalities (DS/COO, Q1 2024/25) • Comms plan to be developed to share examples of impact more systematically following the production of the annual report (DS, End of June 2024)	31 July 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	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				sessions and diversity training ongoing programme in place • Dashboard reviewed in EIIC as part of routine monitoring (waiting times and access)										
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. • 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	4 Major	3 possible	12	1-6 Financial risk	• Partnership agreement and risk share in South Yorkshire – (DFR, end of May 2024) • Submitted benchmarking information as part of national return across the West Yorkshire providers, evaluation to follow in Q4 (DFR, Q4 2023/24) • Progress sub-contracts to signature, a number are outstanding (DFR, ongoing) • Ongoing dialogue with NHS England to resolve contractual position in relation to South Yorkshire provider (DFR, ongoing) proposal put to NHS England (NHSE) to conclude negotiations (DFR, end of May 2024)	31 May 2024	CC Executive Management Team (monthly) Trust Board	4	BAF ref: SO 1	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				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)										
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) • 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 • Changes to delivery system in crisis and eating disorder pathway increase access	4 Major	2 Unlikely	8	1-6 Clinical risk	• Actions relating to access to Child and Adolescent Mental Health Services (CAMHS) and reducing inequalities continue to be implemented as part of the Improving Access priority workstream (COO, review May 2024) • Additional capacity for neurodevelopment assessments in Kirklees is not available after the end of March 2024. Actions are underway to agree what steps can be taken to address demand (COO, May 2024)	31 May 2024	OMG QSC Executive Management Group – monthly Individual district performance reports reviewed by care group Trust Board	6	BAF Ref SO 2 Work with commissioners in relation to the Kirklees Keep in Mind service has led to agreement to fund the service into schools. The capacity gap for demand in neurodevelopment assessment has not yet been agreed beyond March 2024.	May 2024

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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
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 for specific communities or groups. • Priority programmes report to Board, Executive Management Team and Operational Management Group • Internal audit • Waiting lists are reported on SystmOne	4 Major	3 Possible	12	1-6 Clinical risk	• Deprivation data included in the waiting list report alongside ethnicity data – reporting on analysis and understanding of this data continues to be improved through the waiting list report (COO, May 2024) • The personalised care and support workstream and the improvements to care planning workstream are considering how clinical risk can be informed by inequality issues (Lead: DNQ, TRIO ongoing) • Actions to improve reporting, monitoring and management of the newly identified waits (previously hidden waits) in learning disability services are being developed (COO review May 2024)	31 May 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 Improvements in psychological services waits are noted. Concerns remain in relation to ASD/ADHD for children and adults and paediatric audiology.	May 2024
1159	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.	4 Major	3 Possible	12	1-6 Compliance risk	• Task and finish group to continue to review the impact of the implementation of smoke free policy (CMO, May 2024). • The rollout programme reviews of the sprinkler system at the Estates TAG and fire risk assessment take place yearly (Yearly, DFR) • Annual fire risk assessments to be completed annually by March every year (annual, DFR)	31 May 2024	Executive Management Team Estates Trust Action Group (monthly)	6	BAF Ref, SO 2	May 2024

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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
				• 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. • 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					• Compliance reviewed monthly with Learning and Development and reported to OMG with a current compliance at 89.95% (consistently exceeded target of 80%) (DFR, End of April 2024)		Safety Trust Action Group (Quarterly) Operational Management Group (monthly) AC Trust Board			

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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
				been identified with supplies only being available through the Trust • The annual statement of fire safety compliance approved by Executive Management Team on 11 January 2024 • Implementation of smoke free policy in the Trust									
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) 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	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 regularly reported into EMT (DNQ, Ongoing) • Further review of learning disability actions across the Trust to be presented to EMT (DNQ, November 2024) • 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, Ongoing) • Two Task and finish workstreams looking at RRPI and medicines administration (ongoing, May 2024, DNQ/ CMO for respective workstreams)	30 November 2024	Performance & monitoring via Executive Management Team QSC Operational Management Group Trust Board Patient Safety report & incident report as well as monthly reporting in the Integrated Performance Report	6	BAF ref: SO 2	May 2024

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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
				• 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. • RRPI TAG • a metric showing how many days it takes from receiving a complaint to the final response will be reviewed by EMT regularly										
852	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	DFR	AC	• Internal audit report on the Data Security and Protection Toolkit for 2023/24 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 (annual – next due June 2024). • Designated Caldicott guardians and Senior Information Risk Owner (SIRO) (and deputies) in post. • Qualified and experienced data protection officer in post • Trust has appropriate policies and procedures that are compliant with General Data Protection Regulation (GDPR).	4 Major	2 unlikely	8	1-6 Compliance risk	• Additional e-learning is work in progress (DFR, Apr 2025) • Bespoke team training in relation to information governance incidents will be rolled out over 2023/24 (DFR, October 2024) • Currently working on improving processes for capturing positive consent to share using a digital solution (DFR, March 2024) • Review into access hierarchy for Trust bespoke systems to be completed by Information governance manager (DFR, review September 2024)	30 September 2024	ICIG Operational Management Group Executive Management Team AC Trust Board	4	BAF Ref, SO2 Note: The IG training toolkit requirement is changing, and further work is required to be completed by 1 July 2024.	May 2024

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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
				• 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 • Trust communications in place to ensure services are aware of processes for ensuring differences between addresses on SystmOne and the NHS Spine are actioned • Information governance administrator now in post • Increase in training available to teams including self-assessment using workbooks.							

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
				• Awareness has been raised internally due to data sharing via programmes such as Microsoft excel.										
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.~~ therefore they will need to be admitted to an out of area bed or remain in an unsuitable environment (such as an acute hospital) until a bed is available. The distance from home or from the appropriate team 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 • Risk panel review of incidents relating to patient flow • Intensive Home Based Treatment Team pathways • Quality Impact Assessment	3 Moderate	3 possible	9	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, May 2024) • Continue to ensure escalation of clinically ready for discharge issues through to the multi-agency discharge meeting process (COO, review May 2024) • 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 May 2024) • Teams continue to work with partners across the Integrated Care System to make best use of the available resources to support discharge. (COO, May 2024) • Maintain progress on assurance reporting for wider impact of reduced out of area use, including patient flow incidents being reviewed in risk panel (COO, May 2024) • Work is underway with the acute Trusts to fully understand and report delays in transfer / admission to a mental health bed from the emergency departments or acute wards (COO, May 2024)	Review 31 May 2024	OMG QSC EMT Trust Board	4	BAF ref, SO 3 **Note for Trust Board:** Actions have been reviewed and remain appropriate, but as the focus remains, they are not yet considered control measures. The risk description has been updated to include the potential for someone to wait in an inappropriate setting prior to admission to a mental health bed.	May 2024

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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
1585	The current NHS capital regime could result in the Trust not having sufficient allocation to complete all its capital plans in any one year adversely impacting on ability to meet its strategic objectives and priorities.	**DFR**	**FIP**	• Detailed internal capital planning and prioritisation process. • Integrated Care System (ICS) capital allocation process. • Internal cash availability. • Approved updated digital strategy. • System capital planning process. • Effective communication of Trust capital priorities to West and South Yorkshire Integrated Care System (ICS) partners. • Capital allocation for 23/24 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.	3 Moderate	4 Likely	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) • Consider how all capital schemes can be delivered within a reduced capital budget (DFR, review by the end of Q4, 2024) • Capital costs are incorporated into the older peoples strategy which undergoing public consultation (DFR, August 2024) • To consider the ambitions within the Estates Strategy vs available resources (DFR, ongoing)	30 August 2024	Executive Management Team (monthly) FIP (monthly) Trust Board	4	BAF ref: SO 3	May 2024
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	**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	3 Moderate	3 Possible	9	1-6 Compliance risk	• Equity Guardians to be further embedded across services, work has started to further develop the roles and links with the diversity inclusion and belong lead (CPO and DNQ, Ongoing) • Race Forward action plan to tackle racial abuse from service users and families, is being co-produced with the Race Forward Group and taken forward by the Diversity, Inclusion and Belonging Lead. Update was submitted to EIIC on 13.03.24. Four work streams are taking this forward (Review September 2024) • To review the feedback from the engagement sessions with Leadership and Talent development coach to develop recommendations and actions, presented to EMT in March 2024 (CPO, Ongoing, review May 2024)	30 September 2024	Executive Management Team (EMT) (quarterly) EIIC Committee (quarterly) Trust Board	6	BAF ref, SO 1 and 4	May 2024

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Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
	Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).			structure, resources, and associated policies • Workforce Strategy 2021-2024 supporting SWYPFT as a Great Place to Work • Establishment of staff disability network and LGBT network. • Working Carers Staff network established • Civility and Respect Guardians in place to support cultural change and staff experience decision-making groups • 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 • Microaggression resource has been developed by the Race Forward group and is on the Trust intranet. • Phase 1 work completed by Leadership and Talent Development Coach to support inclusive culture • Head of People Experience review on staff networks now complete. Staff networks will be provided with a budget and protected time to deliver actions.				• Use of staff survey data year on year to improve staff experience with a focus on feedback from all diverse groups (CPO, June 2024) • FLAIR survey concluded. Recommendations and actions now being taken forward by diversity and inclusion and belonging lead together with the findings from Phase 1 work with the Leadership and Talent development coach (CPO, June 2024) • Development of equality dashboards for EIIC to track data, progress and improvements (CPO, ongoing)					

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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
1887	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 not supportively heard, do not suffer personal detriment and that they do not receive feedback on action(s) taken which demonstrate listening and learning.	**DNQ**	**PRC** QSC	• Freedom to speak up structure in place with one Working Time Equivalent (WTE) guardian. • There are three Freedom to Speak Up (FTSU) support guardians. • 6 weekly meetings with Lead Director DNQ, non-executive lead for FTSU supported by Deputy Director of Corporate governance • Exec TRIO meet regularly with freedom to speak up guardian • Trust communications (View and Headlines) in relation to speaking up and updates via Trust intranet • FTSU guardian identifies and escalates detriment from any speaking up process • Staff are signposted to other areas of the Trust for support, occupational health, equity guardians, civility and staff guardians or staff side • Mandatory training for all staff on speak up, optional listen up and follow up training available • Focused intervention from executive TRIO into areas of concern	3 moderate	3 possible	9	1 – 6 Compliance risk	• Further embedding of the recently recruited freedom to speak up guardians (DNQ, May 2024) • Further development in relation positive comms from case studies (DNQ, April / May 2024) • Clearer feedback for people who have spoken up (DNQ, April / May 2024) • To recruit additional freedom to speak up guardians (DNQ, April/ May 2024) • Freedom to speak up self-assessment tool and improvement actions, Review May 2024 (DDCG)	31 May 2024	QSC PRC EMT Trust Board	4	Note: Consideration has been given to making listen up and follow up mandatory training for all staff, but this will remain essential to job role.	May 2024
1888	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	**CMO** DNQ CPO	**QSC** PRC	• Signed the NHS England sexual safety charter which reflects Trust commitment. • Reporting system in place via Datix in relation to all sexual safety incidents • The Trust reports via the Joint Safeguarding Strategic and Operational Subgroup and updates will continue through this	4 Major	2 Unlikely	8	Clinical risk 1-6	• The sexual safety improvement group oversees 15 actions against the sexual safety inpatient charter, reporting to EMT and the committee (DNQ, routine report) • Trust communications to raise awareness (DNQ/ CPO, 2024/25 - ongoing)	31 July 2024	QSC PRC Executive Management Team (EMT) Joint Safeguarding	4	Aligns to Sexual Offences Act and Trust policy in terms of definition. The actions against the sexual safety charter are currently either	May 2024

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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
	whilst being cared for, working for, or visiting the Trust.			group to EMT and the Quality and Safety Committee • The sexual safety improvement group will continue to meet every two months. • The sexual safety improvement group have completed an audit of the Sexual Safety Collaborative | Royal College of Psychiatrists (rcpsych.ac.uk) • Sexual safety policy in place • Lone working policy in place • For staff, Standards of Conduct in Public Service Policy (including managing conflicts of interest) in place • Bullying and harassment policy in place • Staff side • Freedom to speak up • HR and civility and respect champions • Junior doctors forums in place • Clinical tutors available • The sexual safety improvement group oversees progress against 26 actions from the Royal College of Psychiatrists audit						Strategic and Operational Subgroup sexual safety improvement group Trust Board		complete or on target. Update on the work of the sexual safety inpatient charter was reported to Committee in March 2024.	

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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) • Appraisal task and finish group established	3 Moderate	~~4 Likely~~ 3 possible	~~12~~ 9	8-12 Business Risk	• A decision taken to expand the scope for a new system to include a wider learning management system which would include appraisals, talent management and broader learning. This is out for initial expressions of interest through procurement process (CPO, Review October 2024) • Extended the Workpal contract for a further 12 months to enable a full and proper procurement process to take place (CPO, Review October 2024) • Inpatient Lead supporting improvement work across the wards (DNQ / COO, ongoing throughout 2024) • Work has commenced between the people planning performance and PB&R team to develop wider workforce systems and capacity through the use of business intelligence reporting (CPO, review June 2024) • 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 Quarter 1, 2024/25)	31 October 2024	PRC Executive Management Team (EMT) Operational Management Group (OMG) Trust Board	6	BAF Ref: SO4 **Note to Trust Board:** There is a proposal to reduce the likelihood to 3 possible, bringing the overall risk score to 9 (amber). Systems interoperability (ESR does not link to the system so managers are not automatically assigned correctly) Note: Recent data show staff appraisal at 85.3% (April 2024)	May 2024
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 • Workstreams in place to address specific areas	3 moderate	4 likely	12	8-12 Strategic risk	• Clinically ready for discharge issues continue to be escalated through to MADE meetings ,improvement work and the partnership group (COO May 2024) • Where MADE meetings have not reached a solution, a Gold command meeting will be established. (Ongoing, COO review May 2024) • 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 May 2024)	31 May 2024	Executive Management Team Operational Management Group QSC Trust Board	6	BAF Ref: SO2	May 2024

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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
				• Pathway for people with trauma informed emotionally unstable personality disorder is in place. • Barriers to discharge reports link into place-based delays in discharges - Multi Agency Discharge Meetings.					• Review is underway in relation to the identification and reporting of people who are clinically ready for discharge in Forensic services (COO to review May 2024)					
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 junior doctors and consultants	3 Moderate	3 possible	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, 2024/25) • Multi-disciplinary operational work in place to manage the impact of industrial action and mitigate risks (Ongoing, Lead: COO / CMO) • Trust will be kept informed via paper to PRC by CPO (CPO, as required)	31 May 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:** This risk remains under review dependant on the outcome from national conversations.	May 2024

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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
				• 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. • Trust-wide integrated change process in place • Focus on working towards the strategic ambitions of the Trust. • Internal place integration group now established • Stakeholder engagement plans reviewed and in place.	3 Moderate	2 Unlikely	6	1-6 Clinical risk	• To ensure digital innovations that support modernisation of clinical services are tested and developed with clinical teams (DFR/ DS/ COO) Ongoing, this will be refreshed as part of the Trust Strategy (DS, June 2024) • To further embed creative and cultural approaches in clinical services and integrated pathways via the recovery college and involvement team (DS/ COO, June 2024) • Review and update all of you approach to support systematic impact and improvement (DS, June 2024) • Develop and introduce sustainability impact assessments (DS, May 2024) • Develop and implement a clinical strategy (DNQ/ CMO, June 2024)	30 June 2024	EMT (monthly) Transformation board (monthly) Operational Management Group (weekly) QSC Trust Board	6	BAF Ref: SO1 & 2	May 2024

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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
				• Measures in place to monitor the impact of the headline initiative from the social responsibility and sustainability strategy for responsive and inclusive services • Close involvement in Barnsley place to monitor potential impact and take measures to mitigate will continue.										
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	3 Moderate	2 Unlikely	6	8-12 Strategic risk	• On-going review with Integrated Care Boards of our plan during 2023/24 (DPD, End of April 2024) . • To continue to develop Barnsley Integrated Health and Care Alliance with partners delivering on agreed plans and priorities (DS/COO, End of April 2024) • Consider the guidance on responsibility and partnership working and how we build capacity and capability to respond (DS/ DPD review May 2024) • Development of Trust clinical strategy (Co leads: CMO/ DNQ March 2024) • Development of Trust clinical strategy (CMO/ DNQ September 2024)	30 September 2024	QSC Executive Management Team (monthly) Trust Board	6	BAF Ref, SO 1 & 3	May 2024

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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
				• Approach to collating and reporting insight from stakeholders place. • Horizon scanning for new business opportunities. • Trusts pro-active involvement and influence in system transformation programmes, which are led by commissioners and includes new models of care. • Clinical and quality Trust representation in place and Integrated Care System level quality boards • Trust have been involved in all Place based plans • On-going review with Integrated Care Boards of our plan during 2023/24 is complete										
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	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 May 2024) • The Equality, Involvement, Communication and Membership strategy is in place with action plans agreed. Delivery of key actions ongoing. Refreshed as part of the Trust Strategy Refresh (DS, review September 2024) • As part of Trust Strategy refresh, seek views of external stakeholders to ensure alignment with health and care system strategies and stakeholder views (DS, Review May 2024).	30 September 2024	Bi-monthly focus by EMT on transformation. QSC Trust Board reports as appropriate	6	BAF Ref, SO 1 & 2 **Note for Trust Board:** Currently seeking to engage with all our communities and partners to seek external views. The Trust will have clear analysis following this engagement period. After the analysis DS will review risk score in Q2 2024/25.	May 2024

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
				place-based planning initiatives. • Equality, Involvement, Communication and Membership strategy. • Stakeholder plan developed with regular 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 • Trust Board approved stakeholder engagement plan. • Alignment of priorities through provider alliances and integrated care partnership • Maintain strong links with national bodies to influence local and national systems thinking in relation to mental health and community services.									

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
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 • 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	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 May 2024) • Trust central resource for SALT. Substantive funding from Wakefield, Calderdale and Kirklees has been confirmed. Barnsley place have agreed to fund the service using non-recurrent funds until the end of the 23/24 financial year, staff posts have been filled and and the team are working in work plans (DNQ, review May / June 2024)	30 June 2024	QSC Operational Management Group Executive Management Team (monthly) Trust Board	6	BAF Ref: SO 2 Note: The business case for substantive Trust wide SALT service was developed, presented and funded by commissioners in all four places associated with the Trust. . Barnsley place have agreed to fund the service using non-recurrent funds until the end of the 2024/25 financial year. This non-recurrent funding is being used to commission a private SLT provider to provide an additional day support focussed project on the Barnsley wards.	May 2024

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 of process/es for staff when patients are on escorted and unescorted leave and have an existing choking need principles have been produced and approved via internal clinical governance processes. This is available on the Trust intranet. • Choking as a form of self-harm SBAR was produced and communicated in June 2023. These have been approved and circulated to inpatient wards in February 2024.										
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 • Improvement work in the garden area at the Dales is complete.	4 Major	3 Possible	12	8-12 Business risk	• Where necessary to maintain safety, a blanket restriction is applied in order to manage an immediate risk. This will be for the shortest time possible and within the guidance. (COO/DNQ, Review quarterly) • Each area will maintain a risk assessment to understand the potential climb risks. (COO, ongoing, review quarterly May 2024) • Where appropriate, supervised access to garden areas is maintained. (ongoing, review quarterly (COO, May 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 May 2024) – see notes.	31 May 2024	QSC Clinical Environment Safety Group (CESG) Executive Management Team (monthly) Trust Board	6	BAF ref: SO 2 Note: The risk actions remain appropriate to manage the ongoing risk.	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• The clinical environment safety group review this risk and make recommendations for future actions										
1217	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. • Quality strategy approved and implementation plan established. • Improvement Network established to develop critical mass across the organisation. • Additional capacity aligned to the Trust to support Alliance and partnership work in Wakefield, Kirklees and Barnsley • Additional capacity secured for identified programmes • Discussions have taken place in each place Integrated Care Board (ICB) team to review opportunities for transfer of capacity as part of ICB operating cost review.	3 Moderate	3 Possible	9	8-12 Strategic risk	• Agree resource availability to support system-wide programmes of work in view of current financial position and how to best focus our resource and energy (Joint – EMT 2024/25) • Work with Directors of Service and strategy and change to monitor areas of focus and prioritise effort and resources (DS/ COO September 2024) • Review prioritisation and include stopping some activities based on risk assessment and progress following the completion of the strategy refresh. (DS, in line with quarterly review of programmes and capacity, July 2024) • Build capability to enhance capacity (DS, Review September 2024)	30 September 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:** EMT have discussed the risk score. Possibly increase the likelihood score, in Quarter 1 2024/25 in light of resources.	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
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 • Bank opportunities available for all substantive staff • OD tactical plan shared in PRC in January 2024, will be reviewed on a quarterly basis	3 Moderate	3 Possible	9	8-12 Strategic risk	• Develop our approach to diversity and leadership including our approach to talent management, (CPO, review June 2024) • Supporting Fellowship Programme across the system as opportunities arise (CPO, Ongoing 2024) • Organisational Development plan being developed (CPO, review May 2024) • Review of succession plans following new Board appointments (CPO, Review July 2024) • 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) • Executive sponsorship for staff networks to be established (CPO, May 2024)	31 July 2024	PRC Executive Management Team Trust Board	4	BAF Ref: SO 3	May 2024
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**	**PRC** QSC	• 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.	4 Major	3 possible	12	8 - 12 Business Risk	• Further consideration taking place to identify the rights systems needed to support our recruitment and onboarding systems (CPO, review September 2024) • Explore any potential collaborative recruitment initiatives with West Yorkshire Mental Health and Learning Disabilities and Autism Collaborative (CPO, ongoing) • Internal transfer system to continue to be promoted (CPO Ongoing 2024) • Working through the NHS workforce plan to understand implications and actions (CPO, Review – ongoing and review by July 2024)) • Paused the number of international nurse recruits while considering the impact on clinical teams (CPO, May 2024)	31 July 2024	Care Group (weekly) QSC PRC Executive Management Team (monthly) Trust Board	9	BAF Ref, SO 3, 4	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• 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. • A careers microsite is now live • Review of entry level qualifications in support worker roles complete • The care certificate for all new non registered support workers available					• Improvement work taking place to support international recruits to be fully operational on the ward (CPO/ DNQ, review July 2024)					
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)	3 Moderate	2 unlikely	6	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 May 2024) • South Yorkshire Integrated Care System (ICS) are working through options for 136 provision for 16-18 year olds (COO, review May 2024)	Review 31 May 2024	QSC Operational Management Group (OMG) Executive Management Team (EMT) Trust Board (each meeting through integrated performance report)	3	BAF ref: SO 1 **Note to Trust Board:** The intention to close the risk was reviewed and, although the controls are effective, pressures on 136 and inpatient beds remain. Therefore the risk will remain on the risk register for a further 3 months and be reviewed again. This action was supported by Quality and	May 2024

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk ID	Description of Risk	Risk Owner	Nominated Committee	Current control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				• Clinically ready for discharge escalation processes									Safety Committee in February 2024.	

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

COVID-19 RISKS

Risk level <15 – risks outside the risk appetite

Risk ID	Description of Risk	Risk Owner	Nominated Committee	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 conditions or certain	4 Major	3 Possible	12	1-6 Clinical risk	• Work continues around promotion of vaccination programme to service users as part of the admission process, and to staff as part of the national campaign. (DNQ, Ongoing) • Continuing monitoring and review for learning of any Covid-19 cases and outbreaks (DNQ, review ongoing) • Currently delivering the autumn/winter flu vaccination programme 2024 and planning for how we approach this for 2024/25 given our learning from this year (DNQ / CPO)	Review 31 May 2024	QSC Executive Management Team (monthly) Moving Forward Group Operational Management Group Improving Clinical Information Group (ICIG) Trust Board	4	BAF ref: SO 2	May 2024

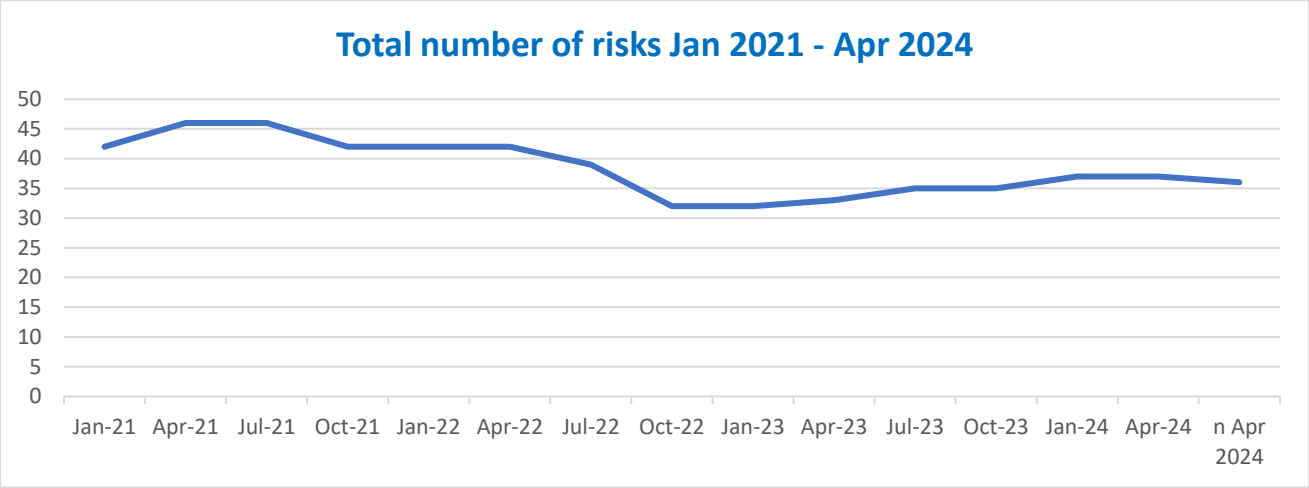
Risk ID	Description of Risk	Risk Owner	Nominated Committee	Control measures	Consequences (current)	Likelihood (current)	Risk level current	Risk appetite	Summary of risk actions	Expected date of completion	Assurance and monitoring	Risk level target	Comments	Next Risk review date
				protected characteristics (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, May 2024) • 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 May 2024)	31 July 2024	AC Moving Forward Group Covid Inquiry Task and Finish Group Operational Management Group Executive Management Team Trust board	6	The inquiry is underway and at parliamentary decision stage therefore the review date has been extended to April 2024 after which the Trust should have outputs and further information.	May 2024

Appendix 1

Trust Board
30 April 2024
Organisational Risk Register (ORR)
Quarter 4 analysis, January 2021 – April 2024

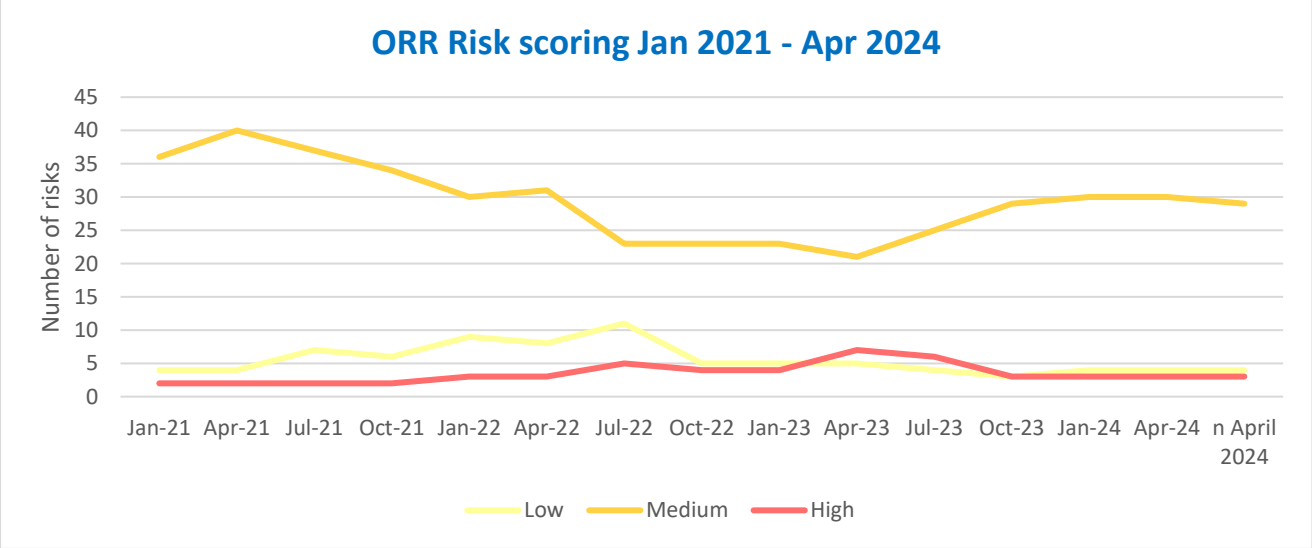
This heat map includes figures from the current Organisational Risk Register from January 2021 to April 2024 as well as the proposed changes.

Total number of risks from January 2021 to April 2024



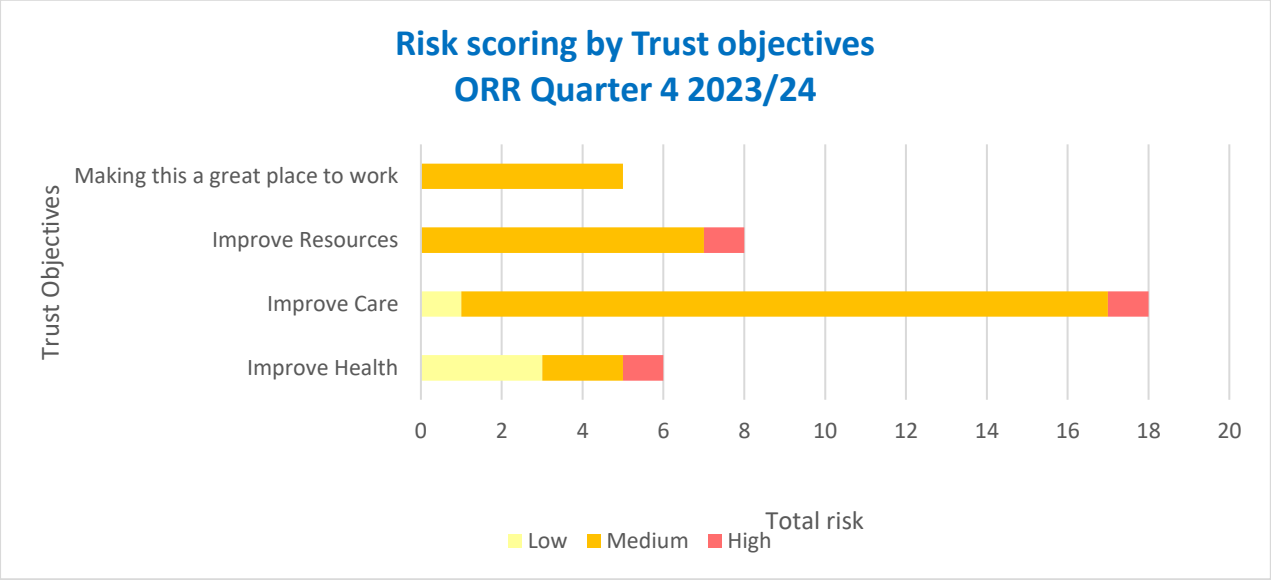
Proposed changes = n April 2024

Total risk by grading from January 2021 – April 2024

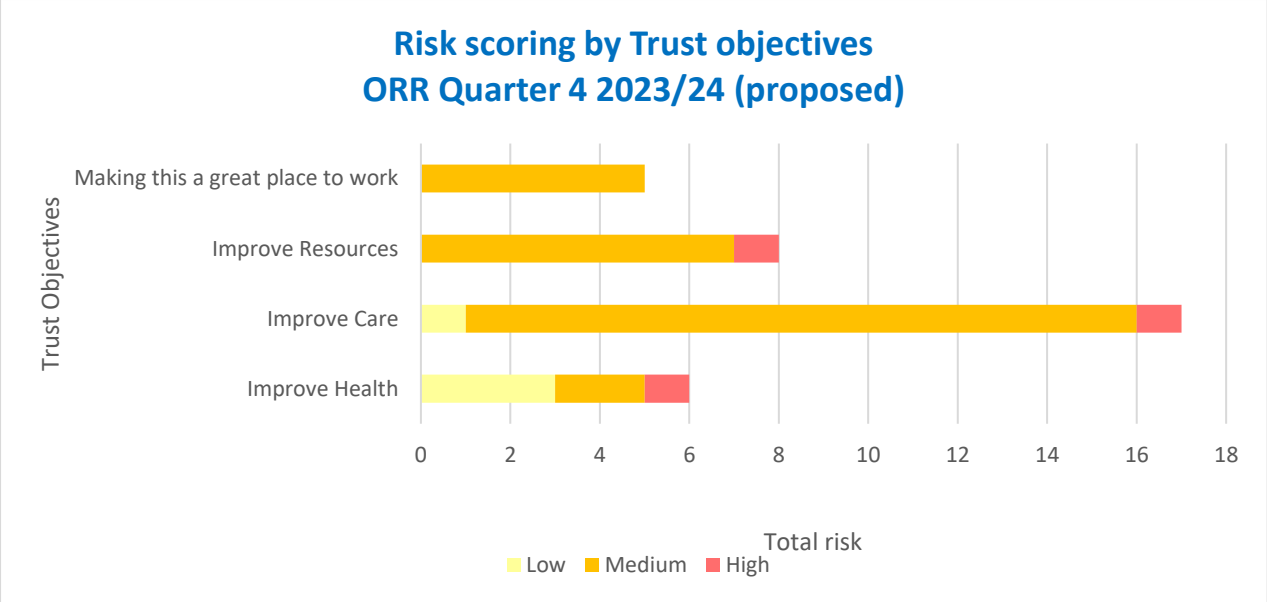


Proposed changes = n April 2024

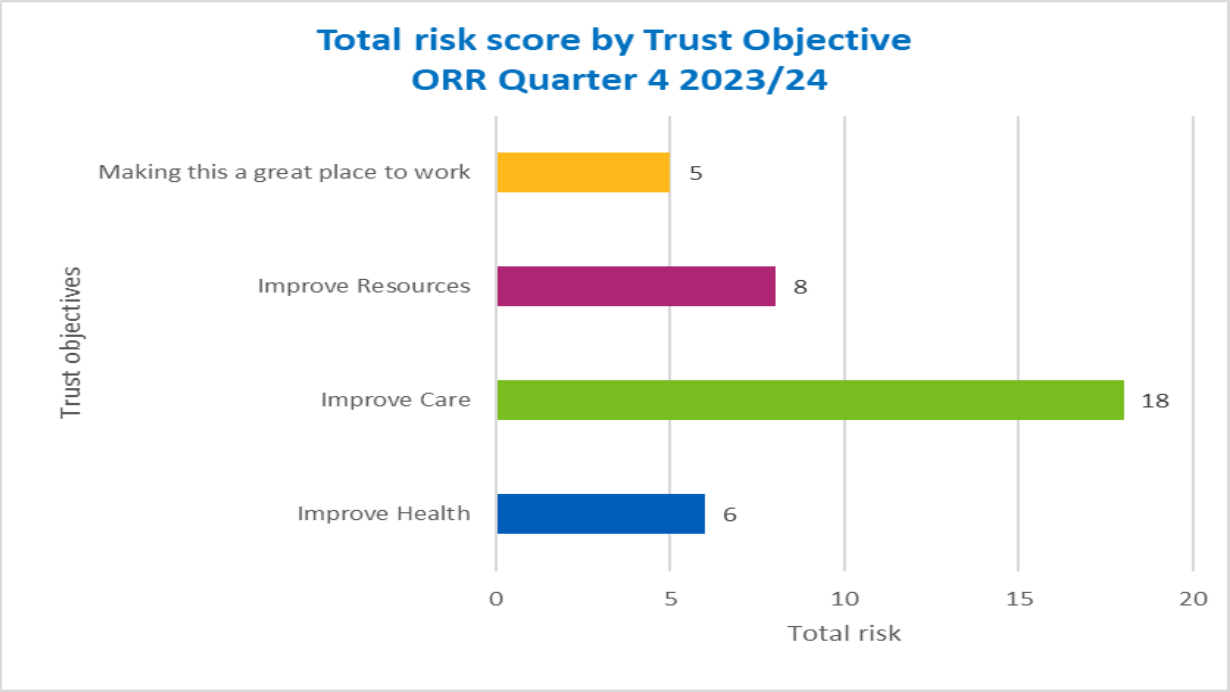
A current breakdown of Trust objectives ORR Quarter 4 2023/24



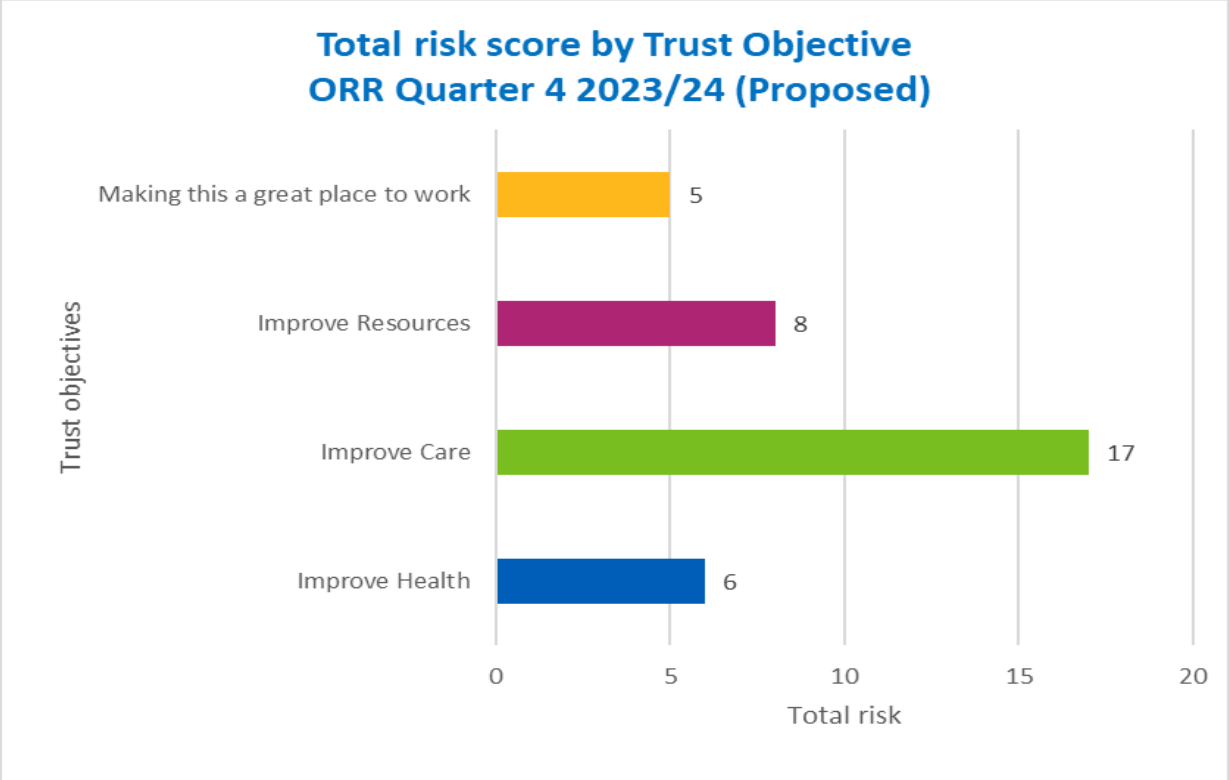
Proposed changes



Total number of risks by Trust objectives ORR Quarter 4 2023/24



Proposed changes



If the proposal is accepted, there will be a reduction in the total number of risks under Trust objective, **Improving Care** by one risk.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 9.3

Private/Public paper:	**Public**		
Title:	**Draft Annual Governance Statement**		
Paper presented by:	Adrian Snarr – Director of Finance, Performance and Estates		
Paper prepared by:	Julie Williams – Deputy Director of Corporate Governance Andy Lister – Company Secretary		
Mission/values:	Respectful, honest, open and transparent. Relevant today and ready for tomorrow.		
Purpose:	To enable the Trust Board to review and comment on the draft annual governance statement.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The annual governance statement is a requirement of the accounting officer on an annual basis to be approved in line with annual reporting requirements. This allows Trust Board to ensure the organisations effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnership and Integrated Care Board.		
Any background papers / previously considered by:	Considered and approved by the Executive Management Team (EMT), Audit Committee and Trust Board annually.		
Executive summary:	• As part of the annual accounting and reporting requirements the accounting officer (Chief Executive) is required to provide an annual governance statement (AGS), which needs to be approved in line with other annual reporting requirements. • The outline of the requirements of the AGS is provided in annual guidance by the regulator (NHS England). This version will be thoroughly checked against the Annual Report Manual (ARM) 23/24 and subject to audit by the Trust external auditor (Deloitte) • Certain elements of the wording are prescriptive and in other sections there is clear guidance on what to include. • At this stage it is a draft statement with some content only available on completion of the year-end.		

	• This report enables Board members to have an early oversight of the AGS and provide any feedback. • It should be noted that the requirements of the AGS have been carefully reviewed by the Deputy Director of Corporate Governance and Company Secretary to ensure the Trust's AGS complies with these requirements. • An earlier draft was reviewed by the Audit Committee on the 9 April 2023. • Areas highlighted in grey are standard wording. • Areas highlighted in yellow still require update once final year-end figures and other information is complete. Please note this document will not be finalised until the Audit Committee meeting on 19 June 2024. A further draft will be presented to Trust Board in May 2024.
Recommendation:	**The Board is asked to:** • **REVIEW** the draft annual governance statement and, • **COMMENT** accordingly.

Annual Governance Statement 2023_24 draft (v06 230424)

Scope of responsibility

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

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

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

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Our Trust Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk. This includes responsibility for standards of public behaviour and accountability, for monitoring the organisation's performance against the Trust's strategy and objectives, and for ensuring corrective action is taken where necessary. The Trust Board's attitude to risk is based on appropriate tolerance to risk. The Board acknowledges that the services provided by the Trust cannot be without risk and ensures that, as far as is possible, risk is minimised and managed within a risk tolerance. This is set out in the Trust's Risk Management Governance Framework and supporting procedure which have been reviewed in year. The Trust's Risk Appetite Statement has been reviewed by our Board in year to ensure it reflects changes in the operating environment and the Trust's additional responsibilities as a commissioner and lead provider.

The Board is supported and governed by an involved and proactive Members' Council, a key part of the Trust's governance arrangements. Since becoming a Foundation Trust in 2009, the Members' Council has become well established in upholding the code of governance for foundation trusts including its role of representing the interests of the members of the Foundation Trust as a whole and the interests of the public and holding the Non-Executive Directors individually and collectively to account for the performance of

the Trust Board. Non-Executive Directors to account for the performance of the Trust Board. The agendas for Members' Council meetings, produced in partnership with the Members' Council Co-ordination Group, focus on its statutory duties, areas of risk for the Trust, and on the Trust's future strategy. Training and development programmes ensure governors have the skills and experience required to fulfil their duties.

During 2023/24 I have recruited a new substantive Director of Strategy and Change. Due to long term sickness the Deputy Chief People Officer has been acting into the role of Interim Chief People Officer since June 2023.

Executive	Role	Date Commenced	
Dawn Lawson	Director of Strategy & Change	11 September 2023	
Lindsey Jensen	Interim Chief People Officer	4 July 2023	

There is a balance of directors with internally and externally focused roles. Director portfolios are regularly reviewed to ensure appropriate balance and capacity is in place to meet the needs of the Trust.

The Members' Council, Trust Board and Executive team are operating in an environment of external change and wider system pressure where risk is constant and at a high level. This has been driven by demand for services, the cost-of-living crisis, and workforce pressures, including industrial action taken across the NHS nationally and locally.

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

This approach reflects the Trust's framework that devolves responsibility and accountability throughout the organisation by having robust delivery arrangements. Capacity for delivery is assured through business planning processes and control is executed through an appropriate scheme of delegation and standing financial instructions.

We identify and manage clinical and corporate risks at care group level. These risks are overseen by the operational management group (OMG) and escalated to the executive management team (EMT) when necessary. Trust wide risks, that qualify, are added to the organisational risk register (ORR) and reported to the Board. Risks that have the potential to impact on the delivery of the Trust's strategic objectives are developed and monitored via the Board Assurance Framework (BAF). The ORR and the BAF are reported to Board on a quarterly basis as part of the role and responsibilities of the Board in overseeing risk These processes are described in detail below and include a summary of the Trust's key risks.

The Trust continued to operate with comprehensive risk management arrangements during 2023/24 with regular reviews of risk at Executive Management team (EMT) meetings, and the Trust Board, alongside the Committees of the Board. This recognises the dynamic

nature of the environment in which we operate and the need to constantly focus, assess and manage risk.

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

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

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

The risk and control framework

In June 2023 the Trust Board received a self-certification (FT4) entitled the Corporate Governance Statement for approval. Following approval this was published on the Trust website.

The self-assessment sets out detailed statements (numbered 1-6) the Trust Board is required to make and provide assurance to support self-certification and compliance with the NHS provider licence section 4 (governance).

The statements were as follows:

1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

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

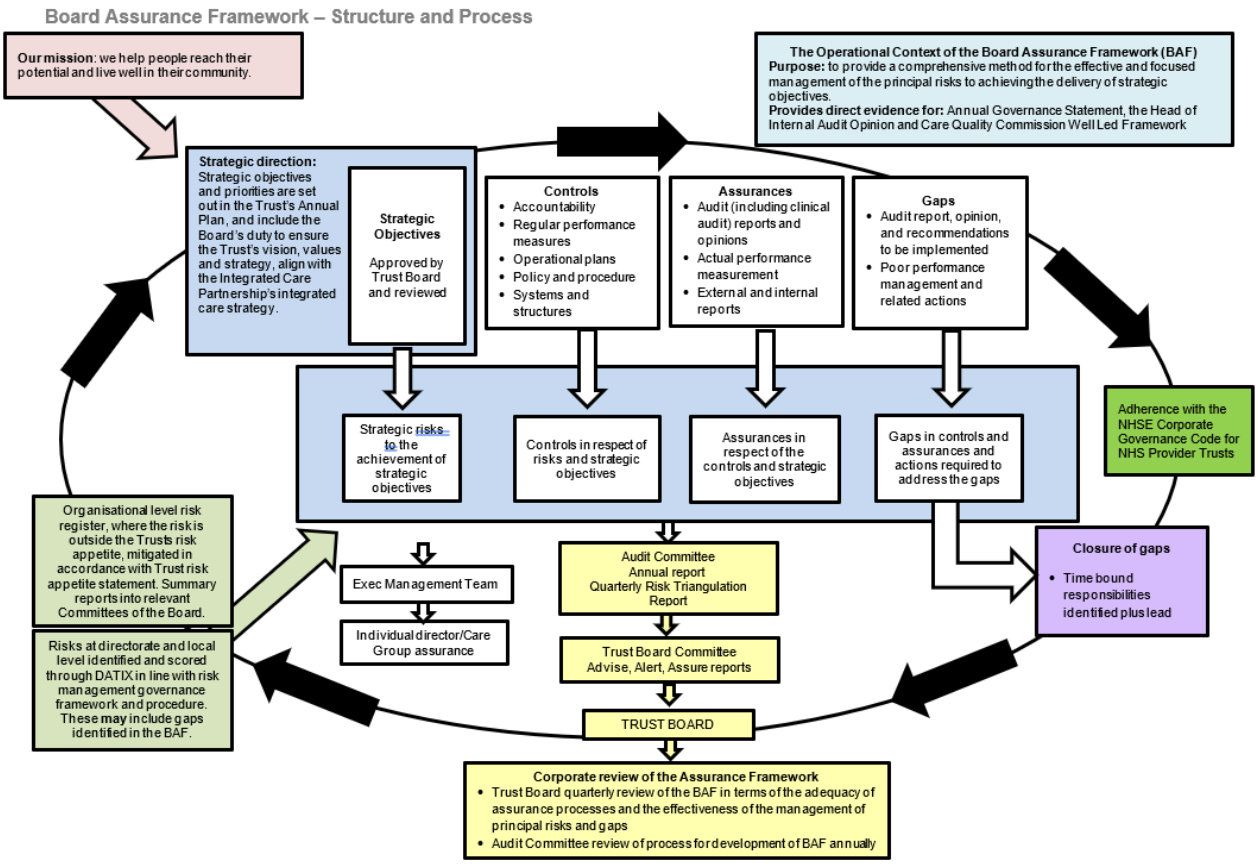
3. The Board is satisfied that the Trust implements effective board and committee structures, clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees, and clear reporting lines and accountabilities throughout its organisation.

4. The Board is satisfied that the Trust effectively implements systems and / or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively, for timely and effective scrutiny and oversight by the Board of the Licence holder's operations, to ensure compliance with healthcare standards binding on the Licence holder.

5. The Board is satisfied that there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided.

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

The risk and control framework flows from the principles of good governance. It uses effective board and committee structures, supported by the Trust's Constitution (including standing orders) and scheme of delegation. The Risk Management Framework describes in detail how risk is applied within this framework which is depicted below:



The Audit Committee assures the Board and Members' Council of the effectiveness of the governance structures through a cycle of audit, self-assessment and annual review. The latest annual review was received by the Board in April 2024.

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

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

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

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

The Committees in Common with West Yorkshire mental health, learning disability and autism provider partners reports in line with other committees of the board.

The Trust's Risk Management Governance Framework sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk. The Trust's Risk Appetite Statement was defined in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix aligned to the Trust's own risk assessment matrix. The Statement was reviewed and approved by Trust Board in March 2024.

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

All organisational level risks are aligned to and monitored by an appropriate Board Committee. During 2023/24, further work has continued to review risk registers, to consider where organisational risks scoring level 15 and below fall outside of their risk appetite. This ensures risks are managed within their tolerance where appropriate or escalated for further debate and action.

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

The Board Assurance Framework (BAF) describes the strategic risks that will continue to be managed by the Trust. The BAF is aligned to the four strategic objectives of the Trust. – improve health, improve care, improve resources and make this a great place to work. This ensures alignment between the business of the Trust and the risks we manage across the organisation and the system. The BAF is used to help shape the agenda of the Board and its committees. In 2023/24, the Trust Board conducted the annual review of strategic risks. The BAF is reviewed quarterly at Trust Board. A comprehensive review of all strategic risks will take place in July 2024 as part of the Trust's strategy refresh process.

As Chief Executive and the Accounting Officer, my accountabilities are secured through delegated executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, ensuring there is a high standard of public accountability, probity, and performance management. In 2023/24, personal objectives were set for each director and reflected in the Board Assurance Framework through the strategic objectives assigned to each Director. My objectives were discussed and agreed with the Chair and shared across the Trust, alongside a high-level summary of how Directors' objectives fit within this framework.

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

The Trust's key risks at the end of Quarter 4, 31 March 2024 that have been an area of focus for all or the majority of the year are shown below. They are presented in the same order as they appear on the Organisational Risk Register for consistency:

Area of focus	Example of actions completed or underway
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.	Key risk actions: • Explore potential collaborative recruitment initiatives with the West Yorkshire Mental Health, Learning Disabilities and Autism Collaborative. • Internal transfer system continues to be promoted. • Working in alignment with the NHS workforce plan. • Improvement work taking place to support international recruits to be fully operational on the ward. • Improve capacity to ensure there are placements available for all newly qualified nurses. • Refresh the Trust's workforce plan including development of new clinical roles. • Annual actions plan following staff survey results Key control measures in place: • Safer staffing levels for inpatient services agreed and monitored. • Reporting to the Board through the Integrated Performance Report • Datix reporting on staffing levels. • Strong links with universities. • Marketing of the Trust as an employer of choice. • A careers microsite is now live
Risk that demand continues to rise placing further pressure on access to services and **waiting lists**	Key risk actions: • The operational management group will review refreshed demand data and make a recommendation to the executive management team on the future management of this risk • Quality and Safety Committee will receive a presentation of the demand data and future actions to manage the risk in May 2024 Key control measures in place: • Working as a key partner in each of the Integrated Care Systems. • Health and wellbeing boards. • Digital and telephone solutions are part of the standard offer for service users. • Service delivery is prioritised to meet need, manage risk and promote safety with cross service and care group support utilised. • Where demand exceeds capacity, this is escalated through the Operational Management Group (OMG) with bespoke arrangements put in place. • Quality impact of increased demand is overseen in the Clinical Governance Group
Risk that the Trust's IT	Key risk actions:

Area of focus	Example of actions completed or underway
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.	• Business continuity plans are reviewed as part of an emergency preparedness, resilience and response (EPRR) tabletop exercise. • 6-monthly cyber security update reports provided to Audit Committee. • Cyber security phase 2 enhancements to support move towards advanced monitoring capabilities business case being developed. • Cyber and phishing campaigns and staff awareness communications schedule remains in place. • Testing of Windows 11 completed ahead of Windows 10 going End of Life in 2025. Key control measures in place: • Microsoft Windows Defender in place including advanced threat protection (ATP). • Comprehensive security patching regime in place. • Annual penetration testing and ongoing regular cyber health checks. • Disaster recovery and business continuity plans are tested annually. • NHS Digital Care Certificate obligations fully met. • Data retention policy in place with regular backups. • Cyber security is included in mandatory Information Governance training. • Cyber Essentials Plus re-accreditation complete • Use of Multi-Factor Authentication (MFA) across the Trust
The risk of disruption to services and reduction in staff due to **industrial action** and our inability to deliver care.	Key risk actions: • 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. • Continue to develop supportive communication messages to staff asking for support to maintain essential service. • Multi-disciplinary operational work in place to manage the impact of industrial action and mitigate risks. Key control measures in place: • 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 partners in our two Integrated Care Systems. • Joint Task & Finish Group to work through implications on service delivery and identify priority areas.

Area of focus	Example of actions completed or underway
	• A separate strike committee was established to manage and consult with the British Medical Association on the terms and conditions for those doctors striking. • Regular reporting to OMG and EMT established. • High level communications messages agreed.
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	Key risk actions: • Draft longer-term financial sustainability plan being developed • Reinstatement of efficiency delivery and monitoring. • Implement patient level costing for use by directorates. • Cost controls are in place which will require further review in 2024/25 to confirm effectiveness. • Further staff engagement is required to develop more efficiency ideas • Participation in regional and national productivity work Key control measures in place: • 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 (ICSs). • Active engagement in place-based plans (Wakefield, Barnsley, Calderdale and Kirklees). • Enhanced management of Cost Improvement Programme (CIP). • Continued Mental Health Investment Standard funding. • 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. • 2024/25 financial plan presented to and approved by the Board in April 2024. • Monthly financial reports to assess impact of inflationary pressures
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.	Key risk actions: • Partnership agreement and risk share required in South Yorkshire. • Evaluation of submitted benchmarking information • Progress all sub-contracts to signature • Ongoing dialogue with NHS England to resolve contractual position in relation to South Yorkshire provider. Key control measures in place: • 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. • Financial management and control processes in place.

Area of focus	Example of actions completed or underway
	• 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 • Clinical Lead roles in place for West Yorkshire • Clinical Director in place for South Yorkshire. • Focus and clinical oversight of patient repatriation plans in place. • Quality assurance processes and monitoring in place across the Collaboratives. • 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)

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

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

We are closely engaged in the leadership and delivery of these plans. The Director of Provider Development, Director of Finance, Estates and Resources, and Director of Strategy and Change roles mean we have senior capacity aligned to each of the four places in which we provide services in West Yorkshire and South Yorkshire Integrated Care Systems. The Chief Operating Officer, Chief Medical Officer and Chief Nurse/Director of Quality and Professions are senior responsible officers for specific system wide programmes of work and other staff are also engaged in system-wide programmes. Further information on workforce safeguards can be found on page ??.

Priority programmes

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

Working in partnership

In May 2022, the Trust established a Collaborative Committee, as a committee of our Trust Board. This committee has continued to develop during 2023/24. The purpose of the committee is to ensure delineation between provision and commissioning responsibilities as coordinating provider (finance, contracting, planning and quality assurance) for the West Yorkshire Adult Secure Provider Collaborative, oversight of commissioning responsibilities

as the Trust leading the Adult Secure Provider Collaborative for South Yorkshire, and other specialised mental health provider collaboratives as appropriate.

The Trust is an active participant in two Integrated Care Systems (ICS), and we have continued to work with partners. In both ICSs we have participated in the development of the transformation of community mental health services. A detailed description of our work across our integrated care systems is described in the main body of the report (see page ??).

The Trust works in partnership with health economies predominantly in Barnsley, Calderdale, Kirklees, Wakefield, and the Integrated Care Systems of South Yorkshire and West Yorkshire.
The Trust continues to lead the provider collaborative for the South Yorkshire and Bassetlaw Adult Secure services. Provider collaboratives are a partnership of service providers led by an NHS lead provider working to provide co-ordinated and improved specialised services across a specified geography.

They work in partnership to improve services and ensure that services are provided as close as possible to patients' homes, using commissioning budgets innovatively to improve patients' experience and outcomes across whole care pathways. Commissioning arrangements for the collaborative are established through the South Yorkshire and Bassetlaw (SYB) Mental Health Provider Collaborative Commissioning Hub. Oversight of the Trust's commissioning responsibilities for the collaborative is via the Collaborative Committee (described earlier). The Trust are members of the South Yorkshire and Bassetlaw Partnership Board which oversees the SYB specialised provider collaboratives (Adult Secure, CAMHS and Adult Eating Disorders). For clarity, although the South Yorkshire ICS doesn't include the Bassetlaw population, phase one provider collaboratives include Bassetlaw.

In the **West Yorkshire Health and Care Partnership** we have been involved in a range of work under the auspices of the WY Mental Health, Learning Disabilities & Autism Partnership Board, including work streams on neurodiversity, complex mental health rehabilitation, perinatal and maternal mental health, adult secondary mental health services care pathways, and children and young people's mental health. The Trust is coordinating provider for the West Yorkshire maternal mental health service, currently in implementation.

The Trust is the coordinating provider for the West Yorkshire Adult Secure Lead Provider Collaborative, working with NHS and independent sector providers in West Yorkshire. In April 2023, the Trust took on the Coordinating Provider role for Forensic CAMHS across Yorkshire and Humber. A Collaborative Committee is established as a Trust Board Committee, the purpose of which is to ensure delineation between the Trust's provision and commissioning responsibilities (finance, contracting, planning and quality assurance) for the specialised mental health provider collaboratives and to provide oversight and assurance of the Trust's commissioning responsibilities as Lead/Coordinating Provider.

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

Over the past year, the Trust has continued to work with partners to further plan for Phase 2 of the Specialised Provider Collaborative Programme, which includes Forensic CAMHS (Coordinating Provider for these arrangements.

Sustainability

The Trust continues its commitment towards 'Delivering a Net Zero Health Service' under the Greener NHS programme. The Foundation Trust has undertaken risk assessments and has a green management plan in place, which takes account of UK Climate Projections 2018 (UKCP18).

The Trust ensures that its obligations under the Climate Change Act and the Adaptation of reporting requirements are complied with. The Trust Board approved the Trust's Green Plan in March 2021, progress against the plan was monitored by the Board in 2022/23. The Green Plan (was integrated into the Trust's Social Responsibility and Sustainability Strategy which was approved by Trust Board in July 2022.

The Foundation Trust has undertaken risk assessments and has a green management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensure that its obligations under the Climate Change Act and the adaptation of reporting requirements are complied with.

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

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

Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, Finance, Investment and Performance Committee, through Executive Management Team (EMT) meetings, the Operational Management Group (OMG) has finance and performance as standing agenda items, in addition there are care group specific finance and performance subgroups.

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

The governance framework of the Trust is included at page ??, which includes the Board's committee structure.

Attendance at Board meetings is included in the table at page ?? and attendance at Trust Board committees is included in the accountability report which starts at page ??and includes coverage of committee work and highlights of reports received by Committees, including the Audit Committee.

Reference to the work of the Nominations Committee is included in the Remuneration report on page ??

The Trust's compliance with the Code of Governance for NHS Provider Trusts is included in Section 2.4 NHS Foundation Trust Code of Governance.

Our Licence

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust continues to assess its compliance with CQC registration requirements on a regular basis through our quality improvement and assurance team. To

support our assessment, we have developed a quality assurance and improvement 'self-governing' assessment model. This philosophy builds on our emphasis on self-governance and evaluation. As a series of methods and tools, this approach helps map the relationships between quality improvement and quality assurance and will provide a continual source of evidence for teams to inform how well they are performing against appropriate and helpful metrics for quality.

In May 2023/24 the Trust's core services of acute wards for working age adults, psychiatric intensive care units (PICU), and adult secure inpatient wards were inspected by the CQC. The initial outcome letters were presented in public to Trust Board on 27 June 2023.

On Wednesday 6 December 2023 the reports were published by the Care Quality Commission (CQC). These inspection reports were presented to Trust Board in January 2024. Both of these services received a requires improvement rating.

In March 2024 the Board received a report containing an update on the Trust's progress regarding the action plans against the 'must do' and 'should do' actions within the CQC inspection reports. Actions are signed off as complete at Care Group level before final sign off by the Chief Nurse / Director of Quality and Professions, once evidence of assurance has been reviewed.

Quality improvement approaches are being used wherever possible, either with individual actions or where actions are part of broader improvement work.

Current progress against CQC actions

Forensic service 'must do' actions:

- One of the seven must do actions has been completed.
- Six of the seven actions are in progress and on track.

Forensic service 'should do' actions:
The Forensic Care Group received seven 'should do' actions, alongside their 'must do' actions. The Care Group are considering all seven 'should do' actions as 'must do' actions and are progressing these as detailed below.

- One action is complete.
- Four actions are on track.
- Two actions are being progressed with input from other areas of the Trust.

Acute and PICU 'must do' actions:

- Of the 16 'must do' actions all are in progress and on track

Acute and PICU 'should do' actions:
The Care Group are considering six of the 12 'should do' actions as 'must do' actions and are progressing these as detailed below.

- Two actions are complete.
- Ten actions are in progress and on track.

Progress will continue to be presented to the Executive Management Team, the Quality and Safety Committee, Trust Board and the CQC.

As a Trust we welcome feedback from our regulators and the opportunity to learn and improve our services. Regular engagement meetings remain in place with the CQC.

A full CQC inspection was not completed during 2023/24, however, the CQC rated our Trust as Good in 2019, recognising the improvements made since the previous inspection in 2018 and the strength and quality of the services we provide.

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

Routine CQC Mental Health Act visits have continued in 2023/24. There were eighteen in total across the following sites:

- Appleton
- Bronte
- Hepworth
- Preistley
- Waterton
- Sandal
- Thornhill
- Newhaven
- Walton
- Stanley
- Enfield Down
- Lyndhurst
- Ward 18
- Ward19 (male and female)
- Beamshaw
- Clarke

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

During 2023/24 The Trust assessed itself against the NHS Constitution, in line with good practice. The report was presented to the Trust Board in October 2023. This set out how the Trust meets the rights and pledges of the NHS Constitution and new Code of Governance for NHS Provider Trusts (October 2022) which came into effect on 1 April 2023. At the time of writing, I believe that our performance metrics and risk register contain no material or substantial risk of significant breaches of the constitution.

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

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

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

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

Values based culture

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

Learning from incidents and the impact on risk management is embedded in the way we work.

From 1 December 2023, the Trust transitioned to the new Patient Safety Incident Response Framework (PSIRF) in line with NHS England guidance. The new framework replaces the Serious Incident Framework (2015). The Trust has developed a PSIRF plan and policy to support new ways of working.

PSIRF is a new approach to develop and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. It prompts a significant cultural shift towards systematic patient safety management and embeds patient safety incident response within a wider system of improvement. PSIRF prioritises compassionate engagement with those affected by patient safety incidents.

We have developed a range of systems focused learning response methods which we will use to obtain new learning where needed, alongside a Trust wide patient safety improvement plan, and focused quality improvement workstreams. We continue to embed PSIRF in practice and develop our supporting structures. From 14 February 2024, we launched the 'Learn From Patient Safety Events' within our Datix incident reporting system. This is for capturing patient safety events for submission to NHS England.

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

The Trust works closely with safety teams in NHS England and uses systems analysis as a tool to undertake structured investigations to ensure learning from incidents of a serious nature. Our aim is to identify any contributory factors, or problems in care, that lead to the incident occurring. We then identify learning and improvement actions to minimise the opportunity of recurrence and to ensure that the Trust takes every opportunity to learn and develop from an incident and mitigate future risk.

The provision of mental health, learning disability, autism, and community services carries a significant inherent potential risk. Unfortunately, incidents of a serious nature do occur which require robust and well governed organisational controls.

The Trust transitioned to working under the new Patient Safety Incident Response Framework (PSIRF) from 1 December 2023. From this date, the Serious Incident Framework no longer applies to new incidents and serious incident (SI) reporting ceased.

Under the new framework, we have Patient Safety Incident Investigations (PSII) which are set out in the Trust's Patient Safety Incident Response Framework plan. PSII's do not directly replace SIs.

In 2023/24, there were 15,141 incidents reported (an increase of 5% on 2022/23). 96% of incidents reported resulted in low or no harm to patients, service users, staff or people external to the Trust's care, recognising that the Trust has a risk based and strong reporting culture.

During 2023/24, there were 7 serious incidents reported across the Trust (to 30/11/2023). There were no PSIIs reported in 2023/24. There were no 'Never Events' (as defined by the Department of Health) relating to serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

There were 282 notifiable safety incidents during the year where "duty of candour" applied. There were six duty of candour breaches representing 2% of all applicable incidents. These incidents all involved community patients. Five incidents were in relation to self-harm resulting in moderate harm. There was one patient death. Details of the six breaches are below:

- Death of a community patient due to suspected suicide. There were no next of kin (NOK) details recorded on SystmOne. Contact made with GP surgery and no record of NOK held.
- A community patient completed self-harm at home. Patient was intubated and transferred to acute hospital intensive care overnight. The apology was not given within the required timescale. Learning for managers in the service has been taken from this incident.
- A community patient had been injured in a physical attack. The alleged perpetrator had been staying with the patient's family. This was contrary to the safety plan agreed by social care. Police were informed of the incident. The clinician had tried to make contact to give an apology, but to no success.
- A community patient completed self-harm at home. The patient was transferred to the acute hospital and had surgery following the incident. Duty of candour was completed when the patient was medically fit for this to take place.
- A community patient completed self-harm at home. The patient was transferred to the acute hospital. The delay in completing duty of candour was due to patient being taken into the acute hospital.
- A community patient completed self-harm. Patient was taken to acute hospital via ambulance and was admitted to the Intensive Care Unit (ICU). There was a delay in the apology being given to the patient. A training issue was identified and supported. The team was not aware duty of candour was applicable in this instance, and have taken learning from the incident.

The Quality and Safety Committee has a leading role to play. It scrutinises and monitors quarterly serious incident reports and bi-annual reports on how and where lessons have been learnt and practice improved and/or changed. The Committee also monitors

implementation of recommendations arising from external reviews and reports. In the last year, this has included the Trust's action plan in response to the CQC's inspections of its inpatient services. The Committee routinely monitors infection prevention and control, reducing restrictive practice interventions, safeguarding, patient safety, health and safety, quality impact assessments and issues identified at the drug and therapeutics committee. During the year, the Committee continued its review of the implementation of the Trust's priority programmes from a clinical perspective and receives a regular 'exception' report as well as more detailed presentations as appropriate. The Committee continued to review its allocated risks. The Committee oversees all quality and safety action plans until completed and closed and it is satisfied that risks have been moderated.

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

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

- The Trust's approach to quality reinforces its commitment to high quality care that is well led, safe, caring, responsive, efficient, and effective. The Quality Strategy outlines the responsibilities held by individuals, directorates, the EMT and Trust Board. The Trust Board approved an updated Quality Strategy on 28 March 2023.
- The Trust's Quality Strategy sets out our commitment to providing high quality care for all while achieving our organisational mission to help people to reach their potential and live well in their communities. It sets out what we mean by quality and provides a framework for how we assure and improve quality across the organisation. It also describes our integrated change framework that supports innovation and improvement at all levels. The Quality Strategy has three main aims: 1) To deliver the quality priorities, both our current priorities and future priorities, and be flexible in what our priorities are to ensure that they are always fit for purpose and reflective of need; 2) embed quality improvement across our organisation to support our journey to becoming a Trust that delivers outstanding care; 3) monitor and identify success, through measuring, reflecting and ensuring we have robust systems in place to understand where there have been improvements in quality, and where we could do better.
- This is supported by the Patient Safety Strategy to improve the safety culture throughout the organisation whilst supporting people on their recovery journey. It aims to reduce the frequency and severity of harm resulting from patient safety incidents, to enhance the safety, effectiveness, and positive experience of the services we provide, and to reduce the costs, both personal and financial, associated with patient safety incidents. The new Patient Safety Incident Response Framework (PSIRF) was released in Spring 2022.
- Annual quality priorities are agreed through the Board and published in the Quality Account.
- The Quality and Safety Committee is the lead Committee for quality governance.
- The Safeguarding Strategic Sub-Group provides assurance to our partners that we are compliant with national standards and adopt a quality improvement approach to developing our service offer.
- Monthly compliance reporting against quality indicators sits within the Integrated Performance Report. The Quality and Safety Committee receives a quarterly report on complaints, concerns, comments and compliments through a patient experience report, the outcome of which is presented in Trust Board through the alert / advise / assure document as necessary. In addition, Trust Board receives an annual Patient Experience Report.

- The CQC monitors performance against CQC regulations, and the Trust quality team coordinates and undertakes quality monitoring visits across Trust services which are supported by non-executive Directors and governors.
- External validation, accreditation, assessment, and quality schemes support self-assessment for example: accreditation of electroconvulsive therapy (ECT), Psychiatric Intensive Care Units (PICU) and memory services; CQC Mental Health Act visits; and national surveys (staff and service user).
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as serious incidents, infection prevention and control, information governance, reducing restrictive practice group, drugs and therapeutics and policy development.
- Quality impact assessments are carried out on all Trust cost improvement plans with Chief Medical Officer and Chief Nurse / Director of Quality and Professions approval required before a scheme can proceed. Quality Impact Assessments (QIAs) can also be invoked in year where concerns trigger the requirement to do so.
- Measures are implemented and maintained to ensure individual practice, teams and services are reviewed and improvements identified and delivered. This includes the Trust's prioritised clinical audit and practice evaluation programme.
- The annual validation of the Trust's Corporate Governance Statements as required under NHS Foundation Trust conditions. The Board certified that it was satisfied with the risks and mitigating actions against each area of the required areas within the statement (as described on pages ??).
- Freedom to Speak Up (FTSU) Guardians ensure that where staff feel unable to raise concerns through the usual channels, there is a mechanism for doing so. The Trust has a full-time Guardian who is supported by three part-time guardians and civility and respect champions across the Trust. A Freedom to Speak Up Steering Group has been established to further strengthen the Trust's arrangements. Over the year 54 concerns were raised through this mechanism, 7 of which followed the freedom to speak up process (1 concern related to patient safety) and the remaining 47 were signposted to the appropriate avenue for support including staff side, service-based equity guardians and champions, and the people directorate (human resources). Reporting was shared with the Office of the National Guardian.

Equality, involvement, and inclusion

Patient and carer race equality framework (PCREF) is the NHSE accountability framework to eliminate the unacceptable racial disparity in the Access, Experience and Outcomes (AEO) of Black, Asian, and Minority Ethnic communities and to significantly improve their trust and confidence in mental health services. Implementation of the PCREF will be one of the pieces of evidence that CQC will consider when scoring quality statements as part of their new regulatory approach.

The Trust have already made considerable progress on several areas set out in the PCREF and will continue to deliver progress through the annual Trust wide equality and inclusion and involvement action plans for 2024/2025.

Further work to ensure the Trust can respond to the PCREF will be identified through the Equality, Inclusion and Involvement (EII) sub-committee which reports into the EII Committee.

Health inequalities are unfair and avoidable. To reduce health inequalities, we need to act to tackle them through actions with a specific focus on disadvantaged groups and deprived areas. We know that there are groups who are more adversely impacted. The Trust is using the CORE20PLUS5 approach to identify the target audience and the areas of improvement.

The equality diversity and inclusion (EDI) improvement plan builds on the NHS people plan to use the latest data and evidence to identify six high impact actions (HIAs) which organisations across the NHS can take to improve equality, diversity and inclusion.

The aim of the plan is to improve equality, diversity and inclusion and to enhance the sense of belonging for NHS staff to improve their experience. The plan references the protected groups covered by the plan as those set out under the Equality Act 2010. For our Trust, this will include carers.

The plan describes the six intersectional HIAs, underpinned by success metrics. The document also outlines targeted interventions by protected characteristic, which align with the HIAs and their goals to address the widely known intersectional impacts of discrimination and bias.

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

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

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

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

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

- The equality, involvement, communication and membership strategy is supported by annual equality and involvement action plans. These plans set out our Trust wide approach to delivering strategic objectives and describe the Trust actions for the forthcoming year. The plans align with existing internal resources, data, and insight frameworks to ensure a systematic and integrated Trust wide approach.
- The effective use of insight and data underpins what we do. This includes robust equality monitoring. Data is used to identify who uses and works in services, highlighting areas of inequality that can be addressed through insight work and action planning.
- Equality Impact Assessments (EIA) are in place for all services, strategies, and policies. This ensures that equality, diversity, and human rights impacts are considered, recorded and action taken for every service. Action to mitigate impacts are taken through service level actions plans which are used to implement service improvements.
- A Trust wide Equality Impact Assessment (EIA) and approach was developed in direct response to the pandemic. This approach includes a Trust wide EIA that has regularly been updated, reviewed, and agreed by the Equality, Inclusion and Involvement Committee and the development of a resource and research bank which is an internal

resource of all literature published during this time. These tools have ensured that our public sector equality duty to advance equality of opportunity and consider impacts has been a core focus in response to and following the pandemic.

- The Trust has a clearly articulated approach to formal consultation, this includes a training pack, plan on a page, and governance through EMT and Equality, Inclusion and Involvement (EII) Committee who sign off the appropriate approach.
- The Trust wide change framework includes the process for involving people at each stage. A 'checklist' approach and dedicated inbox for involvement ensures that a systematic and considered approach to engagement, co-production and consultation is considered at the start of any new project or programme of work.
- All networks meet with Board members at least once a year to share achievements, issues or concerns for awareness and possible action.
- The Board and governors believe they should be reflective of communities and represent the workforce and population they serve. Over the last year a good level of diversity has been retained across the Board with a good balance of gender, age, and ethnicity. Governors use a targeted approach to support recruitment from local communities and those with lived experience.

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

The equality, involvement, communication and membership strategy will be reviewed in 2024/25 following the overarching Trust strategy refresh.

In 2023/24 the Trust has improved in two of the 4 and declined in 2 of the Workforce Race Equality Standard (WRES) indicators published in the NHS Staff Survey 2022, and has plans identified to improve on all areas.

The Trust submitted its 2023 gender pay gap audit as required by law, in March 2024

The Trust has adopted the National Equality Delivery System (EDS2) Framework and focused on improving the following areas, working closely with service users, public and commissioners:

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

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

"Making SWYPFT a great place to work" supports the provision of a healthy, resilient, and safe workforce and aligns to NHS People Promise. This covers five key areas:

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

The key ways in which the Trust ensures that short, medium and long term workforce strategies and staffing systems are in place which assure the Board that staffing systems and processes are safe, sustainable and effective can be found on page ??.

All NHS trusts are required to deploy sufficient, suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively. They should also have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times. The approach used must reflect current legislation and guidance where it is available. (National Quality Board (NQB), Safe sustainable and productive staffing 2016).

Trust Board is updated bi-annually on safer staffing including right staff, right skills, right place; establishment reviews, workforce planning, new and developing roles and recruitment and retention in line with NHS Improvement (NHSI) Developing Workforce Safeguards policy 2018.

The report provides an outline of the work in progress and plans in place for the future to ensure our care groups are appropriately staffed and can deliver safe and effective services.

The Trust reports monthly on safer staffing through the Integrated Performance Report (IPR) and other reporting mechanisms related to quality of care, and service user and staff experience.

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

In 2023/24, the Equality, Inclusion and Involvement Committee received reports on the following:

- Equality and diversity annual report prior to Trust Board.
- Learning from the NHS staff survey
- Progress on development of peer support workers
- The Committee received delivery updates on the carers’ agenda
- Received Care Group reports on equality and involvement
- Received Equality and Involvement exception and highlight reports
- Received the Insight report based on feedback from service users, the public and partners
- Received equality dashboard aligned to CORE 20 PLUS 5
- Development of an approach to address inequalities including deep dive and use of data to support service change.
- The Committee monitored the Trust’s progress against the equality standards including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES); and the Trust’s progress against the Equality Delivery System 2 (EDS2).
- Received feedback from staff equality networks.
- Reviewed inclusive leadership and development programme updates

The Trust is a member of the NHS Benchmarking Network , and participates in a number of benchmarking exercises and has an internal benchmarking group. This information is used alongside other benchmarking metrics, such as the Model Hospital, to review specific areas of service in an attempt to target future efficiency savings and reduce waste. Work has continued with care groups to implement patient level and service line reporting, including the use of bespoke performance dashboards.

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

Overall, the Trust had a financial target, as agreed with the West Yorkshire ICS to break even. This position supported delivery of a breakeven financial plan with the West Yorkshire ICS.

A robust process is undertaken to assess the impact on quality and risks associated with cost improvements both prior to inclusion in the annual plan and during the year to ensure circumstances have not changed. The process and its effectiveness are monitored by the Quality and Safety Committee. Quality Impact Assessments (QIAs) take an objective view of the impact of cost improvements on the quality of services in relation to the CQC five domains of safe, caring, effective, responsive, and well led. The assessments are led by the Director of Nursing, Quality and Professions and the Chief Medical Officer with the Chief Operating Officer, Operations Directors and senior care group staff, particularly clinicians.

As part of the annual accounts review, the Trust's efficiency, and effectiveness of its use of resources in delivering clinical services are assessed by its external auditors and the auditor's opinion is published with the accounts.

There are various levels of surplus or deficit referred to in this report. The following table provides a reconciliation between the Trust total comprehensive income for the year of £2.7m as noted above and the £0.5m surplus reported in our management accounts. This excludes the Trust charity which is consolidated in the overall group accounts. It should be noted the Trust had a control total target for the year of breakeven as agreed with, and performance managed against by, the ICS and this has been exceeded.

	£m
Group Comprehensive Income/(Expense)	2.5
Exclude: Charity	(0.2)
Trust Comprehensive Income/(Expense)	2.7
Remove:	
Peppercorn rents (IFRS 16) – leases and disposals	0.6
Net impairments	(2.8)
Pre adjusted surplus in our management accounts	0.5

Information governance

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

servers. Trust compliance with information governance training as at finalisation of this report was 96.1% against a target of 95%.

Information governance has had continued focus through 2023/24 through proactive monitoring of incidents, providing awareness raising sessions at all levels in the organisation, including senior level through the Extended Executive Management Team, and offering advice and increasing availability of training for staff. Information governance had a continuous and high profile in the Brief, cascaded monthly to all staff.

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

The Trust is required to report any information governance incidents where the severity is graded 2 (minor) or above and the likelihood scores a 3 (meaning likely) externally to the Information Commissioner's Office (ICO). Two incidents were reported during 2023/24. One incident related to one patient's information being shared in error. The individual concerned did report an impact on their health and wellbeing and the Trust has supported the person concerned. Learning has been identified and implemented. The second incident related to staff information being shared inappropriately within the Trust as part of appraisal rate monitoring. On identification the process was immediately ceased, and a robust revised process implemented. The ICO has reviewed the first case, and no further action was taken against the Trust. The second case is still under review by the ICO.

The Trust has an appointed Senior Information Risk Owner (SIRO), who is an Executive Director with overall responsibility for an organisation's information risk policy. In addition to the SIRO the Trust has the following:

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

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

Good information governance will continue to be a feature of the Trust in 2024/25.

The Data Security and Protection Toolkit audit for 2023/24 was substantial assurance and this has been submitted to the information commissioner's office in line with national requirements.

Data Quality and Governance

We have a strong system of quality reporting:

- Quality metrics are reviewed monthly by Trust Board and the EMT, alongside the performance reviews undertaken by care groups as part of their governance structures.
- The Integrated Performance Report covers substantial quality and performance information and is reported to the Board and EMT. This is supplemented by detailed reports on specific elements of quality, such as incidents, complaints, and patient experience.
- The Quality and Safety Committee oversee the development of the Quality Report and associated detailed reports.
- Corporate leadership of data quality through the Director of Finance, Estates and Resources, supported by the Chief Nurse / Director of Quality and Professions.

- Data quality objectives that are linked to business objectives, supported by the Trust's Data Quality Policy, and evidenced through the Trust's Information Assurance Framework.
- The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, mandatory training for information governance and training for the Trust's clinical information systems.
- The Chief Nurse / Director of Quality and Professions (Caldicott Guardian) and Director of Finance, Estates and Resources (SIRO) co-chair the Trust wide Improving Clinical Information and Information Governance (ICIG) meeting. The group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation.
- The effectiveness of the Trust's governance structure, arrangements and reporting are scrutinised by the Audit and Clinical Governance and Clinical Safety Committees.

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

- Good clinical record keeping is part of good clinical practice and provision of quality care to the people who use our services.
- There is comprehensive guidance for staff on data quality, collection, recording, analysis, and reporting which meets the requirements of national standards, translating corporate commitment into consistent practice, through the Data Quality Policy and associated information management and technology policies.
- There are performance and information procedures for all internal and external reporting. Mechanisms are in place to monitor compliance against the data protection and security toolkit with an annual audit report submitted to the Audit Committee.
- Management of specific

Systems and processes

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

People and skills

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

Data use and reporting

- Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through the Executive Management Team meeting and Trust Board, with key performance indicators set at both service and Board level. This includes identification of any issues in relation to data collection, quality and reporting of data with focussed action to address such issues. Work has continued in 2023/24 and included the completion of a Trust wide waiting list project to ensure waiting lists are fully captured, reviewed and appropriately managed. In addition, dedicated "making data count" resources have been put in place to support data completeness, accuracy and analysis to inform decision making.

The Trust is committed to continual improvement in the quality of its data in order to support improvement of the service it offers to users of its services and to address health inequalities.

Regular reviews of the quality of the Trust's clinical data are undertaken by the ICIG and, where data quality standards are identified as a risk factor, these are reported to the Trust's Senior Information Risk Owner (SIRO) for further investigation.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee [and risk/ clinical governance/ quality committee, if appropriate] and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

The Trust has a values-based appraisal system for staff and also uses values-based recruitment and selection. During 2023/24, we continued to embed and streamline our electronic appraisal platform, helping to facilitate meaningful conversations. 3,307 staff had received an appraisal within the last twelve months as at 31 March 2024. This is 84.2% of the 3,926 staff eligible for appraisal as at 31 March 2024.

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

During 2023/24 governors have continued to be invited to gain further insight into the role and contribution of Non-Executive Directors by observing Board committee meetings. All Board Committees are chaired by a Non-Executive Director and include other Non-Executive Directors as members.

The Audit Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and has done so as part of its annual work programme. This was reported through its Annual Report to the Board. The Audit Committee was able to provide assurance that, in terms of the effectiveness and integration of risk committees, risk was effectively managed and mitigated. Assurance was provided that committees met the

requirements of their terms of reference, that committee work programmes were aligned to the risks and objectives of the organisation, in the scope of their remit, and that committees could demonstrate added value to the organisation. Areas of development identified in the last Audit Committee annual report have been acted upon.

The Head of Internal Audit's overall opinion for 2023/24 provided '**significant assurance**' that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The role of internal audit at the Trust is to provide an independent and objective opinion to the Trust, its managers, and Trust Board on the system of control. It provides a Head of Internal Audit opinion each year. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The internal audit function within the Trust for 2023/24 was provided by 360Assurance.

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

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

Action plans are developed for all internal audit reports in response to the recommendations and the Audit Committee invites the lead Director for each 'limited' or 'no assurance' report to attend to provide assurance on actions taken to implement recommendations. For all 'limited' and 'no assurance' reports, a follow up audit is undertaken within twelve months. Completion of recommended actions is tracked by the Audit Committee and over the course of the year 86% of actions were completed within the original time frame specified and 94% of all recommendations have been completed.

Conclusion

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

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

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

Mark Brooks
Chief Executive Date: x

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 9.4

Private/Public paper:	**Public**		
Title:	**Update on Quality Account 2023/24**		
Paper presented by:	**Darryl Thompson, Chief Nurse / Director of Quality and Professions**		
Paper prepared by:	Sarah Whiterod – Associate Director of Nursing, Quality and Professions		
Mission/values:	The report demonstrates the Trust's commitment to all the Trust's values, which are fundamental to delivering safe and high quality health care: • 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 provide the Board with an update on the progress of the development of the Trust's Quality Account 2023/24, which is due for publication by 30 June 2024.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	1.3 Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve 2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents. 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		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Each provider trust within an Integrated Care System is governed by regulatory bodies, and production of a Quality Account is a formal requirement of each trust. It is important that regulatory activity is monitored, learning is taken from feedback and action is taken to remedy any findings. Quality of care is a key priority for our Integrated Care Boards and the information provided in the Quality Account supports and describes the delivery of quality care.		

Any background papers / previously considered by:	The Executive Management Team (EMT) and the Quality and Safety Committee (QSC) have previously received updates on the development and completion of the Quality Account for 2023/24.
Executive summary:	Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum. The Trust's Quality Account is expected to be published for the previous financial year by 30 June. The Quality Account is produced annually and in line with the guidance from NHS England, focuses on the quality of services by looking at: • Patient safety • Clinical effectiveness • Patient experience A description of future areas for improvement and achievements against previous year's quality priorities is included in part 2 of the Quality Account. Part 3 covers a review of quality performance and can also looks back at historic performance to highlight trends. Examples will be included as required in line with the three bullet points above. The Trust's Quality Account for 2023/24 is near to completion, and a timeline is included in this report. As part of this, the draft will be reviewed by Quality and Safety Committee members on 14 May prior to external consultation. The final draft will be reviewed by Quality and Safety Committee members on 18 June 2024, prior to recommendation for approval by the Chief Executive and Chair. There are no challenges expected with regards to our ability to meet the expectations of the timeline in this report. The Quality Account will meet statutory requirements set out by NHS England, will provide a view of quality across the Trust for 2023/24 and will be ready for publication on the Trust website as required by 30 June 2024.
Recommendation:	**Trust Board is asked to:** • **APPROVE** the request for delegated authority to the Chief Executive and Chair to approve the final version of the Quality Account in line with the timeline of completion described in the report.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 9.5

Private/Public paper:	**Public**		
Title:	**Independent Review of Greater Manchester Mental Health NHS Foundation Trust**		
Paper presented by:	**Darryl Thompson, Chief Nurse / Director of Quality and Professions**		
Paper prepared by:	Darryl Thompson, Chief Nurse / Director of Quality and Professions Prof Subha Thiyagesh, Chief Medical Officer		
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 aim to improve and be outstanding We are relevant for today and ready for tomorrow		
Purpose:	The purpose of the paper is to present a summary of this independent review of Greater Manchester Mental Health NHS Foundation Trust, to highlight areas of learning identified in the report, and to describe how the findings will be incorporated into the Trust's own improvement work.		
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 2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents. 2.4 Failure to take measures to identify and address discrimination across the Trust may result in poor patient care and poor staff experience. 4.1 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		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	All NHS providers of mental health care will be capturing learning from this independent review, in line with the national work around improving the culture of care across in-patient services. This will contribute directly to the Trust's contribution to mental health care across both integrated care systems.		

Any background papers / previously considered by:	This paper was reviewed in detail at the Quality and Safety Committee on 9 April 2024.
Executive summary:	In September 2022, the BBC programme Panorama showed appalling levels of abuse, humiliation and bullying of patients at the Edenfield Centre in Prestwich, part of Greater Manchester Mental Health NHS Foundation Trust (GMMH). In response, NHS England commissioned an independent review to understand what took place, how and why. Review findings covered areas of learning for GMMH Trust including: • The Trust was not sufficiently focused on understanding the experience of patients, families and carers. • Some patients and families described not being believed when they raised concerns or complained about the care received. • Senior staff told reviewers on various occasions that there was a clear expectation that reports for Board and committees were made 'palatable' and that positive news was underlined. • Qualified staff were regularly holding keys for up to three medium secure wards both during the day and at night. • The reviewers noted that a lack of equality experienced by minority ethnic staff. • There was a culture where staff were not encouraged to speak up. • The executive team did not work well together, most notably between operational services and clinical leaders. • The review team found that the Board focused more on matters such as expansion, reputation and meeting operational targets rather than the quality of care provided. Eleven recommendations were made, and these are included as an appendix. **Next steps** The recommendations from this report will be reviewed against the Trust's existing improvement plans to ensure all opportunities for learning are captured and acted upon. The findings of the report will also be triangulated with the feedback from the strategy refresh, together with the findings of other reports such as Reading the Signals; Maternity and Neonatal Services in East Kent (which was presented to Board in November 2022). Improvement work going forward will be aligned with the recently commenced Trust involvement in the NHS England Culture of Care Programme, where we are undertaking focused improvement work on three mental health inpatient wards and one forensic mental health ward. Progress will be reported through to the Trust-wide clinical governance group, executive management team and the Quality and Safety Committee.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** the content of this report.

Independent Review of
Greater Manchester Mental Health NHS Foundation Trust

This paper is presented as a summary of this independent review. In September 2022, the BBC broadcast the current affairs programme Panorama. The programme showed appalling levels of abuse, humiliation and bullying of patients at the Edenfield Centre in Prestwich, part of Greater Manchester Mental Health NHS Foundation Trust (GMMH). In response, NHS England commissioned an independent review to understand what took place, how and why. The review team were also asked to look at other areas of concern regarding quality of care.

The review was led by Professor Oliver Shanley, a mental health nurse by background who has held various Chief Nurse and Director of Nursing. Professor Shanley appointed a team of experts to support him in his work, consisting of:

- Dr Sarah Markham, visiting researcher at the Institute of Psychiatry, Psychology and Neuroscience, Kings College London.
- Dr Helen Smith, consultant forensic psychiatrist, former Executive Medical Director, and former National Clinical Advisor in mental health to NHS England's Safety directorate team.
- Jonathan Warren, a mental health nurse by background, experienced NHS executive and leader and former National Professional Advisor for mental health nursing for the CQC.

The team were supported by two professional associates and Niche Health and Social Care Consulting, to support, investigate and provide governance expertise.

The primary focus was the Edenfield Centre, however the scope of the review was wider, including the deaths of three children/young people whilst in the care of GMMH trust, and wider concerns about governance. Over 400 people were spoken to, both internal and external to GMMH trust. A SEIPS (system engineering imitative for patient safety) framework for understanding outcomes within complex socio-technical systems (NHS England 2022) was applied. The review was published in January 2024 and is available here.

Review Findings

1. Voice of patients, families, and carers

The reviewers found a Trust that was not sufficiently focused on understanding the experience of patients, families and carers. At all levels of the organisation, the reviewers struggled to see how the patient experience had been embedded into structures and processes. Families told the reviewers that they felt they were not always listened to or able to communicate with either loved ones or key staff members, all adding to a sense they lacked a voice. It was noted that there was limited patient-staff co-produced care planning, risk assessment and risk management plans.

Throughout their work, the reviewers tried to describe what the reality of care is like, versus care 'as imagined' by the Trust. Some patients and families described not being believed when they raised concerns or complained about the care received. Reviewers were told that service users and carers sometimes experienced unkindness, a lack of compassion and respect, and abuse by staff. Others shared how they did not always feel safe to disclose concerns, with many accounts of feeling intimidated, undermined, ignored, or fearful that 'bad news' was not welcomed.

There was a lack of clarity and accountability throughout all the complaints process including an overly complicated tiering system. Of 144 complaints made about Edenfield, only 10% were upheld.

2. Governance, culture and leadership

It was clear to the reviewers that the governance system in both the local services and Trust-wide was unable to triangulate data such as complaints, concerns, or incidents of violence and aggression. Senior staff told reviewers on various occasions that there was a clear expectation that reports for Board and committees were made 'palatable' and that positive news was underlined. The review team found that the Board focused more on matters such as expansion, reputation and meeting operational targets rather than the quality of care provided. Clinical leadership was seen to have been undervalued in GMMH Trust historically.

The reviewers found that there were repeated missed opportunities to act on concerns raised at Edenfield. This included, for example, National Staff Survey results, information relating to levels of restrictive practice, a cultural audit in 2019 which raised concerns, staff vacancies, the instability of ward management and high consultant turnover. The hallmarks of a closed culture, including an absence of psychological safety, incivility between staff, poor leadership, and a lack of teamworking was noted, together with the expansion of GMMH Trust not seeing a corresponding investment in quality oversight. Reviewers noted repeated stories of senior managers treating staff poorly and fostering a culture of fear and intimidation in order to maintain performance standards. Staff throughout the organisation and at all levels gave reviewers examples of how the clinical voice and quality of care suffered directly as a result of this. Also, system partners in Greater Manchester have, at times, relied on the opinion of the Care Quality Commission (CQC) without corroborating this with their own opinion, based on strong quality governance processes. There were 102 allegations of violence by staff, but the number of safeguarding referrals to the local authority was seen as being negligible.

3. Workforce

The workforce information the GMMH Board received was insufficient and there was not a clear strategy to address either the recruitment or retention of staff. Safe staffing reports to the GMMH Board were vague, with an overly optimistic tone, and often contained information which did not reflect the reality on the wards. Qualified staff were regularly holding keys for up to three medium secure wards both during the day and at night. The reviewers found that management information (whether in the form of incident reporting, quality metrics or GMMH Board/committee reporting) had been opaque. Doctors told reviewers about long-standing issues about the reporting of nurse staffing numbers to the Board and Specialised Commissioning, with doctors concerned that the numbers being reported did not fit with their everyday experience of the ward environment.

The reviewers found newly qualified nurses taking on leadership roles that they were ill equipped to deal with, often with little practical support or supervision. They also heard of high levels of turnover across all disciplines, but especially among consultant psychiatrists. Staff recruitment processes were frequently described as lacking openness and transparency, and the reviewers noted that a lack of equality experienced by minority ethnic staff all contribute to deficiencies in the inclusive behaviours that support the safest cultures.

4. Raising concerns and complaints

The reviewers experienced a culture where staff were not encouraged to speak up, and indeed described it as “career suicide” to do so, with many staff described feeling disconnected from the Trust leadership. The GMMH Board appeared to receive performance data in the form of run charts, but reviewers did not see that themes, trends, learning, or actions undertaken by the GMMH Trust were shared in relation to complaints received, and central oversight of safeguarding data was lacking.

Every consultant reported difficulties to reviewers in getting their voice heard about the issues they were experiencing, or indeed about the potential solutions they were proposing. The reviewers were told that the opinions of doctors, nurses and other professionals simply had not been heard or valued in GMMH Trust.

5. GMMH Board

GMMH Board, while having many competing objectives, were seen to have focused more on matters such as expansion, reputation and meeting operational targets rather than the quality of care provided. This led to insufficient oversight of the quality of care, with the Trust relying disproportionately on the periodic opinions of external regulators, rather than forming its own views based on strong governance. The reviewers found that there was insufficient curiosity about the ongoing patient and staff experience across the Trust. The lack of both curiosity and focus on improvement led to missed opportunities for organisational learning across a number of services.

Both groups of board members and executive team members were concerned about their reputation, and this had impacted on the transparency of what was shared both internally and externally. The executive team did not work well together, most notably between operational services and clinical leaders. Concerns regarding the effectiveness of the working relationship between the Chief Operating Officer, the Chief Nurse and the Medical Director were noted. The reviewers saw little evidence that this was effectively addressed, and this dynamic was reflected in multi-professional relationships in various other parts of the organisation.

The reviewers found some commonalities in the Trust's management of significant concerns being raised to them. These included:

- A slow pace of change – Some of these issues were very long-standing, had been known about for a long time and yet improvements were difficult to identify.
- A lack of transparency and/or clarity in reporting. Reviewers found that management information (whether in the form of incident reporting, quality metrics or board/committee reporting) had been opaque.
- A lack of scrutiny of key information – reviewers found a need for more effective scrutiny of information presented to key forums (including sharing this with clinicians at an early stage), and a clearer and more coherent response from management and executives to challenge posed by non-executive directors. The reviewers noted that openness and transparency are critical conditions if GMMH Trust is to create a culture conducive to improvement and learning.
- A lack of rigour in the monitoring of change since the review.

6. Recommendations

Eleven recommendations were made by the reviewers. Full detail of the recommendations can be found in Appendix 1.

7. Summary of the main contributors to the findings at Edenfield

The reviewers summarised that patients, their families and/or carers were not being listened to or taken seriously. There was a poor culture, including a lack of psychological safety and low morale, unsupportive leadership behaviours, unsound human resource practices, perceived unfair recruitment and promotion, and a lack of transparency about formal investigations. Some staff described being treated unfairly because of a protected characteristic, and some staff reported not being supported to acquire the skills, training and knowledge to carry out their role.

There was a weak and fragmented clinical voice, and conditions that led staff to not adhere to clinical policies such as record keeping and observations. There were unsafe levels of staffing, a high use of temporary staff and a poor physical environment. There were also poor governance practices. The reviewers noted a level of distress in many GMMH Trust staff, and reported that most of the staff they spoke to appeared committed to delivering compassionate care to those who needed their services.

8. Next steps for this Trust

South West Yorkshire Partnership NHS Foundation Trust have already signed to participate in the NHS England Culture of Care Standards for Mental Health Inpatient Services. There is also work underway as part of the Trust's mental health inpatients improvement programme, and the improvement work in both forensic and mental health inpatient services in response to the recent CQC actions. The recommendations from this report will be reviewed against the Trust's existing improvement plans to ensure all opportunities for learning are captured. This progress will be fed back to the executive management team and the Quality and Safety Committee.

Darryl Thompson, Chief Nurse / Director of Quality and Professions
Prof Subha Thiyagesh, Chief Medical Officer

Appendix 1

Recommendation 1: The Trust must ensure that patient, family and carer voices are heard at every level of the organisation. The Trust must respond quickly when people experience difficulties with the services they receive and make lived experience voices central to the design, delivery and governance of its services. They have developed a strategy in this area, which now needs to be implemented and evaluated to understand its impact.

Recommendation 2: A strong clinical voice must be developed and then heard and championed from Board to floor, and in wider system meetings.

Recommendation 3: The Board must develop and lead a culture that places quality of care as its utmost priority, which is underpinned by compassionate leadership from Board to floor. This culture must ensure that no staff experience discrimination.

Recommendation 4: The Trust must work with its current and future workforce levels to recognise, adapt to and manage the safety challenges that a staffing shortfall may pose, including ensuring the stability of nursing staff. The Trust must develop a representative, competent and culturally sensitive workforce which is supported to provide services that meet the needs of its communities.

Recommendation 5: The Trust needs to have a better understanding of the quality of its estate and the impact of this on the delivery of high-quality care, including providing a safe environment. It must ensure that essential maintenance is identified and carried out in a timely manner and that the cleanliness of units is maintained.

Recommendation 6: The Trust must ensure that its governance structure (and the culture that this is applied within) supports timely escalation and that the right information can be used at the right level, by the right staff. There must be much greater focus on the validation and triangulation of information to ensure that quality issues can be resolved quickly and learning can take place.

Recommendation 7: The Trust must ensure that Edenfield provides compassionate, high-quality care and that all staff, permanent or temporary, have the skills, knowledge, and support to achieve this.

Recommendation 8: The Trust should review the improvement plan again following receipt of this report's findings to develop further clarity about the problems that they are trying to solve and the actions that need to be taken to achieve better outcomes. It needs to be clear on how all actions will be evaluated so that it can be assured about whether changes being made are having the desired impact. The plan should be prioritised to ensure that actions are sequenced, build on each other, and prioritise the quality of care people receive from GMMH. This includes ensuring a balanced approach between the scale of the improvements required and setting out a realistic timescale for implementing identified actions with the support of their system partners.

Recommendation 9: Reviewers identified some common concerns across services they visited at the Trust, which were also prevalent within Edenfield. The Trust and the wider system must consider how they understand issues identified in these services (and others) in more detail, including through the actions described below.

Recommendation 10: The organisations with responsibility for regulation, oversight and support to GMMH must review their current systems of quality assurance. They must also review how they work together collectively to identify concerns in a provider at an early stage to prevent tragedies like those seen at Edenfield from reoccurring. Where learning is identified that applies nationally, this must be cascaded by the relevant organisation.

Recommendation 11: NHS England must review and clarify the role of the Greater Manchester Adult Secure (Northwest) provider collaborative and the governance structures needed to oversee this role. The responsibilities of the collaborative need to be discharged by staff with the right experience and expertise. In light of the concerns identified in this

report in relation to Adult Forensic Services (and wider issues in the Trust's Specialist Services), the role of GMMH as lead provider needs to be reviewed by NHS England. If this arrangement is to continue, support should be provided to GMMH to stabilise the current situation and to develop it to deliver the role effectively in the future.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 9.6

Private/Public paper:	**Public**		
Title:	**Learning Disabilities Mortality Review (LeDeR)**		
Paper presented by:	**Darryl Thompson, Chief Nurse / Director of Quality and Professions**		
Paper prepared by:	Emma Cox (associate director of nursing, quality and professions) Fareena Rasaq (service manager – learning disability services) Dr Sarah Talari (consultant psychiatrist - Medical Clinical Lead for Learning Disability Services)		
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 aim to improve and be outstanding. We are relevant for today and ready for tomorrow.		
Purpose:	The purpose of the paper is to provide Trust Board members with an overview of the national LeDeR report on the lives and deaths of people with a learning disability and autistic people, and the Trust's oversight and response to deaths of people with a learning disability and autistic people who are accessing Trust services.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources		
	Make this a great place to work		
BAF Risk(s):	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. 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	All NHS providers have a responsibility for addressing the health inequalities and improving life expectancy of this population. Monitoring our own response to the LeDeR report to ensure learning and the sharing of learning helps to reduce risk. Improvements to life expectancy of people with a learning disability and addressing health in equalities are key objectives for both the West and South Yorkshire integrated care systems.		
Any background papers / previously considered by:	This paper was reviewed in detail at the Quality and Safety Committee on 9 April 2024. LeDeR is also included within the quarterly and annual Trust-wide incident management reports.		

Executive summary:	The LeDeR programme, funded by NHS England and NHS Improvement, was established in 2017 to improve healthcare for people with a learning disability and autistic people. LeDeR aims to: • Improve care for people with a learning disability and autistic people. • Reduce health inequalities for people with a learning disability and autistic people. • Prevent people with a learning disability and autistic people from early deaths. LeDeR reviewed deaths of people with a learning disability from all seven regions of England. The data from the 2022 national report is summarised in this paper. The LeDeR 'action from learning' report that is also referred to in this report includes examples of the vital work underway across the NHS and partners, driven by self-advocates and self-advocacy groups, parents / carers, the charitable and voluntary sectors, and colleagues in social care. Areas of local improvement work are noted, including: • Accessible written information • Local review of any deaths of people with a learning disability or autistic people • Working in partnership with primary care to increase the uptake of physical health checks. Despite improvements on previous years, in the reporting period 42% of all the reported deaths of people with a learning disability were avoidable, in that they were caused by conditions that can be mainly avoided through effective prevention or treatment (of note, 62.9 years old was the median age at death for people with a learning disability in 2022. This is an increase from 2018, where the median age at death was 61.8 years. Overall life expectancy at birth in the UK in 2020 to 2022 was 78.6 years for males and 82.6 years for females). The Oliver McGowan mandatory training in learning disability and autism is rolling out across England in line with how it is being rolled out across the Trust, as all regulated service providers must now ensure their staff receive learning disability and autism training appropriate to their role. Learning from LeDeR reviews features in this training. Discussion in the Quality and Safety Committee focused on the relatively recent introduction of autism in the national report and the importance of this having equal focus, in particular the higher potential suicide risk for autistic people. This will be considered further in future Trust reports. Trust Board members can take assurance that the report shows the Trust's engagement with the LeDeR process, both with regards to our oversight and reporting of deaths of people with a learning disability and autistic people who are receiving care from the Trust, and also in the structures that we have in place to ensure that learning is shared.
Recommendation:	**Trust Board members are asked to:** • **RECEIVE** this report.

Learning Disabilities Mortality Review (LeDeR)

1. Introduction to LeDeR

The LeDeR programme, funded by NHS England and NHS Improvement, was established in 2017 to improve healthcare for people with a learning disability and autistic people. LeDeR aims to:

- Improve care for people with a learning disability and autistic people.
- Reduce health inequalities for people with a learning disability and autistic people.
- Prevent people with a learning disability and autistic people from early deaths.

LeDeR summarises the lives and deaths of people with a learning disability and autistic people who died in England in annual reports. The 2021 and 2022 reports are written by researchers at King's College London collaborating with academic partners at the University of Central Lancashire and Kingston University London. Everyone with a learning disability (aged four and over) who dies and every adult (aged 18 and over) with a diagnosis of autism is eligible for a LeDeR review. The 2022 annual LeDeR report (published in November 2023) is available on the Kings College website.

2. The LeDeR Review Process

The Trust reports every death of a person with a learning disability and / or autism to the national LeDeR programme. A trained LeDeR reviewer gathers details on the person's death and starts the review process, with a target for this to be completed within six months. For some reviews, this will lead to a more comprehensive focused review, looking very closely at the person's life and circumstances of their death. These focused reviews, once completed, are then sent to local governance groups with areas of good practice, areas of concern, and wider learning from the case being outlined. The process is outlined in detail on the website.

Families often know the most about the care the person who died received. In sharing their experience of services this will support learning, influence improvements to quality of care and other areas for improvement making things better for other people. Families will be informed when a review is undertaken and will be invited to contribute information about the person who died and provided with the option of receiving a redacted copy of the completed review. Of note, LeDeR does not include the reviews of deaths of children, as these are completed as part of the child death overview panel process (CDOP).

The LeDeR programme also works alongside the many different review processes for people who die, for example:

- Child death overview panel (CDOP)*
- Safeguarding adults' review (SARs)
- Review of deaths of people in hospitals, Serious Incidents, Structured Judgement Reviews and internal mortality reviews.
- Coroners/inquest
- Police Investigations
- Death in Custody Reviews

3. Key facts from the 2022 LeDeR annual report:

This report used data from 2,084 reviews of deaths that occurred in 2022:

- LeDeR reviewed deaths of people with a learning disability from all seven regions of England.
- 1,586 of these were completed as initial reviews and 498 were focused reviews.
- 8% of reviews were of people from ethnic minority backgrounds.
- 55% of people with a learning disability who died in 2022 were male.
- 62.9% years old was the median age of death for people with a learning disability in 2022
- 94% of people with a learning disability who died in 2022 were denoted as white
- 43% who died were denoted as Christian.
- 25% of people with a learning disability who died in 2022 lived in the most deprived neighbourhoods by decile, compared to 10% in the least deprived
- 74% of people who died in 2022 had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) in place at the time of death.
- 25% of deaths were referred to a coroner.
- The five most common causes of death were defined as:
    - Circulatory (16.7%)
    - Cancers 14.6%
    - Respiratory system (14.5%)
    - Nervous system (13.6%)
    - Congenital malformations and chromosomal abnormalities (13.3%)
    - Other causes of death (27.3%)

Congenital malformation, deformations and chromosomal abnormalities were the first leading (underlying) cause of death for people with a learning disability in almost every English region in 2022. The leading circulatory cause of death for 2022 was ischaemic heart diseases, at 35.3%. The leading respiratory cause of death in 2022 was influenza and pneumonia, which caused 37% of the deaths from respiratory diseases. The second most common respiratory cause of death in 2022 was COVID-19, which caused 28% of respiratory deaths.

4. LeDeR Action from Learning

The LeDeR 'action from learning' report (available here) includes examples of the vital work underway across the NHS and our partners, driven by self-advocates and self-advocacy groups, parents / carers, the charitable and voluntary sectors, and our colleagues in social care. None of these efforts would be possible without family members, health, and social care staff and many others contributing to a LeDeR review by sharing their experience of the life and death of a loved one or someone in their care. Some examples that the Trust are involved in include producing easy read documentation to support service users and carers to detect earlier signs of respiratory, constipation, swallowing concerns to improve awareness of the health inequalities that could lead to avoidable deaths.

5. Summary of recommendations from the annual LeDeR report for the year ahead:

- The findings of the LeDeR Annual Report state that, despite improvements on previous years, in the reporting period, 42% of all the reported deaths of people with a learning

disability were avoidable, that is they were caused by conditions that can be mainly avoided through effective prevention or treatment.

- In the last 18 months there have been significant changes in the NHS to drive improvements to services including services for people with a learning disability and autistic people. Integrated Care Systems (ICSs) in England are now fully operational and are joining up health and care services to improve lives locally.
- Good training and support for health and care staff is also crucial in reducing health inequalities. The Oliver McGowan mandatory training in learning disability and autism is rolling out across England in line with how it is being rolled out across the Trust, as all regulated service providers must now ensure their staff receive learning disability and autism training appropriate to their role. Learning from LeDeR reviews features in this training.
- Annual health checks play an important role in reducing health inequalities and premature mortality.
- National guidance on aspiration pneumonia and community acquired pneumonia has been developed to improve the care of people with a learning disability who are at risk of pneumonia and a national constipation campaign is raising awareness of the risks that constipation can pose.

6. Examples of improvements being made locally:

- Local LeDeR reviews have now changed with Bradford being our independent reviewers for Calderdale, Kirklees and Wakefield and Sheffield for Barnsley.
- The learning disability service is already working with integrated care board colleagues across the footprint to deliver a range of non-duplicated written accessible information. We aim to strengthen/widen this work further across the Trust with support from our Comms colleagues.
- We have now established an internal Learning Disability Service learning group, made up of team managers and strategic health facilitators (learning disability nurses in a specialist role to improve health outcomes). This is still in its infancy but intended to:
    - Ensure strategic health facilitators carry out 48hr reviews for any reported death of a person with a learning disability, to ensure independence in reviews.
    - Consider and share any themes, e.g. ethnicity, deprivation etc. to further enhance our learning.
    - Where there has been a death of a person who has been open on our caseloads, an additional internal review will be carried out and any learning shared.
- Create and disseminate a periodic briefing paper of learning from national and local LeDeR reports and other interventions, along with any actions or changes that need to be made locally, across the learning disability services and Trust-wide.
- Work closely with primary care to increase the uptake of annual health checks and different types of cancer screens.

Other areas of improvement work include:

- Focusing on improving care and treatment and raising awareness of reasonable adjustments, diagnostic overshadowing and high levels of health inequality experienced by people with a learning disability and or autism.
- Introducing the Vulnerable in-patient (VIP) red bag project in Wakefield to improve health outcomes through sharing information.

- Bringing together health, community, leisure, and other services to encourage people with a learning disability to be more active and adopt healthier lifestyle choices to help reduce obesity and lower cholesterol.
- Attending community and health events to promote health, spread key messages and signpost to other services where needed.
- Working with advocacy groups to discuss health inequalities and share ideas to bring about change.
- Delivering dysphagia training within care homes and day services within Kirklees.
- Producing a guidance update on learning from lives and deaths of people with a learning disability and autistic people within West Yorkshire. This was shared in the Trust headlines November 2023 (see Appendix 1).
- Delivering a session on respiratory care at the West Yorkshire LeDeR event in December 2023 'Living in the community with a complex respiratory condition'.

A LeDeR quarterly update is now provided to LeDeR Place leads for cascading at Place. The report is shared with all learning disability staff and discussed at the learning disability service line meeting to formulate a view and share wider learning.

7. Action plan for South West Yorkshire Partnership NHS Foundation Trust:

Action	Owner	RAG rating
To establish strategic health facilitators across all four localities.	Service Manager	
To establish partnership working and pathways across all four localities to ensure annual health checks are completed.	Service Manager	
To work collaboratively with the Trust psychiatry services to ensure timely intervention and high quality care.	Medical Clinical Lead	
To recruit into vacant posts	Service Manager	
To continue the STOMP STAMP agenda	LD services and Childrens services	
To review case load activity	Service Manager	
To establish learning disability champions across adult mental health/ forensic inpatient and Trust corporate services	Service Manager / Medical Clinical Lead / Associate Director of Nursing, Quality and Professions	
To review clinical pathways	Learning Disability Trio	
To roll out Oliver McGowan Tier 1 training across the LD workforce and the wider Trust	Associate Director of Nursing, Quality and Professions / Service Manager	
LD teams to provide additional training bespoke to an individual's needs across mental health services	Service Manager	
To continue the Greenlight toolkit work, including advise around care plans, reasonable adjustments and specialist knowledge	Service Manager / Medical Clinical Lead / Associate Director of	

	Nursing, Quality and Professions	
To establish an out of hours service to work alongside the Trust Intensive Home Based Treatment teams.	Service Manager	
To continue to report every death on Datix	All Learning Disability services	
To continue the mortality work (internally and regionally)	Learning Disability Services and Patient Safety Support Team	
To undertake a thematic review of the death of people who are known to our service or used our services within the last six months	Learning Disability Service Learning Group	
To continue to support primary care and acute care colleagues to reduce health inequalities for this population.	All Learning Disability services/ Strategic Health Facilitators	
To adhere to NICE CG191 Pneumonia in adults: diagnosis and management NICE Guidance inclusive of prevention, diagnosis, and management of aspiration pneumonia. Including increasing awareness of aspiration pneumonia and pneumonia.	All Learning Disability services	
Access to respiratory physiotherapists employed across all areas.	All Learning Disability services	
Continued attendance at the learning disability steering group within the South and West Yorkshire Integrated Care System.	Learning Disability Trio	
To share the LeDeR quarterly updates through the service line meeting and the Trust mortality meeting.	Service Manager	
To continue link into any development work that is available to providers to support our learning from LeDeR.	Strategic Health Facilitators	
To support services user to access the VIP passport or Red Bag	All Learning Disability services	
To ensure that the workforce are utilising the LD/ Reasonable adjustment flag on SystmOne This is amber, they aren't up and running in primary care and consistently used across all our acute services. Also, there are some technical things we need to work through as not all our GPs are on SystmOne. This is a partnership piece of work we are progressing so not just our responsibility	Learning Disability local partnership	

8. Summary

The report shows the Trust's engagement with the LeDeR process, both with regards to our oversight and reporting of deaths of people with a learning disability and autistic people who are receiving care from the Trust, but also in the structures that we have in place to ensure that learning is shared. The report also describes some of the work undertaken within the last year to address health inequalities and improve access and service provision for people with a learning disability or autism within the Trust, as part of the Trust's commitment to reducing the risk of an earlier death for people with a learning disability. It highlights strong working relationships and the findings from the LedER report will continue to support the facilitation of collaborative working.

Authors
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South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 9.7

Private/Public paper:	**Public**		
Title:	Autism / autism spectrum disorder (ASD) service – invited review by the Royal College of Psychiatrists in November and December 2022.		
Paper presented by:	**Professor Subha Thiyagesh, Chief Medical Officer**		
Paper prepared by:	Professor Marios Adamou, Consultant Psychiatrist		
Mission/values:	• We are respectful, honest, open and transparent • We put the person first and, in the centre, • We improve and aim to be outstanding		
Purpose:	There are two papers for this agenda item. The first paper is a summary report of the main points of learning, the actions already undertaken and the actions still in plan. The second paper is the full invited service review report from the Royal College of Psychiatrists. Both of these reports are presented to committee as an update with regards to the invited review.		
Strategic objectives:	Improve Health	✓	Please remove as appropriate
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):	1.3 Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve 1.4 Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy. 2.2 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	**West Yorkshire ICB:** • Autism is a priority area for improvement within the current 5-year ambitions • Accurate diagnosis of autism will enable appropriate reasonable adjustments to be put in place in broader healthcare services • Accurate diagnosis of autism will support access to appropriate services, including the promotion of annual physical health checks for autistic people **South Yorkshire ICB:** • Accurate diagnosis of autism will support the planned redesign of services for people with learning disabilities and autism including diagnostic pathways.		

	• Accurate diagnosis of autism will support the plan to reduce reliance on inpatient care, for those with a learning disability and/or autism.
Any background papers / previously considered by:	This review has previously been referred to within the Care Group Quality and Safety Reports with regular updates provided. January 2024 Quality and Safety Committee
Executive summary:	In July 2021, a request was made to the Royal College of Psychiatrists' Invited Review Service for a meeting to discuss a review of the autism pathway within the adult ADHD and Autism service. This invitation was in response to: • Disagreements over referral acceptance thresholds, with some referrals possibly being rejected based on historical data or perceived insufficient evidence. • Issues related to the rate of autism diagnoses. • Concerns about changes in autism diagnoses, including cases where diagnoses were removed, and the criteria and comprehensiveness of information used in these decisions. • Perceived difficulties in communication and engagement with local system colleagues, including third sector organisations, during autism assessments and in gathering broader stakeholder feedback. • A lack of recognition of the potential co-occurrence of mental health problems with autism. The request acknowledged that addressing these concerns internally was challenging due to the specialist nature of the service. Therefore, external expertise and an objective review was sought to appropriately respond to these issues and identify areas for improvement. The review included the following approaches: • A Structured Judgment Review of 33 Clinical Records • Interviews with a range of stakeholders including Trust staff from other services, service users, autism advocacy group and other relevant parties • A review of service documentation • Triangulation of data sources The review fed back evidence of good practice, conclusions with regards to 12 areas of consideration for improvement and four recommendations, each with sub-sections. **Evidence of good practice:** • The clinical reviewers were able to identify several individual examples of good clinical practice from the records. • The autism service team was described by an interviewee as well-staffed and very cohesive, with a low staff turnover, and good service performance. **Areas identified for improvement:** • Communication with patients needs strengthening. • Referrals require a different emphasis. • The referral acceptance rate is probably lower than average. • The existing triage process is problematic.

	• Screening is more an initial clinical assessment. • Clinical assessment requires a stronger focus on formulation. • The interpretation of the diagnostic criteria is too narrow. • Reassessment of autism has ceased. • A lack of post diagnostic support. • Better partnerships needed with other clinical teams. • More coherent clinical record keeping. • Audit to better understand quality and performance. **Recommendations:** • The autism service must strengthen its communication and engagement with people referred to the service along the whole pathway • The autism service should review the whole autism pathway, from referral to post-assessment support, to clarify how one stage relates to the next, avoid duplication, and facilitate efficient use of time for both practitioners and patients. • The autism service should revise its approach to autism diagnosis. • The autism service should strengthen clinical record keeping **Summary:** The autism / autism spectrum disorder (ASD) service engaged positively throughout the invited review process and provided appropriate feedback in relation to the report. The invited review has highlighted opportunities to reflect, learn and amend practice within the autism service, particularly with regards to diagnostic threshold, communicating with people who access or are referred to the service, working alongside other clinical teams, and reviewing pathway and documentation processes. Some actions are already complete. Progress against the more detailed remaining action plan, including appropriate metrics and timescales, is being overseen by the executive trio, reported routinely to the Executive Management Team, and to the Quality and Safety Committee as appropriate. With regards to next steps, the action plan will be updated to ensure actions have clear metrics and timescales. The evidence to provide assurance of completion of actions will be directly reviewed by the executive trio. Progress will be reported through to the Executive Management Team and Committee.
Recommendation:	**Trust Board is asked to:** • **RECEIVE** the invited services review report and • **NOTE** the actions in response to the report as detailed in the accompanying paper.

Autism / autism spectrum disorder (ASD) service – invited review by the Royal College of Psychiatrists in November and December 2022.

Background

In July 2021, a request was made to the Royal College of Psychiatrists' Invited Review Service for a meeting to discuss a review of the autism pathway within the adult ADHD and Autism Service. This invitation was in response to:

- Disagreements over referral acceptance thresholds with some referrals possibly being rejected based on historical data or perceived insufficient evidence.
- Issues related to the rate of autism diagnoses.
- Concerns about changes in autism diagnoses, including cases where diagnoses were removed, and the criteria and comprehensiveness of information used in these decisions.
- Perceived difficulties in communication and engagement with local system colleagues, including third sector organisations, during autism assessments and in gathering broader stakeholder feedback.
- A lack of recognition of the potential co-occurrence of mental health problems with autism.

The request acknowledged that addressing these concerns internally was challenging due to the specialist nature of the service. Therefore, external expertise and an objective review was sought to appropriately respond to these issues and identify areas for improvement. The executive trio of the chief medical officer, chief nurse / director of quality and professions and the chief operating officer informed the clinical lead/general manager and the director of services, who also supported this external review.

The invited review determined the following approaches:

Structured Judgment Review of Clinical Records:

- Selection of Records: A total of 33 clinical case records were selected for review. These records represented a diverse range of categories, including new referrals, cases that were triaged, assessed with or without an autism spectrum disorder (ASD) diagnosis, and others. This diversity aimed to provide a comprehensive view of the service's functioning across different types of cases.
- Independent Review: Each case was independently reviewed by two specialist clinical reviewers. This was done using a structured judgment form, which likely contained criteria and questions designed to assess the quality and appropriateness of the care provided in each case.

Interviews

- Diverse Stakeholders: Interviews were conducted with various stakeholders, including Trust staff, patients, and other relevant parties. The interviews included staff from other services within the Trust, autism advocacy group and service users. This approach aimed to gather insights and perspectives from a wide range of individuals directly or indirectly affected by the autism service.

- Use of Technology: To facilitate broader participation, video conferencing facilities were employed for some of these interviews, allowing stakeholders who could not be physically present to contribute their perspectives.

Document Analysis:

- Review of Service Documentation: Key documents related to the autism service were reviewed by the invited review team. This included operational policies, referral forms, and communication templates, among other relevant documents.
- External Submissions: The review also considered submissions and feedback from external groups, such as the Autism Advocacy Group, which would provide an external viewpoint on the service's operations and impact.

Triangulation:

- Integration of data Sources: The findings from the case reviews, interviews and document analysis were integrated to form a comprehensive understanding of the service's performance.

The review fed back evidence of good practice, conclusions with regards to 12 areas of consideration and 4 recommendations, each with subsections. The findings of review are summarised as follows:

A. Evidence of good practice:

- The clinical reviewers were able to identify several individual examples of good clinical practice from the records.
- One general point that emerged from the case note review was that the assessment process was generally felt to be comprehensive.
- The autism service team was described by an interviewee as well-staffed and very cohesive, with a low staff turnover and good service performance.
- The autism team was said to have been responsive when the COVID-19 pandemic began and altered the pathway such that performance remained the same.
- The team was said to be constantly looking for ways to broaden the service to meet the needs of local communities.

B. Recommendations for improvement:

1. Communication with patients needs strengthening:

- Inadequate communication with patients, particularly regarding the reasons for referral rejection or diagnostic outcomes.
- Reliance on template letters for communicating decisions, which lacked a person-centred approach.
- Instances of parallel consultations without clear coordination, leading to patient confusion.
- The service's diagnostic criteria were considered too narrow, potentially excluding non-classical presentations of autism.
- The diagnostic rate (approximately 30%) was perceived as low compared to other services.
- Concerns over the service's approach to reassessment and potential removal of autism diagnoses.

- Reports of patients feeling disrespected, dismissed, or traumatised by their interactions with the service.
- Instances where patients sought diagnoses elsewhere after being rejected by the service.

2. Referrals require a different emphasis:

- The service should pivot away from an overriding emphasis on diagnosing autism to why has this individual sought referral.
- More proactive engagement with potential referrers would be advisable in enhancing the quality of referrals, by spreading understanding of the type of information needed to support a referral.
- Need for increased training and awareness among GPs and other referrers regarding autism and the referral process.

3. The referral acceptance rate is probably lower than average:

- The review team concluded that there was an element of exclusion happening at the triage stage of the Trust's autism pathway.

4. The existing triage process is problematic:

- The service was perceived by some as searching for reasons to exclude patients from assessment.
- The referral form was considered complex and challenging for GPs to complete within a standard appointment time.
- The triage process was perceived as overly restrictive, with a high rejection rate of referrals.
- Lack of transparency and documentation in the triage decision-making process.
- Potential conflict of interest with commissioners involved in triage decisions (this is no longer applicable, neither GP leads nor commissioners have taken part in triage decisions since February 2020).

5. Screening is more an initial clinical assessment:

- The screening process was seen as too comprehensive, almost duplicating a clinical assessment (of note, from the service's perspective this part of the process is a clinical assessment)
- Overreliance on standardised diagnostic tools, potentially overlooking the broader clinical picture.
- Lack of evidence of formulation in the assessment process, failing to integrate different sources of information holistically.

6. Clinical assessment requires a stronger focus on formulation:

- The review team observed an apparent overreliance on standardised diagnostic tools across the multi-disciplinary team (MDT), which raised questions over whether the diagnostic criteria used were too restrictive.
- The formulation should be person-centred, kind and focused on understanding the person in their context.

7. The interpretation of the diagnostic criteria is too narrow

- There are no nationally agreed benchmarks for referral acceptance rates, which can range from 40% to 90%.
- The diagnostic rate (approximately 30%) was perceived as low compared to other services.
- The service's diagnostic criteria were considered too narrow, potentially excluding non-classical presentations of autism.

8. Reassessment of autism has ceased

- Concerns over the service's approach to reassessment and potential removal of autism diagnoses.
- The service reported having listened to concerns regarding reassessment of people previously diagnosed with autism, which was linked to managing access to the care coordination pathway that had since closed.

9. A lack of post diagnostic support

- Limited post-diagnostic support, particularly in certain areas like Calderdale.
- Lack of a comprehensive follow-up strategy for patients post-diagnosis.

10. Better partnerships needed with other clinical teams

- Perceived poor engagement and communication with other mental health teams within the Trust.
- Reports of a lack of multi-professional, cross-team forums to discuss patient care and service issues.
- Concerns over the service's reputation among patients and other mental health staff.

11. More coherent clinical record keeping

- Inconsistencies and gaps in clinical record keeping, particularly regarding decision-making processes.
- Questions over the effectiveness of the comprehensive risk assessment form used by the service.

12. Audit to better understand quality and performance

- There is a need to better understand how referral acceptance rates and diagnostic thresholds compare with neighbouring services.

C. Recommendations:

1. The autism service must strengthen its communication and engagement with people referred to the service along the whole pathway.
2. The autism service should review the whole autism pathway, from referral to post-assessment support, to clarify how one stage relates to the next, avoid duplication and facilitate efficient use of time for both practitioners and patients.
3. The autism service should revise its approach to autism diagnosis.
4. The autism service should strengthen clinical record keeping.

D. Action taken since the review:

A follow-up meeting was set up by the Executive Trio with the service leads including the director of service to provide feedback from the report. Following this, the service has promptly taken actions to respond to all the areas of suggested improvement. These include:

Referral Process:
The referral form has been simplified and aligned with the template provided by the ICB Guidance. Efforts are ongoing to gain commissioner support for uniform adoption across all localities.

Diagnostic Rates and Criteria:
The service has reviewed its diagnostic criteria, focusing on a holistic, formulation-based approach. Comparison with other services following NICE guidelines and NHS England guidance is underway to ensure alignment with national standards.

Communication and Engagement:
A comprehensive review of service correspondence has been undertaken to ensure compassionate, clear and patient-centred communication. Feedback mechanisms have been enhanced to gauge patient experience at every assessment stage.

Co-morbid Mental Health Issues:
The service has strengthened its clinical assessment approach to include a stronger focus on co-morbid conditions, ensuring a comprehensive understanding of each individual's context.

Post-Diagnostic Support and Follow-Up:
Post-diagnostic support has been expanded where commissioned with ongoing efforts to address commissioning gaps and ensure consistent support across all areas.

Inter-Professional Collaboration:
Enhanced training and cross-team case discussions are in place to foster better understanding and collaboration among mental health teams.

Clinical Record Keeping:
Steps have been taken to strengthen record-keeping, particularly post-MDT discussions, with audits planned to ensure compliance with improved practices.

E. Highlight overview of remaining actions:

Aspect	Invitation Letter Concerns	Invited Service Review Findings	Service Actions
Referral Process	Concerns about thresholds for acceptance of referrals, and the use of historical data or insufficient evidence.	The review found a need for a more inclusive referral process. It noted issues with the existing triage process and the overlap between screening and clinical assessment. The referral acceptance rate was identified as probably lower than average.	Review the entire autism pathway to clarify how stages relate to each other, avoid duplication, and facilitate efficient use of time. Introduce a simpler, more inclusive referral process. Reformulate the triage process to focus on the reasons for referral. Consider implementing a more streamlined screening process.

Aspect	Invitation Letter Concerns	Invited Service Review Findings	Service Actions
Diagnostic Rates	Concerns about diagnostic rates and changes in diagnosis, including non-recognition of previous diagnoses.	The review highlighted a need to revise the approach to diagnosis, emphasising a stronger focus on formulation and considering the thresholds used for diagnosis. It found the interpretation of diagnostic criteria possibly too narrow.	Revise the approach to autism diagnosis, emphasising understanding each referred individual and supporting them irrespective of the diagnosis outcome. Demonstrate a stronger focus on formulation during clinical assessment and reconsider the threshold for diagnosis. Collaborate more with other mental health teams on suspected autism diagnoses.
Communication and Engagement	Concerns about communication with colleagues in the local system and feedback from wider stakeholders.	The review identified a need for better communication and engagement with patients throughout the service pathway. It noted issues with patient interactions and the need for stronger partnerships with other clinical teams.	Strengthen communication and engagement with people referred to the service. This includes revising the template letter for declining referrals, ensuring a coordinated approach to patient management, and focusing on making interactions as therapeutic as possible. Seek patient feedback during screening and assessment stages.
Co-morbid Mental Health Problems	Lack of acknowledgement of co-morbid mental health problems alongside autism.	While this specific concern was not directly addressed, the review recommended a comprehensive approach to clinical assessment, which should include consideration of co-morbid conditions.	Enhance the approach to clinical assessments to include a stronger focus on understanding the individual in their context and considering co-morbid conditions.

Final points to note:

The autism / autism spectrum disorder (ASD) service engaged positively throughout the invited review process and provided appropriate feedback in relation to the report. Alongside this, the service has also acknowledged and adopted the guidelines for integrated care boards published by NHS England in April 2023 (NHS England » Operational guidance to deliver improved outcomes in all-age autism assessment pathways: Guidance for integrated care boards).

The actions taken and still in plan reflect a committed response to the review's findings, aiming to enhance the quality of care and service delivery. The focus on continuous improvement and

stakeholder feedback highlights the service's dedication to providing patient-centred, effective care.

Progress against these actions, and the metrics that evidence this progress within defined timescales, will continue to be reviewed with the service by the executive trio, with progress reported to the executive management team routinely, and to quality and safety committee as appropriate. Included in this will be consideration of how we communicate and engage with all stakeholders who contributed to this report, to ensure an open route of feedback with regards to the ongoing effectiveness of all these actions.

Professor Marios Adamou

South West Yorkshire Partnership NHS Foundation Trust

Trust Board April 2024
Agenda item 9.8

Private/Public paper:	**Public**		
Title:	**Older People's Inpatient Transformation**		
Paper presented by:	**Prof. Subha Thiyagesh – Chief Medical Officer**		
Paper prepared by:	Ryan Hunter – Change and Innovation Partner		
Mission/values:	The programme closely aligns with the Trust mission and values as well as the national vision for effective, good quality care in adult acute inpatient mental health services that ensure: • Care is personalised. • Admissions are timely and purposeful. • Hospital stays are therapeutic. • Discharge is timely and effective. • Services actively identify and address inequalities. • Services grow and develop the acute inpatient workforce in line with national workforce profiles.		
Purpose:	To make the board aware of the recent activity, the current position and the forward timeline for older people's inpatient transformation.		
Strategic objectives:	Improve Health		
	Improve Care	✓	
	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. 1.3 Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve.		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The West Yorkshire ICB states the following in its strategy: If you need hospital care, it will usually mean that your local hospital, which will work closely with others, will give you the best care possible and that access to care is equal for all. Local hospitals will be supported by **centres of excellence** for services such as cancer, vascular (arteries and veins), stroke and **complex mental health**. They will deliver world class care and push the boundaries of research and innovation. This programme therefore aligns closely with the ICB objectives and is being delivered in a true partnership approach with a partnership programme board and partnership activity across all work strands.		

Any background papers / previously considered by:	Trust Board were updated on the public consultation progress in March 2024. A final draft business case, draft consultation document, including the proposed consultation questions, draft consultation plan, draft EIA and clinical senate report were all shared into October 2023 Trust Board. Quality & Safety Committee (Q&S) – review of quality and quality impacts in October 2023 Finance, Investment & Performance Committee (FIP) – review of finances in September 2023 Update to Trust Board in Jun 2023 1st draft business case and front sheet presented to Trust Board in April 2023.
Executive summary:	In October 2023, the programme team brought the final draft business case to Trust Board, with supporting documentation and received approval to progress the programme to public consultation. In March 2024 the Trust Board were updated on the progress of the consultation, which has now closed. The formal public consultation took place between Friday 5th January and Friday 29th March 2024 and over 1,500 responses were received to the consultation survey. Through the process we have heard from a diverse range of people from across our population and have some extremely valuable insight into our proposals. <u>Communications on launch and through the consultation:</u> • Consultation document – electronic and hard copy, full version and summary version, Easy Read, text only webpage, audio only option, posters, printed and distributed thousands of copies. Translations into Ukrainian and Punjabi. • Consultation website: Single source of information for public, staff, stakeholders, and other interested parties; Resource library; Consultation video – subtitled, British Sign Language (BSL) version and transcript; Animation – subtitled, BSL version and transcript; Digital screen: For use on TV screens, e.g. in GP practice waiting areas. • Information points with banner stands and documentation in locations across the Trust and in communities. • Radio interviews and local newspaper articles. • Social media and partner toolkits. • Letter to all Trust staff working in older people's mental health services, letter to patients who are classed as 'in scope of our service', email/letter to all Trust members, Weekly newsletter and monthly brief to all staff, Chief medical officer message to all staff on launch day, MPs and stakeholder letters, letter to partner organisations inviting a response. <u>Consultation events, meetings and roadshows:</u> • The programme team met over 300 people across 6 public events and 4 digital meetings.

- We also met many hundreds of people more across 14 roadshows and events.
- We presented into numerous system / network meetings through the formal consultation.

Other activity in consultation:
The programme team worked closely with partners in the Voluntary and Community Sector and Advocacy to collect a wide range of stakeholder views including current inpatients.

Summary of responses and reach:
1532 surveys submitted:

I am a member of the public	726
I work in healthcare	236
I work for a voluntary or community organisation	194
I care for someone living with dementia	188
I am a member of staff working in the older people mental health service	158
I am someone living with functional mental health needs	124
I care for someone living with functional mental health needs	85
I work in social care - including care homes	68
I am someone living with dementia	38
I am a Governor or member of South West Yorkshire Partnership FT	25

4250 website homepage views (between 12.01 and 28.03).
744 video / animation views.
64,000 people reached across the Trust social media accounts with many more across partner social media.

Current Activity and Next Steps:
The data from the survey and final themes from free text responses are being analysed by external partners and the full consultation report will be completed by end of May 2024.
Several work-strands are now being established to take the work programme through to the decision and then implementation.
This activity includes:

Finance (capital and revenue): to review workforce model, capital and costs, to review value for money and ensure system wide sign up to prioritisation of the model and capital allocation remains.

Travel, Transport and Parking: A working group is now established with a mix of carers, governors, SWYPFT and ICB staff. It is tasked with making recommendations to support family, carers and loved ones that have difficulty travelling to a transformed model, considering feedback from the public consultation and agreeing principles for when support is needed.

	Quality Impact: The Quality Impact Assessment is to be reviewed using feedback from the public consultation. This will help inform the review of the quality aspects of the options appraisal. *Equality Impact:* The equality Impact Assessment is to be reviewed using feedback from the public consultation. This will use the data collected against each of the protected characteristics and themed feedback. It will flag issues with any options and make recommendations of mitigations required. As well as these groups, work is taking place on estates and planning changes required, and operational change planning so that we are ready to move forward activity when a decision is taken. **Governance:** • The programme team will seek feedback from Trust Board to inform deliberations in June 2024. • Decision making sign off, via Trust Board will take place in August or September 2024. • As well as Trust Board we are also required to consult with a Joint Health Overview and Scrutiny Committee, seek approval from a Joint Integrated Change Board Committee and receive assurance to proceed from NHSE.
Recommendation:	**Trust Board is asked to:** • **RECEIVE** this update, • **NOTE** progress to date and that the programme team will be seeking feedback and approval to proceed in future meetings this year.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 9.9 – Assurance from Trust Board Committees

Collaborative Committee

Date	2 April 2024
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)

Key items to raise at Trust Board	**Alert/Advise:**
	• With respect to the West Yorkshire Adult Secure Collaborative, the following areas were the focus of the Committees discussions
	  ○ The Provider Collaborative Board reported that they were not assured that service users were being managed in the least restrictive environment; furthermore, the Collaborative has a consistent level of unused beds across the providers. The Committee challenged the teams to carry out further work on occupancy and report back. A consequence of the above may be that the Collaborative formerly challenges SWYFT re its performance which raises interesting questions re the roles of the NEDs on the Committee.
	  ○ Further work will also be undertaken on the impact of the Community Workstream not being taken forward.
	  ○ Contracting work remains behind schedule. Further work needed to progress this.
	  ○ The Collaborative is likely to break even financially for 23/24 but future years will be more challenging due to out of area charges and exceptional package of care costs.
	  ○ The launch of the Phase II Perinatal Mental Health Collaborative has been delayed from April to October; this does not impact on the current activity of the SWYFT led collaboratives.
	  ○ The Committee approved changes to the risk profile for specific independent providers in the light of recent quality reviews.
	• With respect to the South Yorkshire Adult Secure Collaborative, the following areas were the focus of the Committees discussions:
	  ○ Detailed discussion held re specific independent provider.
	  ○ A new form of risk reporting was presented for further review.
	  ○ Continued concern is being flagged in relation to availability and access to low secure services. Potential expansion of community services to be explored and Committee kept in the loop.
	  ○ There was a focus on incident and investigation reporting across providers; the results of this will be discussed a future meeting.
	  ○ Finance outturn for 23/24 being managed in light of issues with independent provider but likely to be near to break even.
	• A significant amount of equality data is presented as part of the performance reports for both Collaboratives but further work is needed to move beyond collection to analysis and action; West Yorkshire and South Yorkshire terms will work together on this.
	• An assessment of the Collaboratives' compliance with the key findings/recommendations in the report on the issues at Edenfield will be presented to a future meeting.

	• Detailed reporting on the Phase 2 collaboratives to be provided on a quarterly basis going forward but not to the same level of detail as adult secure collaboratives **Assure:** • The Committee reviewed its annual report and effectiveness review alongside consideration of the annual workplan and terms of reference. • Discussions to be held regarding structure/TOR/membership of Collaborative Committee in the light of developments re Wakefield place collaborative and the issues raised in the detailed papers re potential conflict of NED roles as a result of performance challenges to the Trust as a provider. • The Trust is seeking legal advice re the above issues.
Approved Minutes of previous meeting/s for receiving	6 February 2024 to be presented in private due to be being commercial in confidence.

Audit Committee

Date	19 April 2024
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Assure:** • The Audit Committee received annual reports from all board sub-committees; positive feedback was received regarding the improvements to the annual committee effectiveness reviews. • The annual report, updated terms of reference and effectiveness review for the Audit Committee itself was also reviewed. • Positive assurance received from regular reporting of o ORR risks assigned to Audit Committee o Triangulation of risks between ORR and IPR o Internal Audit and Counter Fraud activity by 360 Assurance o Treasury Management o Procurement activity • The Internal Audit update included the latest draft of the Head of Internal Opinion; as in previous years the forecast opinion is that the work of Internal Audit has provided Significant Assurance. • A full paper was presented covering the Trust's systems development activity with significant progress reported. **Advise:** • A detailed review of the Trust's Business Assurance Framework (BAF) was carried out with reference to recent/relevant external reports (PwC's "Managing Risk in the NHS" and The Internal Audit Network's "How good is your BAF"). Whilst there are some areas for continued review and improvement, positive confirmation was received that the Trust's BAF measures well against external benchmarks. • Further papers received covering the preparation for annual accounts process including: o Final approval of accounting policies o Updates to the national guidance re the NHS Foundation Trust Annual Reporting Manual o External Audit Plan o The draft Annual Governance Statement for initial review o A positive update on progress re the production of the annual accounts

	• Positive progress reported in implementing the actions arising from the limited assurance internal audit reports into
	  ○ Care planning and clinical risk assessments,
	  ○ Accessible information standards
	Alert:
	• The Committee approved the draft Internal Audit Plan for 24/25 subject to a couple of queries:
	  ○ There was some discussion considering whether the terms of reference for individual audits should be reviewed or approved by relevant board committees.
	  ○ The value of a further audit of the Freedom to Speak Up Process was challenged.
	• The Counter Fraud Plan for 24/25 was also approved.

Approved Minutes of previous meeting/s for receiving	9 January 2024

Quality & Safety Committee

Date	9 April 2024
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**Alert:** • The committee agreed to merge the risks ID 905 and 1614. The latter (risk 1614) is with the PRC as the lead committee. • The committee noted the emerging risk around shared care with ongoing discussions taking place and involvement of our medical director in these. • The committee agreed the new risk description for risk ID 1319 regarding the risk that there will be no bed available and expanded that there 'will be a need to be admitted to an out of area bed *or remain in an unsuitable environment (such as an acute hospital) until a bed is available.* • The committee to escalate to the People and Remuneration Committee to continue to review the work on EDI, originating at Quality and Safety Committee through the route of raising concerns via CQC. This committee will not continue to oversee this with the wider remit with PRC. **Advise:** • Patient Safety Partners are being introduced as part of the PSIRF implementation. A decision is still to be taken on how this will work in practice with an expectation that they are involved and attend or observe committees/subcommittees. Quality and Safety Committee is informing the board at this stage. • The committee agreed that the quality priorities will remain as they are and into next year. • The committee is advising the board that there are changes around the approach to quality oversight, monitoring and support systems (QOMSS), Quality Monitoring Visits (QMVs), 15 Steps and walkabouts. Further information will be forthcoming. The feedback from these processes and visits will be through the Quality and Oversight report and therefore be received by the Quality and Safety Committee.

	Assure: • QIA challenge panel process is being established for 24/25 with sign off from the Chief Nurse/Director of Quality and Professions and the Medical Director. • The committee received the LeDER, Learning Disabilities Mortality Review) report and noted that this is the first time that autism has been included and the identification of any specific actions related to this. The committee was assured on the progress around the action plan including learning and receiving this quarterly. • The committee noted and celebrated the Trust's accreditation for the pastoral support it provided to international nurses and were keen to understand how we can learn from this to support them throughout their employment journey with us. • The committee received an update on the Trust's learning process of the Independent Review of Greater Manchester Mental Health NHS Foundation Trust and were assured about the process and next steps including a review of the 11 recommendations against existing improvement plans. Further reports will come to the committee in May.
Approved Minutes of previous meeting/s for receiving	14 March 2023

Finance, Investment & Performance Committee

Date	22 April 2024
Presented by	David Webster, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert** • System showing large deficit for 24/25, expectation is that we will need to get to break even, closing a small gap **Advise** • Comparable to other Trusts we remain in a positive financial position, recommendation of the committee is that the Board should focus on Value For Money (formerly Cost Improvement Plans) and the quality/benefit impacts from that • All six of the top KPIs for finances are green and delivered for 23/24, including Agency and Capital which were red for much of the year • Balance sheet is now tight, subjective funds no longer exist, therefore significantly reduced flexibility **Assure** • Pay is now in line with funded amount (historically been below funding), more focus on value for money and agency to ensure we can maximise the return on the funding • Our Value For Money plans are strong and some areas (such as Out of Area, and Agency) appear to be ahead of our peers, therefore likely that we will share best practice on these areas • Updated performance focussed agenda carried out for the first time. Learnings ongoing, but will aim to deep dive into areas that are flagged in the monthly reports at Board • National metrics reviewed, and where there are obvious mitigations, assurance was provided that these are being acted on.
Approved Minutes of previous meeting/s for receiving	18 March 2024

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

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Audit Committee held on 9th January 2024

Present:	Mike Ford (MF) Mandy Rayner (MR) David Webster (DW)	Non-Executive Director (Chair of the Committee) Non-Executive Director (Deputy Chair) Non-Executive Director
Apologies		
In attendance:	Rob Adamson (RA) Imran Ahmed (IA) (item 9) Caroline Jamieson (CJ) Claire Croft (CC) Leanne Hawkes (LR) Lianne Richards (LH) Nick Phillips (NP) (items 17 & 18) Adrian Snarr (AS) Julie Williams (JW) Nicola Wright (NW) Paul Foster (PF) (item 15) Jane Wilson (JWi)	Deputy Director of Finance Head of Procurement Senior Manager, Deloitte Principal Anti-Crime Specialist Deputy Director, 360 Assurance Client Manager, 360 Assurance Deputy Director, Estates & Facilities Director of Finance and Resources Deputy Director of Corporate Governance Partner, Deloitte Assistant Director of IT Services & Systems Development Note taker

AC/24/95 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, Mike Ford (MF) welcomed everyone to the meeting. There were no apologies received 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/24/96 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/24/97 Minutes from the meeting held on 10th October 2023 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the Audit Committee meeting held 10th October 2023.

AC/24/98 Matters arising and action log from the meeting held on the 10 October 2023 (item 4)

It was recommended to close the following actions:
AC/23/79(ii), AC/22/80(ii), AC/23/84, AC/23/85(i), AC/23/85(ii), AC/23/88(i), AC/23/89(i), AC/23/89(ii), AC/23/93, AC/23/71, AC/22/57.

MR remarked that some of the actions go back quite some time and she questioned whether some of these would happen naturally. MF remarked that from a good governance point of view if there has been a request for an action, he would want assurance that this has been carried out. He said it was a good challenge from MR and when Jwi has drafted the latest minutes from this meeting he will look at them with a different lens, so we do not collect a whole set of matters arising actions that are not needed.

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

AC/24/99 Actions delegated to Audit Committee from Trust Board (item 5)

MF confirmed there were no further actions delegated from the Trust Board to Audit Committee

AC/24/100 Consideration of items from the Organisational Risk Register

allocated to the Audit Committee (agenda item 6)

AS provided the update stating there were no new risks, also no rescored risks. He said the document had tracked changes on so the Committee can see where changes have been made.

AS commented that the only one he wanted to call out related to Cyber, where there has been an action for a while. He said it is becoming increasingly evident that because of the commercial nature of the supplier that was subject to a cyber attack they are not going to share anything on this, so we are not able to do a lessons learned on this, for this reason we have removed this action and will rely on the control measures we have in place.

DW remarked there was no reference to the EPRR feedback that we have received in relation to risk 1159. MR said she had also noticed this. AS responded they were both right and what he is working through the consequences of the revised scoring. MR remarked that maybe there is something around the review of the new compliance standards.
AS agreed that it should be referenced it and we can refer to it in the action plan that we have in place.
MF remarked that the reason he had not considered it, was that he thought the risk of fire remains the same, and if there was a serious fire does the downgrading of our EPRR compliance suggest that we would not be dealing with the outcome of a fire very well. This would imply that the consequence element should be increased because the EPRR compliance would suggest we would not be dealing very well with the consequences of a fire, he suspected this was a bit of an unfair comment.
AS responded that it is a valid point but he would suggest that if we had a fire we would respond to it in the way we would have responded to a fire before and after the EPRR assessment, so there is no new risk.

MR said there is something about acknowledging what has been submitted but feeling assured we have processes in place to deal with these kinds of incidents.
AS said it a tricky one and he does not want to diminish the NHS England review of EPRR by saying it does not matter, because it does matter, but he does not think there is any more risk before or after the review, and he thinks there is something about how we compile the evidence to show what we would do as it is certainly going to be a hot topic next year as we work through the standards.

MF remarked that there are a lot of risks here and across the ORR generally that have a completion date for the actions of 31st March, and he would be disappointed if we get to the middle of the second quarter of the financial year and we have not seen some downward trend, as he would then question, why are we bothering with all these actions. He said he is not sure what we are expecting to see in the early part of 24/25.
AS responded that every action has a date against it and every month the risk register is reviewed as to whether that action has progressed and whether the date is still valid, so a lot of the dates get reset each time it is reviewed, and we should be aiming to get to the point where that risk is dealt with and it becomes an assurance measure. He said he finds it quite challenging as he sees it as a target date but they are actually review dates and they do quite often get reset.
MF remarked the distinction between review and reset is an important one.

MR commented that for her the actions are probably ongoing for many of the risks and what she would expect to see is a reduction in score that would show the progress that those actions have had an impact, rather than the fact that the risk goes away completely. She said there will come a point where we may have to accept a risk and Cyber could be one of these where we cannot reduce the scoring anymore, so for her it is the score that reflects the progress rather than the action.

MF agreed that he would like to see some of the scoring coming down and wherever possible getting those risks back within our stated risk appetite, and this is what we would hope the delivery of the actions would achieve.

JW referred back to when she first joined the trust, when the actions were reported as ongoing rather than having a review date, this has now been added to make sure we are looking at those risks in detail. She said there is a system in place that does work and she gave an example of two risks that have reduced in score that have gone to the Quality & Safety Committee this month for approval to reduce the score.

MF still felt we should be looking at closing off as many of these actions as we can in a timely way. JW assured the committee that the risks were under constant review from EMT and Executive Directors.

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

AC/24/101 Triangulation of risk, performance, and governance (agenda item 7)

JW presented the update stating she would take the paper as read and that it is a retrospective look using the October ORR report. There are a total of 35 risks on the report, and of these 29 can be broadly linked to the performance measures and narrative in the IPR for month 7 which was October 23/24, this is an increase in alignment of two compared to the Audit Committee report in October. She said in terms of the BAF, 27 are cross referenced between the ORR and BAF which was reported to Trust Board on the 31st October, this is a decrease in alignment of one. There are a few risks that are not listed in the IPR or the BAF and these are the service pressure ones.

MF remarked that he had some detailed questions around some of the numbers and that he would contact JW offline about these. He said the report is very good and the Committee were happy to receive this every quarter and are comfortable that there is nothing in the IPR relating to the legal risks around the Covid inquiry.
MR said the report was really consistent and a really good update, and that you can clearly see where the triangulation is as they regularly go through the IPR, ORR and the BAF.
MF remarked that over his tenure in this committee the gap has increased, so there are more risks now that do not appear in the IPR, which is why he raised the question the last time around, he said from a governance perspective this has now been closed off satisfactory.

JW remarked that she is going to look at some sort of diagram that looks at this on a page rather than lots of narrative going into the new year.
MF advised that he would be happy to work with JW on this. He said that once the Covid inquiry starts to become a bit more relevant to our organisation he would expect that JW would be preparing a separate paper for Board anyway, and that is still did not feel right to put it in the IPR.
JW responded that it is on the workplan for an update to come to this committee.

It was RESOLVED to NOTE the updates on the Triangulation of risk, performance, and governance.

AC/24/102 Board Assurance Regrading (agenda item 8)

JW presented the update stating that on the 31 October 2023 a paper was presented to Trust Board proposing a grading system change for the BAF.

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 Trusts internal auditor, and sought guidance on what is considered to be best practice.

Following discussion at Trust Board it was agreed that the new grading system should be presented to the Audit Committee on 9 January 2024 for consideration and discussion, prior to final submission to Trust Board for approval on 30 January 2024.

JW stated that following discussions with Leanne Hawkes (LH) at 360 Assurance they came up with something that a few organisations are using that we think we can adapt and would improve how our BAF represents where we are to the Board and to the public, and hopefully make it easier for other people who do not sit on NHS Trust Boards or work closely with BAFs to read and interpret. She explained that the paper includes a new key reflecting the new grading system descriptions for assurance and risk likelihood and an illustrative example of how the gradings will look is also included.

DW remarked that he liked the paper, and the only thing for him was the colour coding, and he asked if the risk and assurance side colours could be more aligned.
MF commented that he assumed that the old rating was a more traditional merging of likelihood and consequence, and therefore what we do not seem to have in our new version is the reflection of consequence.
JW responded it is our inability to meet our strategic objectives so it is the highest level of risk in our organisation and this allows you to describe the risk and assurance in more detail.
MR remarked it is about the achievement of our objectives and the risk associated with that.
MF commented that it is recommended that we change this from the 1st April and is that right.
JW responded yes that is correct, it has been discussed with the internal auditors, and to make a mid-year change would make the Head of Internal Audit Opinion quite challenging for both of us so the first report in the new style would be from July 2024.

MF asked if Deloitte had any questions around this.
Nicola Wright (NW) said they did not have anything to add over and above what had been discussed.

MF stated that the Committee are happy to approve this on the basis of a response being provided in the Trust Board action log.

AC/24/103 Board Assurance Framework Effectiveness Review (agenda item 9)

It was agreed that this item would be deferred to the April meeting.

It was RESOLVED to AGREE the decision to defer the Board Assurance Effectiveness Review update to the April meeting.

AC/24/104 Annual account progress update (agenda item 10)

Year End Timetable
RA stated that the timetable used to be much more comprehensive, and it has been included in the January committee meeting to highlight the main dates. He said the two dates they know so far are that the draft accounts will be submitted on Wednesday 24th April, and audited accounts are to be submitted on Friday 28th June. He advised that a detailed internal timetable will now be developed to ensure these deadlines are met.
MF asked when do we expect to hear about the new dates.
RA responded that over the last couple of years they have been really slow in sharing these.
MF asked if we have put a holding meeting in for the Audit Committee.
RA responded that he thinks that is an action that we have as a committee to try and work out where that goes in conjunction with Deloitte.
AS remarked that it may be the case that the delay on confirming the timetable is because nationally they are still having some issues concluding last years accounts, so their efforts will be

focussed on that. He suspected there would be some feedback from the audit community on the timetable and timelines as well.

MF asked if Deloitte had any feedback on this.
NW remarked that if it is the 28th June that is very much in line with last year, she said there had been noise about moving it back to the end of May, and she thinks the audit community's response to that was not positive, especially given that there are a lot of issues around the local government backstop date and there is quite a lot of moving parts in the next 12 /18 months, so knocking a month off the timetable could be quite challenging.

MF remarked it would not seem intuitive to bring it forward if they are still struggling to sign off last year. NW remarked there are some of last years March accounts that are still unsigned which means they cannot sign the group as there are some ICBs in particular where the audits are not concluded, so we are still suffering the after effects of Covid and probably a bit of Brexit and various other things.

Accounting Judgements - IFRS 9
RA explained that the next series of papers are for the committee to comment on regarding accounting judgements. He said they are brought to the committee well ahead of year end so that everyone can be clear on the main judgments that finance are making to ensure they are in line with peoples expectations and what they are going to see in the accounts.

RA stated that the IFRS 9 financial instruments is our bad debt provision and the proposal we have in the paper is very much based on our positive performance, in that we will not provide for any invoices or charges other than those relating to staff which tends to be the salary sacrifice/lease car scheme invoices which we know are tricky, once they get older than 30 days to recover. He said this proposal is a change from last time where we were providing for others that were greater than 180 days, and he said he was happy to put forward this proposal.

DW remarked that he wanted to clarify that these are the actuals that we have seen in 22/23 and that is what we are rolling forward.
RA responded yes and we make our assessment based on historical performance.

MF remarked that despite the good performance up to now, it does seem strange to not have anything for over 90 days for council and other.
RA responded that we have a very slick process in terms of making sure we have purchase orders in place so the income is pretty much guaranteed, and we do not have an awful lot of debt that is not resolved and paid.

MF confirmed the committee were happy to approve the update.

Accounting Judgements - IFRS 16 / leases
RA stated this paper provides the committee with an update on the actions that are being taken and has been subject to the Deloitte audit and review.

Accounting Judgements - Annual Estates Revaluation
RA advised the committee that the full assessment has been done by the district valuer and they are awaiting the outcome of this, this will be shared with the committee once it is received.
He said one thing he wanted to flag was that we currently value our estate on a modern equivalent asset basis and his understanding is the guidance is changing and this is no longer an approach you can take. There will be an update coming in later this year, so it does not change our value for this year.
AS remarked that in reality it means our assets will likely have a higher value when we move away from the modern equivalent asset value.

MF commented that as we are waiting for the report would this committee need to be involved in anything offline before the April meeting.
RA responded only if there were any changes, but for this year because we are not changing our approach on anything, there are no decisions to be made.

It was RESOLVED to NOTE the Annual account progress update.

AC/24/105 Review of draft accounting policies (agenda item 11)

RA provided the update stating these are shared at this time of year to give committee members and Deloitte an opportunity to review and make sure they are in line with current expectations. He said he is not expecting many changes this time around, the main change being that leases will be business as normal, as opposed to being implemented. Discount rates have also been updated in line with what has been announced over the last couple of weeks.

It was RESOLVED to NOTE the Review of draft accounting policies update

AC/24/106 FT ARM update (agenda item 12)

RA confirmed the FT arm had not been published as yet. JW to provide a further update at the April meeting.

It was RESOLVED to NOTE the FT Arm update.

AC/24/107 National Cost Collection (agenda item 13)

RA presented the update stating finance have submitted our 2022/23 submissions and we believe we have done this correctly and that they have been accepted. He said we have not received any confirmation to formally confirm this, which is what we would normally report into this committee.

AS remarked that in relation to the FT arm, and the guidance, along with things that have just been discussed, it is just for the committee to note, that planning guidance normally comes out before Christmas, and we work on that through the last quarter in readiness for getting a plan together for the end of March, there is also a lot of prep work for doing month 9 accounts and working that through to the end of the year. He said it puts a lot of pressure on the finance team when there is slippage and uncertainty on the timetable, so there is a risk that we will end up doing month 9, preparing for month 12, and preparing for next years plan, all at the same time, so it does put some challenges through the finance team that the committee need to be aware of.

It was RESOLVED to NOTE the National Cost Collection update.

AC/24/108 External Audit Plan progress update (agenda item 14)

Caroline Jamieson (CJ) presented the update stating that Deloitte had signed the Charitable Funds pre-Christmas so they have all been filed and are on the accounts with the Charities Commission. She said there is a planning meeting with AS & RA tomorrow to talk about the 23/24 audit, ahead of starting this work, and bringing the audit plan to the next meeting in April.

MF asked if the timetable for this meeting is correct, as it feels a little bit out of sync.
NW remarked that some Trusts do have a March committee so that the audit plan can be put in place, this committee is just a little bit early in terms of when they can do the planning procedures. She said in an ideal world they would be able to present it to the committee in March, obviously if there were any real concerns, or change in risk profile they would communicate outside of the committee cycle anyway.
MF remarked do we think this is something we need to look at and would this meeting be better in mid-February.
AS responded he would like to take this away as an action to have a look at this. He said part of

the problem is the national deadlines on things are slipping, so in years gone by, we might have had the FT arm etc, and over the past few years this has not been the case. Also, as we have come out of the other side of Covid it has not necessarily gone back to pre-Covid times, so maybe we should be a little bit more realistic to the fact that we are not going to have some of this stuff in January where we might have done some 4 or 5 years ago.

MF commented that this meeting is also very early in January and so the first week back at work for a lot of people.
AS responded we will just have a look back over the past few years and see when things have actually landed and see whether we should reschedule. He said it might end up that we have two meetings closer together but not in January.
MF stated that MR, DW and himself would be happy to look at that as an option if that would help in terms of presenting papers.

ACTION: Adrian Snarr

It was RESOLVED to NOTE the External Audit Plan progress update.

AC/24/109 Cyber progress report update (agenda item 15)

Paul Foster presented the update.

Key headlines:-

- Preparatory testing activities have concluded for the introduction of Windows 11. Windows 10 does not go out of support until 2025.
- Exploring additional functionality within the Cisco AnyConnect product suite, this provides additional security controls for staff when working remotely via VPN.
- In November 2023, the IM&T team and Emergency Preparedness, Resilience and Response (EPRR) team ran a table-top exercise focusing on cyber resilience in the event of a cyber-attack against SystmOne. This was to assess business continuity arrangements and mirrored the situation that Advanced Health had where they were impacted by a cyber-attack, also a number of other NHS organisations were also impacted as a consequence of this. The report is being drafted and is currently under review. The event was found to be beneficial and it was agreed that another session would be arranged in early 24/25 that will include colleagues that have a more operational perspective, which will give a more rounded and complete view of our plans and approaches should an issue of that nature occur.
- ~~The business case for cyber security enhancements remains with EMT for consideration as part of resource prioritisation given the current financial landscape.~~
- The Trust's latest independent annual penetration (PEN) test is currently underway with outputs expected later this month.
- The Trust's next annual Cyber Essentials Plus reaccreditation is scheduled for this month.
- In December 2023 the Trust adopted a new early warning system provided by the National Cyber Security Centre (NCSC), which alerts the Trust if NSCS detects any malicious activity on the Trust's IT network.
- Staff awareness remains one of the main cyber security controls, with measures adopted serving to protect staff both in the workplace and at home. Communications are regularly published to all staff to raise awareness and inform them of the latest cyber threats.
- A survey was conducted in August 2023 which has been used to further enhance the rolling 18-month Cyber Communications Plan. Key areas of focus were around password and account management and further information to provide support to staff when identifying suspicious emails, and handling of those.
- ~~We have identified in collaboration with 360 Assurance a new risk for the organisational risk register relating to Cyber fraud. This is something whereby NHS England through~~

~~their Cyber Security operations centre may identify and issue and block it for their NHS mail community, they do not necessarily communicate this out in a forthright manner to non NHS users. This has been picked up in our regional cyber forums and raised directly with our regional leads at NHS England, who are currently looking at how they will approach and address this.~~

MF remarked that he thought they had all been encouraged to move away from NHS.net email addresses.
PF responded there was no encouragement to do this, it was where organisations such as us back in the day were reliant on two email platforms, so we used NHS mail for secure, personal sensitive information transfer. With our email accreditation that means that the @swypft emails can do the same sort of activity, so rather than maintain two email accounts we now only have the one, so we have moved away from the NHS mail. ~~He said there is a mixed economy of the two in the NHS, and it is the ones who are not NHS mail that may not get that insight.~~ He said it is also worth flagging that because of our relationship with our IT provider Daisy we may get insight of things that might not have come to the fore in NHS England, so again we are looking at mechanisms whereby we can communicate these through so they can flag these accordingly. He said it is all about trying to make sure that all parties are suitably informed in a timely manner to do the necessary activities.

MF thanked PF for the helpful update. He asked AS if this risk was going to be assigned to this committee.
AS responded that as it comes under Cyber so it probably should.
MF asked if this would be added to the main risk or would it be an individual risk.
PF suggested it should be a separate risk.

Claire Croft (CC) 360 Assurance confirmed that there had been a separate risk added to the Counter Fraud risk register.
PF responded that he thinks it has also been added to the ORR, so is now in both.

MR remarked that the report demonstrates really good progress, she liked the fact that they are ahead on the Windows 11 deployment, bearing in mind Windows 10 does not run out until 2025 and that it is also great news that we are getting Cyber essential work done.
MR referred to a discussion offline with PF relating to Wetherby YOI staff and trying to make them feel inclusive, she said hopefully there will be a resolution to this and they will feel part of our organisation.
MR remarked that the staff awareness piece comes out much better this time in the report compared to last time and it reads well, and she thanked PF for that. ~~She asked AS if we are sure that we have put the right investment in keeping and maintaining our current level of focus on Cyber, as the papers says this is ever evolving, also have we ringfenced funds to do this.~~
~~AS responded that a paper has been to EMT twice now and that paper consists of a whole range of recommendations as to where we can further enhance cyber security. He said we then try to make an assessment of risk reduction versus expenditure, and at this point in time we have held the position, so we will continue with the level of control that PF and his team have in place now.~~
~~AS stated we decided at EMT not to invest more because we thought that it was diminishing returns on risk reduction~~. The agreement is that we continually take this back to EMT for reassessment, so we have a mechanism to be sighted on this by PF and any enhancements that the team recommend.

MR asked how PF felt about that.
PF responded he understands the finance position has to be balanced across the trust. He said as part of the annual planning process they also build into the digital programmes significant cyber work, so there is a continuous programme for this, and the digital agenda is growing and we need to stay ahead of the curse.

MF asked if there was any national funding for this or are we that good we will not get any. PF responded there is national funding, but this year has been a bit strange in the approach, and having been filtered down at ICS level, they then started to break that up and issue it to individual trusts, which was nominal amounts, so they were looking at best ways to try and spend that. He said previously they have focussed on improving backup capabilities within organisations and we have bid against this and we have been successful in previous years. He said we do need to reflect that we are quite mature but that should not be a reason to get any central funding.

MF thanked PF and his team for the excellent work.

It was RESOLVED to NOTE the Cyber progress update.

AC/24/110 Procurement progress report (agenda item 16)

Imran Ahmed (IA) presented the update.

Key headlines:

- Sixteen contracts which exceeded the Trust's tender threshold were awarded in the third quarter of 2023/24, totalling £8.7m.
- The largest contract placed was for the Estates Refurbishment Programme with a contract value of £7m over a 3-year contract term awarded to Tilbury Douglas.
- Eleven major contracts are currently in progress which are or have been formally tendered via the Trust's eTendering solution or through frameworks.
    - The Trust is leading on a project within the ICS looking at non-emergency secure transport. This involves 5 or 6 trusts combining their spend on this, which should result in us getting better rates from the suppliers. We are looking at having a robust governance process within the trust for the use of non-emergency secure transport. Currently some service areas have good governance process in place whilst some others do not, we are therefore looking at a consistent approach across the trust which should therefore bring about savings.
    - The Trust is leading on a piece of work within the ICS on Translation services, again this is about us putting all our spend together and getting better value for money.
- IA apologised for an error in the report in relation to the Quarter 3 single tender waivers, he said there were 5 single tender quotation waivers which equated to £96k, and only one tender waiver which equated to £43k. Compared to this period last financial year these have remained low. A lot of work has gone into achieving this by giving more challenge to service areas whilst supporting them in finding alternative solutions.
- The analysis of agency expenditure identifies organisations engaged, which are currently on a formal NHS Workforce Alliance Suite of Frameworks and those companies which are non-contracted suppliers.
- Agency activity in quarter one shows a total of £37k was spent off contract with Red Sector Recruitment for CAMHS practitioners, which is a specialty that are in short supply. Feedback from the Agency Scrutiny Group is that agency spend is reducing.
- The agency expenditure information within this report solely reflects payments made via the Trust's financial system to agency providers within the quarter up to the time of writing of this report. It is a snapshot in time and is designed to highlight trends of high-level quarterly agency expenditure and the Trust's compliance with the NHS England instructions on the use of NHS framework suppliers
- The expenditure figures do not include money paid to medical locums via the Trusts Direct Engagement service which is managed by PlusUs and uses the Trusts payroll system. The trend for the third quarter shows a high level of contract compliance, however there is an increase in Contract and Non-Contract Expenditure from the previous quarter

- Within this quarter Company House checks have been carried out on two projects and both of these came back nil. IA confirmed the element that DW had highlighted following the previous meeting had been taking into account.

MF thanked IA for including the proportion figure which he said gave an indication of the context of the spend against the overall spend for the Trust. He asked IA if he was still okay to give the committee a sense of the status of the SWYPFT procurement processes against best practice at the April meeting.
IA responded that this is on his list, but that he wanted to highlight to the Committee that his previous role was in a procurement hub and so is very different to here.
MF responded that he appreciates this but that he is still keen to seek his views on his first few months in the post.

It was RESOLVED to NOTE the Procurement update.

AC/24/111 EPRR Update (agenda item 17)

Nick Phillips (NP) presented the update stating the Trust recently submitted its annual assessment for EPRR preparedness against national standards, with an expectation of partial compliance. He said the assessment was returned as non-compliant following an assessment by NHSE. Papers in relation to this have been received at both EMT and Board and the team are now working on a path to improvement. This will be a multi-year plan as the assessment called for additional work in a number of areas particularly around policies and procedures.

NP stated it should be noted that improvement will be a Trust wide task and not just an exercise within EPRR. Additionally, some of the improvements require ICB level solutions so a key aspect of the plan will be to work as a system within the two ICB's we operate in. He said it should be noted that all trusts assessed have been deemed to be non-compliant, as the evidential requirements were substantially altered prior to submissions with those changes not being communicated until after the submission. NP advised that the completed plan will be submitted to this committee as part of the governance process.

AS stated the whole of the Yorkshire and Humber and North East have moved to this way of assessment and everyone is non-compliant now. He said what they have seen through working with all the peer organisations is that mental health trusts scored slightly lower than acute trusts, and there is some explicit reasons for that, particularly around being a first responder to incidents, to which we are not. He said as NP has stated the only way to solve this is to work collectively.
AS said that he had attended a couple of feedback sessions with the NHS England national EPRR team, as did Emma Hilton, our EPRR practitioner. He said it is fair to say these were challenging sessions and there was a lot of push back to NHS England, but similarly NHS England did not relent on anything they said or did, so we are in quite a challenging position as a community to make sure we can professionally work through all of this and not just blame each other as to what went wrong and why, nobody could see this level of assessment coming through in the way it did. Emma and the team are just looking at the task in hand and pulling all of this together.
AS said the next step for this committee and for the Board will be for us to bring this action plan back in some form which shows some target dates. We will have to think about how best to present this to board as it is a very detailed plan and they will obviously want some assurance of key dates so we can move through the compliance framework. We also want to do that at the same pace as our mental health colleagues across the Yorkshire system.

MF asked do we need to spend money to get more compliant.
AS responded in simple terms he thinks we could do it quicker if we spent more money, but whether we want to do that is a prioritisation question and I suppose it comes back to the point made earlier in that our EPRR processes are robust and function well, and have been

demonstrated to function well throughout the latest rounds of strike action etc. He said this is about making sure we have a robust evidence base it does not necessarily mean our EPRR process will be better.

MF remarked that assuming it is correct to assess the compliance being based on paperwork as opposed to the strength of the processes, what are the long term implications of not being compliant, and would NHS England look at us unfavourably.
AS responded that he wrote to them and asked them that very question but he did not get any response. When they had the feedback sessions they said NHS England will not take any regulatory action for non-compliance,
MF said he would loathe to spend hard pressed capital to get us compliant if it was not going to make us any more compliant in terms of the safety of service users, staff and carers.

NP remarked we also need to be able to do this with the services and make sure they have the capacity to do this properly and safely.

MF asked how do we reconcile receiving a significant assurance internal report with a 15% compliance against the new standards.
NP responded that for us Internal Audit looked at what we did and the plans we had in place, and what NHS England did was say we had to do it in a way we were not aware of.

LH remarked that with all of their work 360 Assurance agree a scope at the time, and their opinion is based on that scope, which is different to what NHSE came in and looked at, she said the two are very different so you cannot compare, and that is why the outcomes were very different.

MF asked NP if he could bring a plan to future meetings that indicates when he thinks we will get to partial compliance.

ACTION: Nick Phillips

MR remarked that she did want people to think they were quiet because they were in the Audit Committee, she said there had been a lot of discussion outside of this committee with the Board so she feels as if she is up to speed. She said it is both challenging and concerning, but we are amongst a pack, and it will be interesting to see what the outcome is at the end of the ICSs response to it all.
MR commented that they were also aware for some time that actually having somewhere to go to if/should our hospital shut down, we knew we were partially compliant because of that and this is one of the key issues.
MF responded that we as a Board would not have pressed for full compliance because either it would be impossible or it would require an enormous amount of capital, and everyone was broadly comfortable with partial compliance, it is the moving of the goalposts that is frustrating.

It was RESOLVED to NOTE the EPRR update

AC/24/112 Health and Safety Update (agenda item 18)

NP presented the update stating he would take the paper as read.

MF remarked the report clearly evidenced the fact that there was a lot of work ongoing and he asked for the committees thanks to be passed on to the team.

It was RESOLVED to NOTE the Health and Safety update.

AC/24/113 Treasury management update (agenda item 19)

RA presented the update stating this was the standard paper and he would take the paper as read.

MF remarked that his only query was with the statement that says intelligence continues to suggest that this rate will rise again, he said we have had a couple of months of holding steady and we are entering an election year where some of the pressure will be on decreasing rates, he asked does this have any impact on our approach.
RA responded because of where we are so late in the year now no, because it is very unlikely we will invest in the current financial year so we are just in the holding position, he said there could be another small increase before it starts to reduce and they are monitoring this.

DW remarked that from everything he has read from economists there will not be another increase if anything there will be a slight decrease towards the back end of this year. The Bank of England base rate is based on inflation and inflation is tracking below their initial expectations which is good, so unless the trend changes he would be very surprised if there is another increase. He said it does sound like we are talking more towards 3 to 4% as being the normal interest rate rather than back down to 0.5/1%.
RA remarked that is good, as finance have not quite started the modelling for the next financial year for the interest receivable and cash, so they can play some of this through.

It was RESOLVED to NOTE the Treasury management update.

AC/24/114 Losses and Special Payments update (agenda item 20)

MF confirmed that this paper was taken as read unless anyone had any questions.
There were no questions raised.

It was RESOLVED to NOTE the Losses and Special Payments update.

AC/24/115 Internal Audit progress update (agenda item 21)

Leanne Richards (LR) presented the update. Since the last meeting, 5 reports have been issued, all with significant assurance, these were:-

- Accounts receivable
- Emergency preparedness, resilience and response
- Policy management framework
- Charitable funds
- Waiting list management (this work is from the 2022/23 Internal Audit Plan)

LR provided the committee with further detail around each report.

Since the last meeting, the following Terms of Reference have been agreed:

- Service user observations and seclusion
- Absence management: sickness

LR confirmed 360 Assurance have issued the memo for stage 2 of their Head of Internal Audit Opinion work programme. She said there was nothing significant to raise, but she did want to highlight that it does contain the results of the Board survey which is run as part of the head of internal audit opinion work programme each year and that those results were positive overall. She said in terms of action tracking, first follow up rate is 89% and there were no follow up actions at the time of writing this report. They have held initial discussions regarding the data quality audit; the focus of this is currently being considered by the Trust with a view to 360 Assurance picking up the work later in quarter 4.
LR confirmed that as part of their PSIRF client-wide project they have been running a series of forums for operational leads and patient safety specialists to share experiences and learning. The next forum is on 25 January.

MF asked if there had been any SWYPFT attendance at these forums.
LR responded that SWYPFT are invited, she agreed to double check and let MF know.

ACTION: 360 Assurance

MF asked LR if she was going to cover the terms of reference.
LR responded not in any detail unless the committee had any questions.
MF asked if the terms of reference get agreed by the relevant committees.
LR responded no they do not go to the committees; they get signed off by the relevant executive lead.
Leanne Hawkes (LH) remarked that is the reason they are brought here so the committee have sight of them, should they have any comments on the contents of the scope. She explained that when 360 Assurance agree the audit plan they put in a high level overview of what is to be included, so if they go to the executive lead and agree the terms of reference and they think it is significantly different to that they will flag that here at the Audit Committee.

MF asked do the plan and the snapshot of the terms of reference that go in the plan only come to this committee.
LH responded yes, but the plan could be shared with the other Committees for information.
MF remarked that he is wondering whether he should share these with his NED colleagues as chair of their respective committees to ensure they are happy with the terms of reference, and to some extent the timing, as he had a conversation some time ago about the timing of a particular report from a Peoples Remuneration Committee (PRC) and a HR point of view, which resulted in a change to the timing.
MR remarked that it is the executive director's job to make sure that it covers the scope of what they need reviewing, and then the NEDs, through their lenses, check does it actually match with some of the trust issues that we are actually having.
MF remarked that he is going to put this as an alert for his AAA report to the Board and ask the question of the Board as a whole, rather than the chairs of other committees getting to see the terms of reference that relate to their areas.

LH remarked could she just make a plea that we do not get into the situation whereby committees take responsibility for seeing the terms of reference, otherwise they will not get any progress and deliver the plan.

MR remarked that in her previous role it was agreed in her director role position and then an oversight of the Audit Committee, so she thought the process was correct.
MF remarked that he would slightly amend what he was going to do and he is going to note it at the Board rather than saying I am proposing a change.
JW agreed with MR in that it is an executive directors decision.

E rostering risk assessment progress update

Lindsay Jensen (LJ) provided the update stating that all actions arising from the action plan have been completed and have been accepted and closed off. She said in terms of e rostering, even though the audit is complete, there is work that is on-going. That work is around check and challenge, and meetings are in place to look at the e roster performance that is taking place and looking at actions to improve, we are also talking to care group representatives around their roster utilisation to make sure that we are using this effectively.
LJ advised that they have also received some information from a company called Liaison who we have used to do a review of our agency spend, and part of their recommendations was also around roster utilisation. They have given us some further recommendations and information around how we might improve our roster utilisation, so we will be using that information alongside what we have already got to inform the work that we are going to be taking forward.

LJ advised that Richard Pascoe, who is the e rostering lead came to the PRC meeting in November and gave a detailed presentation around the e roster role out across the rest of the

organisation, it also included safe care, and he gave a lot of information and assurance in terms of how that plan was rolling out, and how we are using that information to start to work through improvements.

MF remarked that the Audit was focussed on the delivery of the project to implement the system and then the real benefits were coming from the delivery of the use of the system going forward. He said the committee will take assurance that the recommendations from the internal audit report have now been fully implemented as this was also covered off in the 360 Assurance update.

AS remarked that following a discussion with LJ they want the agency scrutiny group to focus on temporary staffing, as a lot of our agency and bank usage is driven by the rotas so there is an explicit link between the two. He said we already provide finance updates through FIP on agency performance and they go through the board reports, and it is going to remain a key focus for us as we go through the next year as we establish next year's plan. He said there is something about embedding the use of e rostering and making sure we maximise the benefits is going to be key, and although it might not come back to this committee, it will certainly get picked up by FIP and within Board updates on the financial performance, also on the people dashboard in the IPR, and the committee will get oversight of these.

MF remarked that the focus should be on the outcome and not on the system itself and that is why we need to know the benefits we are getting out of it. He thanked LJ for the update.

It was RESOLVED to NOTE the Internal Audit progress update

AC/24/116 Counter fraud progress update (agenda item 22)

Claire Croft (CC) provided the update stating she wanted to highlight a couple of the risk areas she has been working on with the trust following some recent fraud alerts that they have provided to the trust. She said one was around employment agency staffing, whereby they have been alerted to a growing trend of offences that basically involves somebody impersonating medical professionals, therefore it represents a risk to the trust.
CC remarked that she is pleased to say the trust have done some work around this and have issued a reminder to all staff to check ID before an agency worker starts on the first day, they are also putting something into the standard operating procedures to make sure that the checklist contains information about what they need to do about checking ID on a workers first day. She said it is important to note that this relates to agency staffing.

CC remarked that they have also identified that some international medical staff are producing false international English language test results to gain employment here in the UK. She said she is pleased to say that the trust has introduced a new process for checking certificates which involves registration with the online checking service, then that result is verified again before that individual starts work at the trust and a record is kept on file for auditing purposes.

CC advised she is currently reviewing national fraud initiative data to determine whether any individuals that work at the trust, whilst they have been off sick might have worked elsewhere for another organisation, and she has done the bulk of that review and is just waiting for the trust to come back to her on information about absences so she can go back to the third party employers to request information from them.

CC advised she was also looking to kickstart a review looking at Wage Stream, which is a salary advanced scheme. It has been identified in some organisations there are overpayments appearing, because the leavers forms submitted by the managers are not being submitted to payroll on time. She said she wants to see how the trust is dealing with this and she has requested some data to help them do this.

MF remarked that the lack of English qualification and the inappropriate agency staff are really important from a care and safety point of view as much as they are from a fraud point of view. He said he would include these in his update to the Board as part of his AAA report.
He remarked that the overpayment of staff leavers is a perennial problem for all organisations as there is a cut off for payroll, and if the form does not meet the cut off then the member of staff gets one more months' salary than they should do. He said he has not yet met an organisation that has found an efficient way of dealing with that.
RA remarked he is aware of this and the numbers are quite small.
MF thanked CC for the update

Counter fraud Risk Register
CC stated that organisations using their own mail servers (@swyt) do not receive notification of high severity blocks issued by Cyber Security Operations Centre (CSOC) to NHS email in relation to known fraudulent email accounts. She said she has contacted the NHS England's Cyber Security Operations Centre (CSOC) to determine whether this issue can be addressed. CSOC have said they are concerned about the issue and are looking at how best to take this forward. The Trust does receive 360 assurance local alerts, usually in relation to mandate fraud, but that does not necessarily mitigate this risk and there could be other high risk email accounts that we do not receive intelligence about, that are routed to CSOC for action.

It was RESOLVED to APPROVE the new Counter Fraud Risk and NOTE the Counter fraud progress update

AC/24/117 Policy updates (if any) (agenda item 23)

There were no policy updates.

AC/24/118 Any other business (agenda item 24)

HMFA - NHS Audit Committee Handbook Checklist
MF remarked that this was a paper he put together himself. As part of our self-assessment process, he had taken a copy of the handbook checklist and then put his own assessment against whether or not we meet the requirements, or how we compare to best practice. He said as the committee can see from the paper there are only two or three areas where there are question marks from his point of view, where he would like clarification on how as an organisation we are meeting that requirement. He said in general it was a good piece of assurance to say that we are very much compliant with the HFMAs guidance on Audit Committee terms of reference and best practice. He asked the committee if anyone had any questions, and suggested AS, JW and himself meet to pick up on a couple of things that are outstanding.
AS responded that they had said it was agreed that as MF had completed it, if there was a question mark, or a follow up comment they would give a response and all audit committee members could be assured that they had either covered it or had a rationale to explain.

It was RESOLVED to NOTE the update on the HMFA - NHS Audit Committee Handbook Checklist

AC/24/119 Audit Committee Work Plan

CC remarked that the Counter Fraud work plan needs adding to the forward planner.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of Quality & Safety Committee meeting
Tuesday 12 March 2024
9.00am – 11.15am
Microsoft Teams

Present:	Nat McMillan (NM) Chair Darryl Thompson (DT) Marie Burnham (MB) Dr Subha Thiyagesh (SThi) Carol Harris (CH)	Non-Executive Director (Chair of the Committee) Chief Nurse / Director of Quality and Professions (Lead Director) Chair of the Trust Chief Medical Officer Chief Operating Officer
Apologies:	Kate Quail (KQ)	Non-Executive Director
In attendance:	Sarah Harrison (SLH) Julie Williams (JW) Yvonne French (YF)	PA to Chief Nurse / Director of Quality & Professions (author) Assistant Director of Corporate Governance & Risk Assistant Director of Legal Services
Observing	Mary McSharry	Lead Matron – Forensic In-Patient Services and Forensic All Age Community Services

QS/23/289 Welcome, introduction and apologies (agenda item 1)

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. Mary McSharry was observing the meeting today.

NM outlined the Microsoft Teams meeting protocols and etiquette.

QS/23/290 Declarations of interest (agenda item 2)

The Committee noted that there were no further declarations over and above those already made.

The Quality & Safety Committee NOTED the declaration.

QS/23/291 Minutes from previous Quality and Safety Committee meeting held 13 February 2024 (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 13 February 2024 as a true and accurate record.

QS/23/292 Matters arising from previous Quality & Safety Committee meeting held 13 February 2024 and action log (agenda item 4)

The action log was reviewed and updated as follows:

- QS/23/274 Chief Nurse Report
  Oliver McGowan training. It was noted that further planning was underway around how we report compliance given that part 2 of the level 1 training was still not available in the region. Darryl Thompson (DT) advised that places could be booked however this was only for 150 people. DT is keen to not report false assurance and not to declare full level 1 compliance, whilst also recognising the significant progress made in colleagues completing the e-learning. Discussions are underway on how to best report this training uptake in the integrated performance report (IPR).

  NM noted the frustration with the requirements. Julie Williams (JW) advised that if compliance for the e-learning was declared then a clear statement should be attached to that to say that this does not mean that the Trust is fully compliant with level 1 training but that it does mean that staff have accessed the training, and we are enabling staff to access the webinars.

  DT advised that the level 1 e-learning was a very good. NM was assured that the Trust was taking all actions possible and can assure Trust Board that this Committee will continue to monitor this. Marie Burnham (MB) agreed with NM on this point was assured that this will continue to be monitored.

- QS/23/275 Quality Regulatory & Oversight report
  NM noted the visuals were now included in the report and found this helpful.
  Closed.

- QS/23/277 Breakdown of Student Placements.
  NM confirmed that this could be closed and will be included in People and Remuneration Committee (PRC) today.

- QS/23/281 Engaging with Service Users, Carers and Families.
  Family liaison officer role to be kept on the action log until September when an update will be brought back.

- QS/23/282 reports from Sub Committees.
  RRPI. A meeting for NM is in the process of being organised.

- QS/23/258 Safer staffing
  NM confirmed that this should be on the PRC agenda today and will confirm at our next Committee meeting in April.

It was RESOLVED to NOTE the changes to the action log and AGREE to close all actions with updates.

QS/23/293 Committee related risks were reviewed in accordance with the terms of reference. Including: (agenda item 5)

DT updated the Committee that there were no changes in the scores to approve today and that where risks have been reviewed these were part of the usual processes.

DT advised that as a result of the discussions from the last meeting regarding executive director leads being identified for the risks that have multiple owners, this is now being navigated with the corporate team to have one identified executive director owner per risk.

This will be reflected in the organisational risk register (ORR) as an identified executive director risk owner, plus contributing director(s) as appropriate. MB was pleased with this outcome and having a clear steer of who is accountable gives a lot of assurance.

Carol Harris (CH) advised that she was late reviewing her risks for this report and advised the Committee that in relation to the 136 suite, RISK ID 1624 and the potential closing of this, on reviewing the risks this week CH advised that the discussion at the last Committee has now been included where CH advised that she was not intending to close the risk for the time being. This will be updated in time for Trust Board.

NM noted the rigorous review of risks at the last Committee.

It was RESOLVED to RECEIVE the update.

QS/23/294 Staff / Team Story (agenda item 6)

There was no staff story or update this month, due to unavoidable cancellation by the team.

QS/23/295 Chief Nurse - Update Paper (update on verbal items) inc update of topical & legal risks, escalations, QIA/EIA reviews / Quality Account (agenda item 7)

The paper had been circulated to all members.
Headlines of topics discussed:

- DT noted that the timeframe for the Quality Account was now coming through and asked the Committee to advise on the timing of the approval given the tight deadlines for bringing the Account to the Committee and sharing with stakeholders in a 28 days turnaround. It was suggested that either June Committee could be moved back a week to accommodate or to have an extraordinary brief focussed meeting to recommend the Quality Account for approval. It was agreed to have an extraordinary meeting for the approval.
  Action: SH to add an extra meeting in June

- Feeback from two Place quality committees has been included where conversations took place around our older people's transformation events and to note that questions were raised in the committees around mixed gender accommodation and being adherent to our single sex occupancy requirements. Darryl was able to assure the Place committees that we were meeting our statutory requirements.

- Our Safeguarding Team's work was also noted in the Place committees along with our Early Intervention in Psychosis Teams. DT noted the overlap of conversations between those committees and our own Committee.

- DT advised that paediatric audiology was a point of discussion at all the Place quality committee meetings and wanted to raise awareness of the similarity of issues other providers are experiencing.

- Stephen Naylor, the Chair of the Calderdale Place quality committee visited the teams at Laur Mitchell House in Halifax, including CAMHS and Working Age Adults, and provided very positive feedback.

- DT advised that the executive management team (EMT) have agreed to an extension to the Learning from Healthcare Deaths Policy.

- The Independent Review of Greater Manchester Mental Health NHS Foundation Trust was published in January 2024. This is being reviewed in the Trust to ensure all opportunities for learning are identified.

MB stated that the report leaves her feeling informed but not assured and leaves her with some questions in terms of the "so what". DT advised that there would need to be some consideration of where the assurance would sit as what is fed back to our Committee is the conversations from the Place quality committee. DT felt that the role of the integrated care board quality committee would cover the "so what" aspects, as this is where the Place quality committees are held to account.

MB felt that we were missing a line of assurance of things that are relating to our Trust. Going forward, DT will map the content of these discussions with the work in the Care Groups. MB was happy with this approach. NM noted the good development of this paper since it started.

NM queried as to why EMT had agreed to extend the learning from healthcare deaths policy to June 2024. DT confirmed that this was to allow for further consultation to consider amendments in relation to the Patient Safety Incident Response Framework (PSIRF), and to update any supporting documentation.

NM noted the Greater Manchester review (Edenfield) and that it is being reviewed within the Trust at the moment, and queried when the headlines of this report would be available for the Committee. DT advised that a member of his team was reading this in detail at the moment. NM would like something to go to the next Board meeting by way of an update on key areas (verbal) and noted that a report will be coming to QSC when available.
Action: DT

CH advised that the above has been added to the Trio report. However, it is not explicit that it was in reference to the Greater Manchester Report but agreed that an overarching paper for Trust Board would be beneficial. MB stated that this was a good example of the Trio needing to further clarify and assure the Committee of learning.

QS/23/298 Quality and Regulatory Oversight Paper Inc Quality Monitoring Arrangements (agenda item 8)

The paper had been circulated to all members prior to the meeting.

DT gave a brief update and advised that Mary McSharry who was observing the meeting today had been a significant contributor to the CQC actions work that is described in the paper for her care group.

The report for March 2024 contained the following information:

- An update on the approach to the action plans and progress against the MUST DO and SHOULD DO actions within the CQC inspection report.
- Detail of the quality monitoring visits to Barnsley East Enhanced Team and the FOCUS child and adolescent mental health service (CAMHS)
- The quality monitoring visit schedule up to March 2024.
- Information about the proposed quality oversight, monitoring and support system (QOMSS) approach which is being developed to enhance and support oversight of monitoring the quality of Trust services.
- Updated data on the new enquiries received into the Trust from the CQC, broken down by Care Group.

- Information about the CQC's single assessment framework.
- An overview of the process for CQC Mental Health Act inspections within the Trust, including the receipt of reports and action plans.
- Update on the plan for developing the Quality Account for 2023/24.
- An update on the implementation of the Triangle of Care across the Trust to support a consistent offer to unpaid carers.

MB stated that it was a really helpful report and felt assured on the actions plans. To enhance the report further she would like to see more of the sequence of events to see what tools will be used to get the actions embedded. This needs to be done on every action plan.

MB noted the QOMSS approach to visits and the 15 steps and that this will mean more impactful visits going forward, which in turn can lead to deep dives in areas that need the support. DT also shared that NHSE colleagues are also very interested to join the QOMSS visits after he shared the approach with them.

MB also highlighted that service users, carers and families are imperative to the approach and quality assurance. DT advised that there is evidence within the report which notes the key part that they play and the triangulation of the information.

JW informed that within the CQC action plans there were embedded documents which had not been included within the papers and thought that they would be key for the Committee to review. DT advised that these were to be removed from the PDF as the Committee do not need oversight of the detail of these documents as EMT and Clinical Governance Group had reviewed these. NM stated that she was assured that DT and team would include any issues within the report.

NM confirmed that she was in agreement with the comments made by MB and liked the layout of the report in terms of the progress made.

NM noted that some of the dates in the report were out for the rest of the year and queried whether there will be a progress report throughout the year for those items. DT confirmed that updates will be included throughout the year.

The Committee thanked Mary McSharry for her input to the report and to pass the thanks on to her team.

It was RESOLVED to RECEIVE the Quality & Regulatory Oversight Paper.

QS/23/299 Patient Safety Strategy Update (agenda item 9)

DT took the paper as read and advised highlighted the following:

Patient Safety training:

- Level 1a training compliance (for all staff) is currently 94%.
- Level 1b training compliance (for Board members and Extended Executive Management Team) is currently 84%
- Level 3 training (engagement and involvement) was completed by January 2024.
- Patient Safety Specialist training – two members of the patient safety team are undertaking this training.

Learn from Patient Safety Events (LFPSE):

- The Trust went live with Learning from Patient Safety Events (LFPSE), the new national reporting system on 14 February 2024.

Patient Safety Incident Response Framework progress:

- Reviewing linked policies and procedures
- Refining our guidance for learning responses using a quality improvement approach
- Reviewing incidents against our PSIRF Plan
- Supporting services with considering if incidents meet the plan and if so what improvement work is already in place
- Developing the format of the Patient safety oversight group (PSOG) (formerly clinical risk panel) to align with PSIRF
- Updated Datix to reflect our processes for PSIRF

Patient Safety Partners

- The three volunteers who have joined us as patient safety partners have been inducted into the team. They will bring significant value in terms of their lived experience, and one will shortly be joining this Committee (as an attendee) and DT will be discussing this with Andy Lister.

Patient Safety Improvement Group

- The first patient safety improvement group was held on the 27 February.

The Committee received and noted the self-explanatory paper.

It was resolved to RECEIVE and NOTE the update.

QS/23/300 Patient Experience Update (agenda item 10)

DT advised that from a governance point of view this was a short highlight report similar to an alert, advise, assure (AAA) paper, and therefore did not have an executive summary and queried as to a whether NM would like to receive a front sheet going forward and NM confirmed that she would

DT noted that the Committee have previously discussed patient experience surveys and advised how previously the Committee agreed to step away from the non-mandated CQC version of the surveys. Therefore, this paper highlights the work the Trust is putting into the Trust's own service user experience survey. This also includes the initial findings from the mental health inpatients survey and captures the voices of some of the young people accessing our services.

DT also informed the Committee that over 8,000 friends and family test results have been received.

Areas where no feedback has been received are of a focus now to the team, to understand why no feedback is being received. The team will be offering help and support should it be needed.

MB fully supported what NM said about the executive summary and that friends and family are a very important part of the patient experience and should not be underestimated.

NM thanked the teams for their work on this.

It was resolved to RECEIVE and NOTE the update.

QS/23/301 Care Group Quality and Safety Report (agenda item 11)

CH advised the Committee of the pressing issues within the report.

CH took the report as read and provided highlights on the following:

Paediatric Audiology

Paediatric audiology performance of being seen within six weeks of referral for a diagnosis dipped further to below 50%. Pressure is evident across the whole pathway with an average wait of five weeks for all children now, with a maximum of 12 weeks wait overall. This means that the longest wait for a diagnosis is 12 weeks rather than the target of six.

Committee were previously advised on the outcome of the national audit. Work has been taking place with partners to address the issues highlighted in the audit.

Prone Restraint

The Trust's focus remains on supporting training of alternative intra-muscular injection sites, and training and equipment to facilitate alternative seclusion exit techniques. Further detail on prone restraint is within the reducing restrictive physical interventions highlight report, on the agenda in this committee.

Industrial action

A further period of industrial action for trainee medical staff took place 24 to 28 February 2024. Although the formal command structure was not stepped up this time, a similar operational approach was used to ensure that all areas had a safe level of cover. Again, staff worked together to minimise the impact on service users with no immediate impact on safety recorded.

Learning disability waits

Committee are aware of the challenges in relation to performance against people with a learning disability having been seen, assessed and started a plan of care within 18 weeks. This has formed the focus of reporting. However, the drill down to understand why performance has not improved further has identified a set of hidden waits. Once people's care has breached the 18 weeks performance because they are waiting for a specific form of therapy, they have then been managed through a professional clinical lead's waiting list to be seen, based on their assessment of need and risk. These waits do not then flag up again through the 18 weeks report. Committee will be updated once more information is available. CH also advised that this will be going to Finance, Investment and Performance Committee to review from a performance perspective.

NM would like an update on the emerging risk for the next Committee and CH will include within the Trio report.

Action: CH

Kirklees Keep in Mind (CAMHS)

Committee were briefed in relation to the changes in the way the service was commissioned and funded and the potential for increased waits for Core CAMHS services. The ICB commissioner agreed to address the shortfall for year one of the contract with plans in place for future years. Therefore, what was a growing concern has been managed.

Calderdale and Kirklees recovery colleges

Recovery Colleges form an important part of the community mental health offer. This month, specific conversations have taken place in relation to service continuity of the Calderdale and Kirklees Recovery Colleges. We are aware that Calderdale local authority have indicated an intention to reduce funding for the college as part of their financial recovery.

Separately, Kirklees Recovery College have worked with Kirklees Council with regards to losing their accommodation in the Pathways building in Mirfield. The Kirklees Recovery College will be moving to a dedicated staff base at Ravensleigh in Dewsbury.

Patient flow
There is a national requirement for all systems and providers to achieve an average 76% performance against the 4 hours A&E (Accident and Emergency) standard in March 2024. Barnsley community physical health teams have actively engaged solution focussed work through the urgent and emergency care board. Mental health performance of 1 hour for adults and 4 hours for children is achieved in all Trust areas consistently.

Work continues on the further review of the quality impact assessment in relation to the ongoing out of area bed reduction. Use of out of area beds has remained low. Decisions continue to be made based on clinical need and risk and if an out of area placement is required, one is sourced.

Neurorehabilitation Unit (NRU)
Staffing levels are being managed safely using temporary staffing and drawing upon support staff where additional registered staff are not available. A position paper was provided to the executive management team that indicates that the service is costing more than the income available. Further work is taking place on pathways, pricing arrangements and the business model. In the meantime, the provision of safe staffing is a priority.

Older people's inpatient services transformation – update on public consultation
Following the successful launch of the public consultation in the beginning of January 2024, there have been 658 digital survey responses with further paper surveys in process of being inputted (estimated 500 paper surveys), and 2,798 website homepage views (between 12 January and 29 February). We have noted 640 video / animation views and 37,000 people reached across the Trust social media, with many more across partner social media. There is ongoing engagement activity taking place (roadshows) till the end of the public consultation period on 29 March 2024. A further update will be shared with the Committee and with the Trust Board.

Veterans
The Trust has been successfully reaccredited as 'Veteran Aware' by the national steering group for the NHS Veteran Covenant Healthcare Alliance. The award recognises our work in demonstrating commitment to the Armed Forces Covenant, and in identifying and sharing best practice across the NHS as an exemplar of the best standards of care for the Armed Forces community.

Overseas NHS Workers
1 March 2024 was Overseas NHS Workers' Day, which provided us with a special opportunity to recognise the fantastic contribution made by our overseas staff. The Trust shared social media posts in recognition of this contribution, and of our gratitude to all our colleagues who have joined us from overseas.

The group overseeing the action plan to support internationally educated nurses has been restructured as a steering group with clear task and finish groups, together with project support from the integrated change team. This group will be overseeing our support offer to internationally educated nurse colleagues and their new teams. Further updates will be provided to committee.

Concern regarding racism in forensics
Committee were briefed following a concern being raised about racism (towards staff) in forensic services to the CQC in October 2023. Specific actions are in place to understand

and respond to these concerns, and to ensure clearly equitable opportunities for promotion and development.

NM wanted to discuss the international recruitment plan and advised that this is being discussed at PRC this afternoon and that she has been briefed in relation to the risk and the expectation that more scrutiny will be given at that Committee this afternoon with a deep dive presentation.

NM was grateful to receive and update in relation to the racism concerns in forensics and saw this as a good indication of an open culture.

Subha Thiyagesh (SThi) advised that the Trio met with the internationally educated nurses last week, which gave them the opportunity to discuss the issues mentioned above and so show them that their concerns are being taken seriously.

SThi also noted that the older people's transformation was going well and that thoughtful questions were being asked at the meetings. The Committee will be kept updated on the progress.

NM noted that prone restraint was included in the report and advised that she had read the AAA on this in detail which is later on the agenda.

NM queried as to whether the paediatric audiology issue was a national one. CH has been informed that this is a national issue and would like to get the data from other trusts to benchmark and provide assurance.

The Committee noted the good and comprehensive report.

The Quality Care Group and Safety Report was RECEIVED and NOTED.

QS/23/302 Committee Annual Report and Annual Governance Statement (agenda item 12)

NM took the paper as read and advised that they will be taken to Audit Committee and then to Trust Board regarding effectiveness.

NM noted that there are a couple of changes in the terms of reference (ToR) in terms of the name change and to ensure that the focus of the Committee is correct.

NM advised that in terms of attendance this will be updated after the March meeting (today) and highlighted that CH and SThi had always sent a deputy to attend on their behalf to the meeting when unable to attend.

DT advised that the declaration on sending the papers out in time would need amending to state that on three occurrences the papers were sent on Thursday morning, giving four days for review instead of five.

MB would like to add to the report that the Committee has always been quorate throughout the year.

SThi would like it noted in the report that deputies had attended the meeting when Carol and Subha had sent apologies. JW noted that technically there is an absence as CH and SThi are members so deputies would be attendees and therefore cannot make any decisions and the meeting would not be quorate with a deputy. JW will consider this issue for the report as this will be the same in other Committees.

NM noted the effectiveness questionnaire and showed no cause for concern. MB noted that she was very happy with this Committee and how far it had come over the last year and it will keep evolving.

The group highlighted how well NM chaired the meeting.

The group were happy to agree the report with the agreed amendments around attendance and deputising before it is submitted to Audit Committee and Trust Board.

The group were happy to approve the ToR for Audit Committee and Trust Board

The group were happy to approve the workplan for Audit Committee and Trust Board.

The Committee RECEIVED and APPROVED the report for Audit Committee and Trust Board.

QS/23/303 Annual Nurse Revalidation Report (agenda item 13)

The report was taken as read.

DT gave the key headlines from the report and advised that assurances and processes are in place each year to support colleagues to revalidate.

All nurses that were required to revalidate have revalidated.

MB asked if any nurses were called to submit evidence of revalidation and DT will check this out as he was not aware. MB asked if this could be included in the report should there be any members of staff who have been asked to submit evidence to the Nursing and Midwifery Council.

The Committee were happy to approve for Trust Board.

The Committee RECEIVED and APPROVED the report for Trust Board.

QS/23/304 Apparent Suicide Report (agenda item 14)

This report will now be brought to the May committee in line with the new workplan for 2024/2025.

QS/23/305 Sexual Safety Report (agenda item 15)

This report will now be brought to the May committee in line with the new workplan for 2024/2025.

QS/23/306 IPC BAF (agenda item 16)

DT advised that this was the six-monthly update that will be sent on to Trust Board which shows the systems and processes in terms of infection, prevention and control and the outcome of our self-assessment.

This has been reviewed in EMT and is here for an update.
All actions are green aside for two which are partially compliant, and the detail is included in the report on these.

NM noted that this was a clear report and recommended for Trust Board.

The Committee RECEIVED and APPROVED the report for Trust Board.

QS/23/306 Reports from Formal Sub-Committees (agenda item 17)

QS/23/306a Drug & Therapeutic TAG (agenda item 17.1)
SThi noted that this group was also looking at the issue of prone restraint and the confidence of staff for the alternative site injections and discussions are being had with colleagues in the Nursing, Quality and Professions Directorate. The group is also considering what alternative medications could be used.

QS/23/306b Infection, Prevention and Control (agenda item 17.2)
Included at item 16.

CQS/23/306c Joint Safeguarding (agenda item 17.3)
There was no update for this item.

QS/23/306d Reducing Restrictive Physical Interventions (agenda item 17.4)
The report was taken as read and received.
NM advised that the Committee had asked for this to be monitored and noted some positive and sustained trends in relation to prone restraints, noted the work around the confidence of staff in wanting more support in relation to injections and liked the culture around this and the steps being put in place.

QS/23/306e Improving Clinical Information Governance Group (agenda item 17.5)
There was no update for this item.

QS/23/306f Clinical Governance Group (agenda item 17.6)
The report was taken as read and received.

QS/23/306g Clinical Ethics Advisory Group (agenda item 17.7)
There was no update for this item.

QS/23/306h QUIT (agenda item 17.8)
The report was taken as read and received.

QS/23/306i Safer Staffing (agenda item 17.9)
The report was taken as read and received.

QS/23/306j Physical Health (agenda item 17.10)
There report was taken as read and received.

QS/23/306k Nutrition Steering Group (agenda item 17.11)
The report was taken as read and received.

QS/23/306l Falls Update (agenda item 17.12)
There was no update for this item.

QS/23/306 Resus Update (agenda item 17.13
The report was taken as read and received.

QS/23/306 NMET Update (agenda item 17.14)
The report was taken as read and received.

QS/23/306 Sexual Safety Improvement Group (agenda item 17.15)
The report was taken as read and received.

QS/23/306 Suicide Prevention Forum Update (agenda item 17.16)
The report was taken as read and received.

QS/23/306 Issues and Items to be brought to the attention of Trust Board / Committees (agenda item 18)

Alert
No change to the risk around the Section 136 suite.
Paediatric audiology waiting times concerns.
Issues around learning disability waits (deep dive attention deficit hyperactivity disorder report for Board will not have the details as discussed above as an emerging risk).
Recovery college local authority funding withdrawal risk in Calderdale.
Patient Flow - Accident & Emergency waits.
Internationally educated nursing support plan.

Advise
Greater Manchester Mental Health Trust Review / Edenfield – this has been published and summary report will come to Committee.
E-learning Oliver McGowan training, as the first part of Level 1 training.
Accreditation as 'Veteran Aware' by the NHS Veteran Covenant Healthcare Alliance.

Assure
Patient Safety Strategy update received.
Ongoing performance on out of area beds.
Received annual committee report, ToR and Workplan.
Annual Nurse revalidation report.
Feedback on forensic work around racism.
Received the IPC BAF and recommended to Trust Board.
Improving trends around RRPI, and the improvement work around alternative injection sites for medication.

QS/23/307 Risk Register review (agenda item 19)
No further discussion was needed.

QS/23/308 Work Programme (agenda item 20)
This was covered at item 12.

QS/23/309 Date of next meeting (agenda item 21)
The next meeting will be held on 9 April 2024 (MS)

Minutes of the Finance, Investment & Performance Committee held on 18th March 2024 (Virtual meeting, via Microsoft Teams)

Present:	David Webster Kate Quail Natalie McMillan Mike Ford	Non-Executive Director (Chair of the Committee) Non-Executive Director Non-Executive Director (Deputy Chair of the Committee) Non-Executive Director (observing)
Apologies:	Julie Williams	Deputy Director of Corporate Governance
In attendance:	Adrian Snarr Carol Harris Rob Adamson Mel Wood (item 14) Jane Wilson	Director of Finance, Estates & Resources Chief Operating Officer Deputy Director of Finance Head of Performance and Business Intelligence Note taker

FIP/24/96 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, David Webster (DW) welcomed everyone to the meeting.
The above apologies were noted, 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/24/97 Declaration of interests (agenda item 2)

There were no further declarations of interests to declare.

FIP/24/98 Minutes from the meeting held on 22 January 2024 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the Finance, Investment & Performance Committee meeting held on 22nd January 2024

FIP/23/99 Items delegated from Trust Board (agenda item 4)

DW confirmed that no new items had been delegated from Trust Board other than the ask to have more of a performance focus which is now being implemented and reflected in the workplan going forward.

FIP/24/100 Matters arising and action log from the meeting held on the 22 January 2024 (item 5)

It was agreed that the following actions could be closed:-
FIP/23/91 FIP/23/88 FIP/23/91, FIP/23/92, FIP/23/73.

In relation to action 23/95 Natalie McMillan (NM) remarked that upon reflection she wonders how we can help AS, JW and the team with the IPR and she wanted to call out the fact that we as a Board are not always very helpful, as there are certainly many different views around what the IPR should and should not contain. NM wondered whether it would be a good idea to have a final discussion in a private board setting to finally thrash out what it is we actually need in the IPR as she felt the FIP committee had been very clear in stating they did not want lots of detail around this, yet Board discussions had been very different around this, and we need to be very clear in terms of what we are asking in terms of the IPR.

AS thanked NM for the helpful comment, he said when we come to the IPR paper it is a very iterative process and we do need to refine it, but there is something about where do we think the end point is, and maybe we need to encourage the Board to use this committee more for the deep dives, so when areas of concern come up through the IPR, rather than expanding or changing it we encourage this committee to do the work, and he was not sure we always do it the right way round at the minute. There is an agenda item that says the Board can ask this committee to do a deep dive, but we also have a work programme where we can decide what to deep dive on and feedback through the Board rather than the other way round.
AS said the overarching aim of trying to automate the IPR preparation as much as possible is something that will stand us in good stead as it will make it easy to flex for the Board.

DW agreed with this suggestion and said he would escalate this through his triple A report, requesting the Board set some time aside at a future board meeting for a further discussion.

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

FIP/24/101 Consideration of items from the Organisational Risk Register allocated to the FIP Committee (agenda item 6)

AS presented the update stating there are no changes to the risk ratings. He said we are getting towards the end of this financial year and we did say that once we had got a fixed position on the plan we would need to review both the revenue and capital risks to see that they are at the right level. He remarked that he did not want to pre-empt the revenue planning discussion but that there is some stretch in there. Also, Capital is a bit more difficult to determine at this point as we do not have a fixed position from the ICB on it yet. We continue to evolve the control metrics within the risk register but there is nothing to indicate that we should change the risk at this point in time.

NM remarked that whilst she does recognise that we will review these scores going into next year the scores are quite low given it has featured heavily in our last few Board discussions, and Mark Brooks, CEO has spoken fairly regularly about the financial challenge that is coming up in the next year. She said her challenge was that this is a risk register in terms of risks coming down the line, and it is now March, so for her the two things do not seem to correlate.
AS responded that this was a good observation, as at a recent time out MB had made a similar point which is there have been 3 meetings in a row now where finance has been the major agenda item. He said this is quite a tough one because if we look at the NHS financial position we know it is really difficult, but if you look at our financial position it might feel difficult to us but it is not in the context of the broader NHS. He said whilst we submitted a deficit draft plan, we are working through to see how we are going to get back to break-even. If we are able to do this it means in the NHS context our financial position is still better than others.
AS explained it will be harder for us to deliver an efficiency, so the debate is if the efficiencies are going to start to impact in a way they have not before, is the risk of financial instability greater, or is the risk of service impact greater, and he was not sure we have quite got there yet because we do not have a full efficiency programme to say what we are going to do.
AS stated there will be a fairly significant update on planning shortly when RA covers what was discussed at EMT and that might either require us to revise the finance risk or other aspects of the risk register, particularly around workforce.

AS agreed this is going to be the dominant conversation over the next year but he was hopeful this was because they are managing the risk and not because we are escalating out of control and our financial risk is growing month on month.

NM replied that for her it is a case of getting the balance between, quality, finance, and workforce, and the flipside of this could be, are we talking about finance being too much of a

risk when it isn't compared to some of the other areas and she felt it was right thing to keep asking ourselves.
AS said that for him the biggest risk next year is workforce and if we do not get this right it is a finance risk, or a quality risk, and keeping the three in check is going to be quite a challenge for us.
DW remarked that having looked at the scoring, whichever way we flip this around we are still going to sit in amber so it is still classed as high risk, and one for us to keep discussing.
KQ remarked that for her the issue is around the wording, and the risk of financial unsustainability sounds like it is catastrophic, which would therefore indicate the need for a higher score, and should we be looking at this wording.
AS responded that it might be worth looking at some of our neighbours nearby who have been running in deficit for a few years to see what narrative and scores they use.

DW agreed this was a good starting point and the committee could then review this.

ACTION: Adrian Snarr

It was RESOLVED to NOTE the update on the risks, relevant to this Committee

FIP/24/102 Month 11 Finance Report update (agenda item 7)

RA presented the financial position for month.

Key headlines:-

- A deficit of £398k has been reported in February 2024 which is slightly behind plan. This is a combination of run rate pressures (workforce) and realisation of a number of one-off adjustments included within the Trust forecast scenario. The forecast position has been reviewed and revised to a surplus of £0.5m. This is higher than the breakeven target. This will support the delivery of the West Yorkshire Integrated Care System financial target although this remains challenging.
- Year to date the consolidated surplus is £594k which is £177k ahead of plan. The forecast has been updated to an overall surplus position of £516k due to receipt of additional income. Due to the timing of submissions this has been included in the month end position to support delivery of the West Yorkshire ICB financial target. RA stated this will require both FIP and Trust Board approval.
  AS explained that the ICB are very close to breakeven but in effect what they have said is that provider organisations would need to deliver about another £0.5m each to bring the ICB back to balance. He said as RA has stated we are slightly fortuitous in that we broadly got £0.5m allocation to do with technical aspects around IFRS16 lease accounting that we were not expecting which happened at the same time,. AS confirmed that the ICB have been told this, with the caveat that it has only been an executive decision and not a Board decision at this point in time.
  AS stated that he thought the ICB approach was that no one would do better than plan which is why the trust have held this line of break-even all year, but a relatively small number of organisations have started to report slight surpluses towards the end of the year, so we felt the right thing to do was to also show a small surplus.
- There has been significant movement in the South Yorkshire Adult Secure collaborative in month. The increase in expenditure recognises the risk associated with ongoing contract negotiations with one independent sector provider.

- The core Trust position for February was a surplus of £788k (£1,037 better than plan) although again this is significantly impacted by the adjustments made.
- Excluding the one-off adjustments, the main headline in month 11 relates to the continued sustained workforce growth. This equated to an additional 71 worked WTE when compared to the previous month. Detailed information has been shared with OMG.
- OOA bed placements continues to be a Trust priority programme to address the operational and financial pressures that this causes. Current activity levels remain low. There has been minimal acute placements, 4 days in February, and 70 in PICU (3 individuals). 2 of the PICU placements are due to specific gender requirements. This continues to be managed as part of overall operational management. This remains volatile and increases in both areas have been included in the baseline forecast scenario. Other West Yorkshire mental health providers have seen rapidly escalating usage of placements over this period.
- Agency spend has continued to reduce in February 2024 and is now forecast to be under the target of £8.7m spend in year. Work continues to maintain and improve this run rate into 2024/25. This has helped to contribute to, and maintain, a reduction in agency staff worked. Spend in month was less than £500k.
- Pay expenditure was low in January due to the release of a number of one off adjustments. It is higher than the underlying run rate in February due to an additional £1m estimate of potential staff claims. February 2024 highlights a further 67 WTE increase of substantive worked and 23 WTE in bank. This has helped to support the reduction of agency WTE utilised (19 less in month). Overall, this is an increase of 71 worked.

  AS remarked that you can start to see an agency trend line that is in the order of 3% which is really positive. We have a lot more work to do to have a granular understanding of the ebbs and flows in the workforce, so whilst this is a finance report and quite rightly reports the numbers, it is what sits behind them that is really important, and it is going to become increasingly important next year because we set an ambition a year ago to grow the workforce by a percentage. AS said in future we are going to have to be much more specific, and we are going to have to say which services are in the greatest need.

  AS said we are also in danger of turning the positive fact that we have recruited that number of staff in a month to a negative because of the cost to us, but if we remind ourselves where we were a year ago when we couldn't recruit staff, we have done really well and much better than plan. This is now starting to translate into a financial run rate, which is going to be one of the key determinants of 24/25, and workforce is going to be the dominant conversation of how we triangulate between, quality, finance and headcount workforce over the next year. He said he did not want to take away from the fact that there has been some really good work done on agency reduction in inpatient services.

  RA confirmed that there is also an estimated £1m spend included for the potential Band 2 to Band 3 reclaim which is currently working its way through the governance process
- Excluding the impact of the impact of IFRS 16 (leases), year to date capital expenditure is £5.1m (61% of plan). Spend in February was £1.9m. Progress on all schemes has been reviewed and the team are confident that the total allocation of £8.3m will be utilised in full.
- Overall, the Trust cash position remains strong although this is forecast to reduce in March 2024 due to payment of invoices and capital expenditure.

DW remarked that whilst noting there have been lots of ups and downs he felt the trust were generally in a good place overall. He thanked RA for the update.

RA confirmed he had some work to do for the ICB in terms of their presentation and once he

has completed this, he will share this with the committee to help them gain a better understanding of this information.

KQ asked what the £5m for NHS services was, as it was not clear from the report.
RA responded that this is what has been paid to Mid Yorkshire as part of our support of the system this year.

NM referred to the non-pay expenditure and the fact that we are spending under budget on training and education and she asked if we needed to be worried about that.
AS responded that this was a good question, he said one of his worries is where we have an underspend in this year do we need to lock it in for next year. He said yes we do need to be worried because the non-pay cost reductions are not planned they are just happening, so if we are significantly underspending on training and development it is not because we are putting financial constraints in place, it is because we do not have a programme of spend for it.
AS stated the run rate has significantly changed in the second half of the year, but we encourage the team to spend it on the right things, and we look for the evidence of value for money for the right schemes. We have challenged a few things that they have put forward.
RA confirmed that there is a study leave panel that oversees all of these bids, also we support as much as we can, he said the bit that concerns him is operational, in terms of the time out to release people to do this, and we have seen a significant uptake of people trying to catch up with study leave that they have not being able to do through covid. Last year's spend was certainly higher than this years, and we have set a substantial budget for next year also.

NM remarked that what she is hearing is that we are not necessarily going to look at trying to make savings around training and education when we know from staff surveys how important it is for staff to be able to access it, also from a safety point of view.
AS responded that when the NHS is under financial pressure that is one of the first things that goes, he said we have not set hard and fast targets for individual budget lines, we have asked people to come forward with efficiencies. He said if that does not work we may have to go back with some hard and fast targets.
NM remarked that she was also wondering how we can triangulate it with PRC, and that the committee are aware of the risks we have had around the people directorate, and there is also something around making sure we have a plan for next year, whether that is the organisational development (OD) plan, but part of underpinning that should be a training and development plan to enable that.
AS agreed and said we have challenged a few lines of spend because it still needs to demonstrate value for money, it is not just because there is a budget available. He said we would always encourage people to have a forward plan for their budgets rather than an ad hoc approach.
NM remarked that she had one final comment and that was in relation to the agency spend, she said we should take a moment to recognise the work that has taken place and there is always something around what can we learn and what do we think has made the real difference around this. Whilst she absolutely recognises the caution around this, it has been exceptional in terms of progress and performance, and it is only right that this committee recognises all the hard work that has gone into this.

KQ said she just wanted to check that the variance is not driven by our focus on agency.
CH responded that she does not have assurance of this but what we tend to say is that people have to complete all their mandatory training before they apply for additional training support. It has been really challenging to release people at a time when mandatory training is available, also to get that aligned and there has been a massive focus on this ensure we can practice safely. CH suspected the large numbers of people that have been recruited now for the impatient will have had an impact on the agency usage, and the recruitment to bank is the biggest thing.

CH remarked that until the internationally recruited nurses have gone through their training, they work in support worker roles which will also have reduced the number of people we need on agency.
KQ remarked she is not sure how we will get assurance on this without causing a massive amount of work to someone. CH said she would take this away as an action to think about this.

ACTION: Carol Harris

It was RESOLVED to NOTE the Financial update

FIP/24/103 Financial forecast (agenda item 8)

RA presented the update stating this position is updated as per month 11, February 2024 and significant progress has been made. There has been movements in individual forecast positions that were not previously factored in, this includes additional income recognised following continued discussions with commissioners. This includes c. £600k since December with Barnsley Place and £500k from West Yorkshire ICB.
RA stated that with the current modelling, the most likely scenario is shown as £639k and he was confident we can deliver this position. This calculation, and the reduction in risk due to the reduced timeframe to the year end, has led to the recommendation to support an improved forecast of £500k surplus with the West Yorkshire Integrated Care system.

DW asked in terms of the more subjective accruals are there any large ones, or any that we are slightly more nervous about that we need to be aware of.
RA responded that we have auditable evidence for everything that is still outstanding that we need to go through so he feels quite comfortable with this.
AS commented that he was not nervous from a justification of how we have estimated the accrual, but that the Band 2 to 3 issue is a live issue. He said there is quite a lot in the media and some trusts are moving towards settlement,.
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DW remarked that for clarification, in terms of what we have committed to externally, is this £0.5m, with an extra £100k essentially, where we are right now.
RA responded yes that is correct and we have communicated that we could potentially do £0.5m. As a result of this he believes this delivers the ICB target overall.
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It was RESOLVED to NOTE the Financial Forecast

FIP/24/104 Financial Sustainability (agenda item 9)

RA provided the update stating there is not a great deal to add on this as it is pretty much the same position as the previous month The numbers show for the year to date, as a total and we are £232k ahead of plan, the detailed schemes are there, therefore there is confidence that the full amount can be secured.
RA remarked one thing for the committee to note is that there were some key lines of enquiries that we have not delivered against this year, and these still remain key lines of enquiries going into next years plan. He said overall the key headline is that this has been driven by the really positive out of area placements and contributions from Mental Health Investment Standards (MHIS).

It was RESOLVED to NOTE the financial sustainability update

FIP/24/105 West & South Yorkshire collaborative financial update (agenda item 10)

RA provided the update with key headlines as follows:-

- West Yorkshire Adult Secure is reported as breakeven in the core Trust financial position with the risk / reward share enacted.
- West Yorkshire CAMHS and Adult Eating Disorder are both reporting deficits for the year to date and forecast. Both also highlight underlying financial pressures.
- South Yorkshire Adult Secure financial position continues to be reported 100% in the SWYPFT position. This has been updated in February 2024 to breakeven (was surplus) to reflect the risk and ongoing contract negotiations with an independent sector provider and NHS England.

RA stated there are financial risks against all the collaboratives going into 2024/25, all are still struggling with exceptional packages of care and OOA placements, and are seeing a reduction in income, which for West Yorkshire is a considerable amount.

AS remarked in relation to the loss of income most Collaboratives all over the country are trying to repatriate patients and not use us as OOA, so where we sell beds OOA is where we are seeing the impact, most of that impact is in SWYPFT, and what that translates to is the fact we have empty beds because we are not selling them OOA in the same way we used to.

He said whilst the financial risk is shared across the collaborative it will inevitably spark some discussions about how we maximise SWYPFTs services, and this is something we will pick up operationally and through the Collaborative Committee. He said if we did not have the Collaborative, SWYPFT as an organisation would be feeling the full impact of loss of OOA income into services we provide.

DW asked if this poses any issues for us long term.

AS responded not as an organisation, but as a Collaborative it is an issue but it was obviously substituting some of our costs where we were generating income. He thinks it will prompt a debate about the best configuration of our bed base across the whole of West Yorkshire.

It was RESOLVED to NOTE the West and South Yorkshire Collaborative financial update

FIP/24/106 Costing update (agenda item 11)

RA provided the update stating this was the Patient Level Costing update, but just to give the committee the heads up on where we are with the National Costing situation, as AS confirmed earlier we have not yet seen or been told anything about when the outcomes of the 2022/23 submission will come. He said we have however received indicative dates for 2023/24 which is expected to be June, so we may well have done another years submission before we get to see any outputs of the last one, which is not ideal, as the benefit from all of this is the outputs, which we need to be able to see and work on.

RA explained that in relation to the internal costing system reports were available up to the end of December with a programme that will update those quarterly internally. He said we are currently validating the numbers that are in there and also trying to compare informally with RDash and Sheffield Health & Social Care just to see what some of the numbers initially look

like. He said it was used as part of the collaborative bid that was done for forensics, which we were successful in, which again is good evidence based. RA stated that he has included a spreadsheet which includes a good level of detail for every service. AS added that now we have this data and are testing its robustness, we will be using it in earnest as we go into 2024/25. RA advised that there was an open offer from Victoria in finance for a session on PLICS, should people want to see some of the more granular detail.

DW remarked that if this is going to become used more in how we do things, and how we look at opportunities, it might be something that is worth all the NEDs being updated on.
RA responded that it was in the development plan that we were going to use this instead of the traditional management accounts, but at the moment we cannot produce it monthly, so it is still going to be focused on the normal I&E for the board report etc. He said this is certainly a big hope for efficiencies and value for money for part of our conversations going forward.
AS stated there is going to be a relaunch of a system called Engagement, Value, Outcome (EVO) for organisations that are using PLICs like systems, working with clinicians to facilitate change. He said they are just about to announce the first cohort and there is a mental health trust in there which he thought was North Staffordshire. He said this is definitely something to watch out for as there is some real clinical value to it, we are probably a little way off it yet but once the North Staffordshire information starts to flow through and we can see what they focussed on we can share some of the results with this group.
AS said he agreed with DW in that we could arrange a drop in session for Board members, as this has been done previously where we run an open session, and if anyone wants to join it they can do. He said he would take this offline with RA and Victoria to make sure we have a package to present.

ACTION: Adrian Snarr/Rob Adamson

KQ remarked that she found the table very helpful, she asked what our own internal benchmarking group are doing around this.
AS responded that largely the benchmarking group centres around the NHS benchmarking network, the submissions we make and the returns we get back. The long term aim is to hopefully triangulate this, so that everything we are producing from a costing point of view and showing variance, does that translate to what the benchmarking network are saying, and areas that could be deemed inefficient or loss making are they triangulating with the benchmarking reports. He said it is early days yet and Victoria has only just joined the group, but ultimately we will also start taking these sort of costing reports through the internal benchmarking group.
KQ remarked that whilst she does appreciate we have a way to go it is important to tie both of these up so this is not just a financial benchmarking arrangement.

It was RESOLVED to NOTE the Costing update.

FIP/24/107 Annual Plan update (agenda item 12)

AS confirmed that there was an executives session last week where finance again was the main agenda point. . He said a lot of the debate was also around workforce and predominantly what are we going to do about workforce growth, and where we got to in that discussion was that we are going to revise the plan to take out the workforce growth. He said we have to come up with an organisational wide workforce plan before we can determine whether we need to grow it or not.

RA remarked that in terms of workforce we have done a lot better than we have said which is positive, but what he did want to flag is that we have still not received final guidance. He heard on Friday that they are changing some of the core assumptions within the guidance they have previously issued, which will take another 0.2% of our income out.
AS remarked it is good that inflation is coming down, and then the national team have decided they are going to take 0.2% off us, as their view is that it is a net nil and because inflation is coming down you don't need it.
RA said this is another pressure which is really late in a process considering we are submitting by lunchtime today.
RA explained he had taken EMT through the changes that had been made since the last submission, where we have subsequently identified some more efficiencies and have revised some of our pay calculations. Total efficiencies identified at the moment are £8.4m.
RA stated that it is hard to explain when you just see numbers on a spreadsheet, but basically if our targets break even and we keep the workforce where we are now we will be able to deliver break even.

DW asked if there was still some workforce growth in there at the moment.
RA responded yes, there is the full year effect of everything we have been doing this year which is locked in. Also, there is still growth up to the £262k level in terms of the baseline plan. He said what the numbers are suggesting is that we cannot afford this necessarily, we can afford to keep on the rate we have got now. He said part of the EMT conversation was around we can still get substantive staff to replace the agency and the bank, so we can still keep recruiting, but the point AS made earlier was about the targeted approach and focussing on the areas with the greatest need.

AS remarked just to put it in context this was nearly a 3 hour discussion at EMT and lots of concerns were raised around what does that mean. He said we went over quite a few times that actually standing still is not always a bad thing because we have had significant workforce growth in 2023/24, so we are just holding the position. We are not reducing our headcount, and the essence of the conversation was that we need to be much better at targeting our recruitment so there were a number of significant actions that came out of this.
AS stated one thing we are going to do is we have vacancy control at care group level at the minute and we are going to put an extra tier in that provides executive oversight and Sean Rayner is going to chair this group.
He said there was a bit of work to do on how we construct that oversight to mean that we do not delay essential recruitment because that is also a tactic the NHS has deployed in the past, and that is not what we are intending at all.
AS stated we are going to make some changes as to how we recruit and what has been hugely successful for us is centralised recruitment, it really has helped us drive up the numbers. He said towards the back end of the year this has caused us some challenges and they have manifested themselves in, we have more international nurses than we originally planned for, and operational colleagues are now struggling to accommodate the numbers above plan, and as a consequence we have had some challenges recruiting our newly qualified staff through British universities, which we have done at risk, but again it is getting harder to place them in teams. He said we are putting some of the emphasis and accountability and responsibility back into teams to recruit, and this is still to be debated a little bit more.

AS stated as a consequence of all of this EMT did support we would hold the workforce without growth until we can work this through. He said tactically externally this buys us a little bit of time. We do need to understand MHIS as this is a legitimate reason to grow your workforce, so we just need to figure out how that fits into it. Also, that we do not necessarily drop all of that into our financial bottom line at this point so we have initially indicated to the ICB that we will remove workforce growth, and therefore we could reduce our deficit to £1.5m. He said if we are being realistic they will keep pushing until we get to zero but we just need a little bit of time to digest

last Thursdays conversation and turn it into a plan and then we will review the figures again. Where we sit today is zero workforce growth, reduce the deficit to £1.5m, and a stepped change in the way that we scrutinise recruitment into the organisation. He said none of this has gone out in a communication to anyone yet as we still need to figure this out as we know we need to get this right.

DW remarked that the workforce plan feels like one of the biggest bits, and in terms of addressing this it feels too big for somebody to do alongside their day job and have we got a plan of how we would approach this.
AS responded there is still work to do on this, and what we do have is a very detailed plan for inpatients, what we haven't got is a very detailed plan for everything else. He said the worry is if we say yes to the inpatients, that sets the parameters for the community, so should we hold back on the decision for a little while until we have more clarity on what we need for community as they carry the highest level of vacancies at this point in time because we have worked really hard on inpatients for over a year now to staff them up.

NM commented that she agreed with DW around the workforce planning and she did not feel it was our place to say what that should look like, and it is about how we get assurance that the executives are doing this and recognising this. She said she felt a shiver down her spine when she heard the two words vacancy control, which has been a very strong feature in most of her career in the NHS. She said we know that often people end up saying vacancy control is a recruitment freeze and it is not, it is a control process to scrutinise and make sure it is happening. NM stated the comms around this is a really important part so people do not jump to the wrong assumption.
AS responded he agreed with NM and that is why we would take a little bit of time to reflect on the comms as it needs to build on the positive messages from 2023/24 which is that we have done brilliantly and therefore that puts us in a very strong position going forward which is why we are able to do this workforce plan. He said everybody recognises that we have to get the comms right or else it could backfire on us.
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AS asked if the committee were happy to formally support what has been talked through today and the fact we will revise our figures down to a £1.5m deficit whilst realising this still requires a full board discussion.

The committee stated they were all happy to support this.

It was RESOLVED to NOTE the Annual Plan update

FIP/24/108 MHIS progress update (agenda item 13)

AS stated this is a detailed report and the committee can see there is a number of green indicators coming through which means we are starting to spend the money on the key mental health investment areas. He said what has been a challenge has been the amount of time taken to agree a position with Kirklees, which is surprising as they are not normally the Place that we have the most challenge with and demonstrates the financial pressure the Places are under to make sure they bring their positions back in on balance, and where they have got to invest in new schemes they do that wisely. AS stated you can start to see this with some of the indicators showing as red, as we will not be up and running with some of them this year.
He explained that beyond the finance metrics you can start to see some high level indicators of where we have been able to staff up, that they are having a positive impact either on access times or amount of people accessing certain services, like police liaison and section 136 is starting to correlate as the investment flows through. He said he wasn't going to call out anything in particular other than it has taken a long time, but this should put us in a better

position for 2024/25 because a lot of what has been agreed has a full year effect going into this year. We are mindful because of the acute financial pressures that people will try and manipulate the MHIS, and part of our task for 2024/25 is to make sure we can hold people to account for that investment. He said that for 2023/24 it is very positive that everyone has honoured it, with significant funds flowing into us and we are just managing to deploy this now.

It was RESOLVED to NOTE the Mental Health Investment Standard update.

FIP/24/109 Performance update (agenda item 14)

Mel Wood presented the update.

IPR development plan key headlines:-

- Live with national metrics and have been for a number of months.
- Work has commenced on quality metrics section
- Developed further metrics that are derived from SystmOne data held within the performance & business information team.
- Made some progress with regards to establishing a project group for getting the people data into trust data warehouse. A project brief is being drawn this week and the proposal will be going to EMT on 4th April. This will then allow work to commence on the people data.

DW stated that as NM raised earlier, this is something else where collectively the Board are giving mixed messages as to the level of detail that is required and this is something that is going to be raised at the Board meeting this month which will hopefully help going forward.

AS stated that MW had alluded to the fact that we are going to start work on the People Data warehouse which is a significant amount of work, and we have spent a lot of time with the People Directorate trying to understand the scope and the segregational responsibilities, which has not been straight forward, and the fact that it is not readily available to understand what the scope is indicates the size of the challenge. He said an awful lot of our people and workforce returns seem to be done on an ad hoc basis and he was confident that when we get to the end of this process it will be much more structured and become part of our annual plan for all data returns, both internally and externally.
AS remarked that as NM has alluded to earlier we do have challenges in the people directorate and there is a risk that this is generating more ad hoc reports, people need to know things and we have not got the systems and processes in place to deal with that. He said we just need to appeal to people to be patient with us and not request lots of additional people data whilst we are making the transition.

KQ referred to the Aqua audit, she said she did not know the scope and parameters of it so was not sure if it covered this, but for her it feels like we need a golden thread from our services to the aggregated reports in the IPR so that we can track this through, and it feels like this is our ambition. She said in the report that feedback was positive, and she would like to see how far we had got with that golden thread and maybe this is a question for Board.

AS responded that we do debate the IPR an awful lot and the Aqua comment is quite a useful reminder that it is a good IPR and there is an awful lot in it, and that is part of the debate
He said what ourselves and Aqua have done is look across at what other people do and their view is that we have an effective IPR.
AS remarked that our latest challenge is can we see the wood for the trees, hence the latest development about the heat map, he does think it has that golden thread it's just a bit difficult to follow it sometimes with everything else that is in there.

KQ thanked AS for the update, and for her that is one of the things with audits, when they say it is positive, it doesn't actually say what is positive, and it was not clear from this, so she would have to go back to the original audit.
AS remarked that we are getting better at this as we have the care board dashboards now and they triangulate well. He said it does feel like it is a continual work in progress but he did think we are in a decent place.

NM remarked that similarly to KQ she feels she has some more questions when she looks at this because we cannot see the detail behind it, she referred to action 12, where it states remove duplication which comes from the Board committees. She said as a chair of one of the committees and a member of them she is not sure what this means.
NM said from a non-executive point of view she felt a little uncomfortable around the Aqua audit/review, as the IPR is a critical tool used both at Board and committee, she wonders how this happened and have we been involved.

AS responded there are two parts to this, one of the references to duplication is in the main body of the IPR itself where we have an introductory section, then we have priority programmes then we have them in IPR, and there was a duplication in all of them so we literally did just duplicate. He felt some of this goes back to some early debate where we did debate the level of detail in the Board IPR, and the level of detail in board sub committees is identical. He said we may have slightly clumsily worded this but there is two separate points, and one is actual duplication, where we have tried to strip out, and the other one is not just looking at what we send to the board but what do we send to sub committees and also executive groups so that we have that oversight of metrics. We have not actually removed anything; we were just trying to better understand what goes everywhere.

NM asked if this was an audit or a review.
AS responded the work that MW and her team are doing is a review and Aqua where an external body who provided an oversight and compared us to others.
AS agreed to pick this up with MW offline as Aqua are coming back and if this is something they are going to look at they need to refine this point.
NM agreed with this as there is something about whether this is an action or a review and she is trying to make the distinction between the two, and if it has been an audit there is going to be some understandable challenge from Board around should we have had some more involvement in this, from a governance, oversight perspective.
KQ completely agreed with this.

ACTION: Adrian Snarr

AS advised the Committee that we have also commissioned Grant Thornton to come in to look at the IPR and also the team on how they construct the IPR, the tools they have available to them and what the outputs are from the team. The reason for choosing Grant Thornton is that they have a data team which is built from a lot of ex audit commission staff who used to do Performance Review Body (PRB) reviews. They have a lot of expertise in NHS data, but they also have a good broad range of clients so they are in an anonymised way comparing what we do to what their other clients do and they are going to send a feedback report to JW, MW and myself so we can have a look at the actions and the learning.
AS confirmed they are doing the fieldwork now and due to complete in a couple of weeks. Once complete we will either bring their report or our report from their findings back to a future committee meeting.

DW remarked that he has a call tomorrow, and he is not sure if this includes all NEDs, so this is including a wider group than what Aqua did.
AS responded this is a very narrow brief and very much around data, so very different to what Aqua did.

New deep dive proposal
KQ remarked that the action log stated the process for the approach for choosing what areas of deep dive would be presented here and she could not see that in the pack.
DW responded that the proposed list is in there.
KQ responded that the table is helpful but for her the original question was what is the Trusts /committees approach in deciding what areas we are going to deep dive into, so for her this still does not clarify what that process is.

CH stated the deep dives that go to the Trust Board are on a rotating basis, so from that perspective there has been no particular approach to this. She said if we want a completely difference approach here, we need to think about the impact on the services for the turnaround of the reports.

KQ remarked that hers was more of a general question really and because we have not necessarily nailed this approach down ourselves there may be big gaps and services we are not looking into which we should be, or duplicating etc. She still felt the action was not quite complete.

DW commented that the conversation we had when we got this list together was looking at it from a rota perspective as currently there are two ways we believe that things will get highlighted, firstly through the rota basis and secondly through delegation from the Board. He said if we do not think this is the best approach we can always change this.
AS responded that we cover every service area in a year so he thinks the only thing we have not covered is how did we choose the order and CH has just described that. He said we do have an override facility which means if we have either a Board or FiP discussion that says I think we should deep dive on something else, we always reserve the right to amending the order, notwithstanding what CH has just said about the impact on services.
AS said we can take this away and look at the methodology but the reality is in a 12 month period we will have covered every service area in the Trust.

KQ responded for her it is still about the risk based approach and is this right as some may require more or less deep dives, also she said she did not remember Board delegating.

DW suggested reviewing this again in 3/6 months which will enable time to see how this work goes, as we have not had a good level of focus on this as yet.
KQ agreed with this but still felt we had not articulated our approach very well.
CH asked is the approach still that the care group reports will still go through Board.
DW responded yes.
AS stated we acknowledge the timing of the reports and the fact that Board will see these reports before FiP but it still allows for a more detailed analysis outside of a board meeting.
MW stated that on the proposed timetable it does note what month it will have been to Board.

DW remarked this is very much a work in progress as we have not had a detailed focus on performance and this is something that will evolve over time, and we may need to tweak this. He agreed with KQ in having a formal checkpoint around the approach is right to ensure this approach in principle is right.

It was RESOLVED to RECEIVE the Performance update

FIP/24/110 Annual Report and Effectiveness (agenda item 15)

DW stated that based on conversations over the last 12 months he was not sure there was any feedback. The Committee agreed they were happy with this.

Terms of reference

DW remarked that the terms of reference were quite out of date in late 2022. The main changes were in respect of attendees at the committee and this has now been updated.
The committee agreed they were happy with this.

Workplan

DW stated in terms of the work plan there were only a couple of minor things, one in terms of the performance, where we had agreed that we would expand this out.
In terms of the waiting list report, as agreed the reporting times have been reviewed and updated.

Effectiveness survey

DW remarked that the survey overall was quite positive and the main take aways from it was that as Chair he was not assertive enough. He said he was always happy to receive feedback and he will see what he can do to improve this. Also, papers have improved timewise, but have been a little bit late. Finally, in terms of performance, everyone commented on this in terms of what can we do more of and the committee are focussing on this.

FIP/24/111 Waiting times report including Paediatric audiology update (agenda item 16)

Carol Harris provided the update.

Key headlines

- Starting to see a new normal for Adult ADHD and ASD services in the data, this means we have got more demand than is commissioned capacity across all areas and this continues to present an increased pressure on routine waiting times. Work continues across West and South Yorkshire to try and find solutions to address the demand that is in line with the national and regional picture
- CAMHS – a discussion was held in EMT around the reduction in referrals and waits increasing. Currently there is a challenge with the reporting of the referral numbers received and then not taken on by the services and signposted elsewhere, so you only see a sub set of demands, and the team are working on this.
- CH stated that if you look at isolated monthly waiting times, particularly in CAMHS, but this flows through all services, if you see a spike that does not necessarily mean that we have hit a concern in that month, it could mean that we have taken someone off the waiting list that has had an extra long wait in that month, and that impacts the average.
- Barnsley CAMHS ADHD continue to see children within 3 months and Core CAMHS see them within 9 months. The data shows that pressure is showing and some of this relates to sickness and other vacancies. A key aspect that the team have noted is there are a number of children coming in through a referral, that are being identified as needing two professions in terms of treatment, and this impacts on our capacity in terms of appointments. We have also identified a shortfall in commissioning capacity and we are having that discussion currently with commissioners, but this is currently not met.
- Kirklees CAMHS, there have been changes in commissioning for Core CAMHS and this has now been addressed and the shortfall has been met by the this is in normal contract business now. There is still a concern in relation to Kirklees Neuro development work, there are 43 commissioned reports a month, but there are 125 referrals. Commissioners are aware and the children's work is part of the neuro development work that is taking place in both of the ICS's
- Learning Disabilities - smaller numbers do impact the percentages in terms of performance for people being seen within 18 weeks and commencing treatment. Drill down work has taken place and we have identified we have some hidden waits that are not being flagged by the usual 18 week reporting. This has been raised at the Q&S committee and there is a

report going to EMT later this week around this and we will feed back to this committee the outcome of this.

- Psychology waits - improvement work continues and we can see that this is having an impact on the length of waits and the number of people waiting.
- Paediatric Audiology - this has been recently added to this report because our performance for diagnostic appointments has deteriorated further and is now at 50% in relation to children that are receiving a 6 week diagnostic appointment. Overall, we are seeing an increased pressure in overall audiology appointments, the wait has now gone up to 5 weeks whereas it used to be quite stable at round a3 weeks. We are working with our partners to try and find a solution for this. It is in line with our regional picture and emerging national picture in relation to audiology. Whilst it is still high, the maximum wait remains stable at around 12 weeks. This does remain a concern.

KQ referred to the paediatric audiology, she said just to be clear are they saying that young children are being referred to audiology to rule out hearing or is this an unintended consequence because we have higher waiting times in other children's services.
CH responded this is not something we are consciously doing in the trust, but it is possible that the referrer, i.e. the GP might have this in mind when referring the individual. In relation to the audit the Trio have taken some exceptional action to approve a number of policies so that we get in line with the rest of the services across the ICS and meet the requirements of the audit.
CH confirmed the audit and the waits are separate.
KQ thanked CH for the helpful update

NM remarked that we need to ensure that an update is provided at a future meeting on the paper that is going to the executive team around the measures in learning disability issue.

NM said it is positive to see the work that is going on around the ethnic monitoring and deprivation data, and it is really good to see we are looking at how do we capture data around inequalities and deprivation that inevitably expand where we want to go

It was RESOLVED to RECEIVE the Waiting Times update

FIP/23/113 Any other Business (agenda item 18)

AS provided the committee with an update on Cheswold Park. He confirmed that the national director for specialist services was briefed on Friday and is supportive of the steps we are taking.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
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 March 2024.		
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 Group (OMG) meeting.		
Executive summary:	This executive summary provides an overview of key insights from the IPR as at the end of March 2024. Three annual indicators have been included this month following the results of the NHS Staff survey: • Staff survey engagement theme score - National staff survey • Staff survey bullying and harassment score - National staff survey • Aggregate score for NHS staff survey questions that measure perception of leadership culture - National staff survey		

	These metrics are included in the NHS England Oversight Framework and are used along with a number of other national metrics included within this report to assist with gaining assurance of place-based systems and individual organisations. Trust performance on these metrics is generally good and in most areas has seen an improvement in this year compared to last and sector averages. Further detail can be seen in the People section of the report. A new indicator was included last month for performance against the Oliver McGowan Mandatory Training on Learning Disability and Autism. This is a legal requirement for CQC regulated service providers, which came into effect from 1 July 2022. The Trust has been following a phased approach in line with the national plan. The Oliver McGowan training was available via e-learning from August 2022 and was attached to all staff as a mandatory training requirement from December 2023 and appears in all staff mandatory training compliance reports. Trust performance against the e-learning module is exceeding the national 10% threshold and further improvement has been since to end March '24. Plans are in place to continue the roll out as it becomes available. 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 94.9% against a target of 90%. For the Trust derived indicators, as of March 2024, disability is at 47.5%, sexual orientation 59.9% and postcode is at 99.8%. 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 and there has been a slight increase in recording over the last month. • 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 to ensure that our approach is fair and does not present needless barriers or disadvantage any protected groups of people. No policy is agreed without an equality impact assessment in place. All services have an EIA in place. Expired EIAs (or EIAs not reviewed and graded within the 12-month cycle) expired in March and have all been offered support to complete. Our approach is to change the

submission and review of EIAs to April-February cycle ensuring March gives the Trust a final position statement.

Quality

NHS England Indicators (national)

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

- Continued service improvement work supports the overall use of inappropriate out of area bed days however, there was an increase in March compared to the last five months with 138 days used. This slight increase in keeping with previous years at this point in the year. The use of out of area beds continues to be an improved position when compared to the first six months of the year and for the full 2023/24 year (3184 days) compared to 2022/23 (4965 days). Need for use of these beds mainly relates to the requirement for gender specific psychiatric intensive care (not commissioned locally), increased acuity and capacity issues due to challenges to timely discharge. Workforce pressures also impact the successful management of acuity. 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 waiting for a diagnostic appointment (paediatric audiology) within 6 weeks decreased to 66.3% in March, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service only. The small in month decline was due to school holidays resulting in staff taking annual leave and parental choice to change appointments. The team continue delivering the improvements on the action plan and have a service review booked in May '24 which will assess the progress against this.

Local Quality Indicators

The Trust continues to perform well against the majority of quality indicators; however, the following should be noted:

Care Planning and Risk Assessments

The March data for care planning shows a drop in the sustained performance to under 80% for the first time since April '23, at 73.6%. This was an unexpected drop based upon the improvement work but has been observed seasonally in previous years linked to increased annual CPA review activity. Performance is expected to improve in April.

For risk assessments, the March data shows a slight increase in performance from the previous month within inpatient services 91.7% this means that 110 service users had a risk assessment within 24 hours, 10 service users had a completed risk assessment but this was outside the 24 hours. For community

services, performance for March has increased slightly to 79.2% - 38 people are showing to not have a risk assessment – all service users without a risk assessment are followed up individually in the care group to maintain patient safety.

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.
  - 'While you wait' offers are in place or in development for children on waiting lists, teams maintain contact with children and families while they wait to ensure appropriate action can be taken in case risks escalate.
  - Waiting times and waiting numbers for neurodevelopmental services within CAMHS remain high, with a specific risk noted where additional capacity is no longer available in Kirklees. 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 challenging due to staffing/operational pressures in community learning disability services, with 76.7% - (35 out of 46) 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. During March the LD team have focussed on people with the longest waits and this has had an impact on staffing capacity to meet the 18 weeks. Improvement work, including recruitment, additional training for staff in specific skills for example dysphagia and pathway development continue.
- Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels significantly higher than commissioned – cases, where agreed with commissioners, are triaged and prioritised according to need. As demand is significant the care remains with the referrer until accepted by the service.

Patient Safety Indicators

95% of incidents reported in March 2024 resulted in no or low harm or were not under the care of the Trust, an overview of key indicators is below:

- The number of restraint incidents increased to 188 (165 in February). Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain static – all incidents are reviewed and learning is shared.
- Positively, 92.3% of prone restraint incidents were for a duration of three minutes or less – this related to 13 incidents for the month of March. The circumstances where prone is used will be influenced by the level of concern during the incident. Improvement work is underway with regards to minimising prone restraint during seclusion exit or when administering intra-muscular medication. All incidents of prone restraint are now reviewed for learning in the Patient Safety Oversight Group.

	• There were five information governance personal data breaches during March which is a significant reduction on previous months (20 reported in February). Following the spike last month, an urgent communications campaign is in progress, and items will be issued via the intranet, the Headlines and the Brief. The appropriate Quality & Governance Leads have also been advised, and the Information Governance team will work with them to ensure improvements are made. • The number of inpatient falls in March was 45 which is in line with numbers over the last quarter. All falls are reviewed to identify measures required to prevent reoccurrence. and more serious falls are investigated. There have been no red or amber Datix incident reported (falls with injury) during the month. • The number of responses provided within six months of the date a complaint remains under the Trust threshold of 100%. Improvement work continues and this is reflected in the overall improvement of this metric since April '23. **Our People** • Supervision data is included in the report at Trust level and by care group and inpatient ward. The data for March is 73.0% which is an improvement from the refreshed performance for February which is 68.7%. This means that more staff have had access to a supportive conversation about their practice. The improvement work continues. Supervision is monitored monthly by the operational management group. • The Trust had 23 violence and aggression incidents against staff on mental health wards involving race during March - incidents are monitored by the Patient Safety Team, and Equity Guardians are alerted to all race related incidents against staff. Recognising that this has an impact on 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. • For the full year, we have had 692.8 new starters and 460.8 leavers. • At the end of March 2024, our Trust growth rate has increased further to 7.7% (staff in post) as a result of targeted recruitment activity over the year. This has exceeded our annual forecasted growth rate of 4%. As the new financial year approaches our teams need to refocus on keeping our workforce numbers static throughout 2024/25 to meet our planned workforce targets. • Overall, our 12-month turnover rate in March has dropped slightly again this month to 11.0% which is a reflection of the low number of leavers and increase in new starters over the year. This means that more skills and experience have been retained. • In March 2024 we have seen a drop in sickness overall to 4.4%. This is seen as a positive and the Trust does not appear to have been impacted excessively by winter seasonal absence. • The combination of reduced turnover, successful recruitment and an overall reduction in sickness along with improved appraisal compliance should be considered to be related as working with regular staff in supportive teams contributes to a great place to work.

- Sickness absence year-to-date in March remains at 5.0% which is above local threshold. This remains the lowest sickness rate since April 2023.
- Estates and Facilities sickness absence continues to be high at 8.92%. This staff group have seen a consistent monthly rise since April (Apr 6.15%). Further work is being done with our Business Partners to help support Estates and Facilities, along with an internal audit.
- We have increased our rolling appraisal compliance rate again in March, which saw an increase from 82.9% 84.2%. This is the second month the compliance of 80% has been reached. Actions remain in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.
- Although our overall mandatory training compliance has increased slightly to 91.9%, we have seen a drop in some areas. Reducing Restrictive Physical Interventions (RRPI) has dropped again this month to 73.0% however our learning and development team and RRPI team are working together to maximise the training places available and are taking a targeted approach to booking staff onto refresher training.
- Information governance training has reduced slightly to 91.5%. Whilst Cardiopulmonary Resuscitation has increased to 77.8% this also remains below the Trust targets - 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). Individuals will be contacted directly by a member of the learning and development team when a place is available to ensure as many staff as possible are able to complete their learning. Weekly e-mail reminders are going out to all staff.

Care Groups

In addition to the care group information found within this report, a separate deep dive into the Barnsley Physical Health & Wellbeing care group can be found under item 10.2 on this board agenda.

The care group summary section describes the “hotspot” performance areas and mitigating actions for the month of March, and we have also provided a breakdown of the 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, particularly whilst focussing on reducing reliance on out of area bed use. Capacity to meet demand for beds remains challenging.
- Although recruitment has been positive, there is increased pressure on the wards from the number of learners that require support, for example student nurses, internationally recruited nurses and newly registered staff, creating additional pressures.
- The Trust currently has higher than usual levels of vacancies in some mental health community teams for qualified practitioners. Work continues to review establishments and create proactive and innovative solutions to the workforce.

	• Demand into the Single Point of Access (SPA) continues. SPA continues to prioritise 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 March performance data indicates that the routine access for assessment target is being achieved in Calderdale and Kirklees and Wakefield whilst performance is below target in Barnsley. Barnsley performance remains below target in March which requires specific measures for improvement in addition to current business continuity plans and improvement work. This will include further consideration of systems and processes within the team, workforce modelling, pathways with core and enhanced, improving pathways with primary care and talking therapies to provide timely assessment and the most appropriate intervention to meet individual need. • Access to tier 4 beds and specialist residential care for children remains a risk and currently more challenging due to pressures within the 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. Concerns have been escalated by the executive trio to the CAMHS inpatient provider collaborative executive trio. • There were two patients under 18 years old in an adult bed during March. Whilst this is measured clearly, other children will wait in other settings, for example acute hospital beds or home, for inpatient care. 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 mental health care group have seen an increase in the number of physical violence (patient on staff) in March. Almost half of incidents related to two service users and the intervention of staff have stopped these from becoming more serious incidents. Staff teams have liaised with RRPI team for specialist advisor input as needed. Recognising the impact of violence upon staff support is offered after an incident. **Finance** • The Trust agreed to a revised surplus position in February 2024. This has been achieved with a surplus of £0.5m (which is £0.5m better than the breakeven target). • Agency spend has continued to reduce in March 2024 with total spend of £8.3m in year. This is a £1.7m (17%) reduction from the prior year. Work continues to maintain, and improve, this run-rate into 2024/25. • Actions are in place to address agency spend, which is being overseen by the Trust's agency group. • The Trust cash position remains strong, although this has reduced to under £70m in March 2024. This was forecast in line with expected revenue and capital payments. • Performance against the Better Payment Practice Code is 98%.
Recommendation:	**Trust Board is asked to:**

	NOTE the Integrated Performance Report and **COMMENT** accordingly.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

March 2024

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Table of Contents

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for March 2024. The development of the IPR continues, with a ward level breakdown of key metrics within the care group section of the report, added from September 2023.

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.

Headlines

This section of the report identifies metrics where there has been a change in performance or where expected levels are not being achieved. A hyperlink has been added to each section so the reader can look at the detail relating to the metrics in that section in the main body of the report as required.

Strategic Objectives & Priorities

Metric	Change from last month	Variation/ Assurance
Improving Health		
Percentage of service users who have had their equality data recorded - disability	↑	
Timely completion of equality impact assessments (EIAs) in services and for policies	↑	
Improving Resources		
Surplus/(deficit) against plan (monthly)	↑	

Metric	Change from last month	Variation/ Assurance
Improving Care		
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	↑	
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community	↑	
Inappropriate out of area bed placements (days)	↓	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	↓	
% Service users on CPA offered a copy of their care plan	↓	

Metric	Change from last month	Variation/ Assurance
Making SWYPFT a great place to work		
Sickness absence - rolling 12 months	↔	
Workpal appraisals - rolling 12 months	↑	
Staff supervision rate	↑	
Mandatory training - Cardiopulmonary resuscitation	↑	
Mandatory training - Information governance	↓	
Mandatory training - Reducing restrictive practice interventions	↓	

Quality		
Metric	**Change from last month**	**Variation/ Assurance**
Complaints - Number of responses provided within six months of the date a complaint received	↑	
Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care	↑	
Number of information governance breaches	↑	

People		
Metric	**Change from last month**	**Variation/ Assurance**
Sickness absence - month	↑	

National metrics		
Metric	**Change from last month**	**Variation/ Assurance**
Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)	↓	
Total bed days of Children and Younger People under 18 in adult inpatient wards	↑	
Total number of Children and Younger People under 18 in adult inpatient wards	↓	
Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week	↑	
The number of completed non-admitted RTT pathways in the reporting period	↓	
The number of incomplete RTT pathways in the reporting period	↓	
Community services waiting lists	↓	

Care Groups

CAMHS

Metric	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% of staff receiving supervision within policy guidance	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↑	
Eating Disorder - Urgent/Emergency clock stops	↑	
Information Governance training compliance	↓	
Reducing restrictive physical interventions training compliance	↑	
Sickness rate (monthly)	↓	

Mental Health Community

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% of staff receiving supervision within policy guidance	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↔	
Information Governance training compliance	↑	
Reducing restrictive physical interventions training compliance	↑	
Sickness rate (Monthly)	↑	
FIRM Risk Assessments - Staying safe care plan in 7 working days	↓	
% Complaints with staff attitude as an issue	↓	

Mental Health Inpatient

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% bed occupancy	↓	
Cardiopulmonary resuscitation (CPR) training compliance	↓	
% of clients clinically ready for discharge	↑	
FIRM Risk Assessments - Staying safe care plan in 24 hours	↑	
Information Governance training compliance	↑	
Sickness rate (Monthly)	↑	
Reducing restrictive physical interventions training compliance	↓	
% Complaints with staff attitude as an issue	↓	

LD, ADHD & ASD

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% of staff receiving supervision within policy guidance	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↓	
% of clients clinically ready for discharge	↔	
Information Governance training compliance	↓	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	↓	
Reducing restrictive physical interventions training compliance	↑	
% Complaints with staff attitude as an issue	↑	

Barnsley General Community Services

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% of staff receiving supervision within policy guidance	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↑	
Information Governance training compliance	↑	

Forensic

Metrics	Change from last month	Variation/ Assurance
% Appraisal rate	↑	
% Bed occupancy	↑	
Cardiopulmonary resuscitation (CPR) training compliance	↑	
Information Governance training compliance	↑	
Reducing restrictive physical interventions training compliance	↓	
Sickness rate (Monthly)	↓	

Key

Improvement from last month but up to 5% below threshold	
No change from last month and up to 5% below threshold	
Deterioration from last month and up to 5% below threshold	
Improvement from last month and below threshold	
No change from last month and below threshold	
Deterioration from last month and below threshold	
Achievement of threshold and increased performance from last month.	
No change from last month and achieving threshold	
Achievement of threshold but decreased performance from last month.	

	Variation Icons The icon which represents the last data point on an SPC chart is displayed.						Assurance Icons If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.		
ICON									
SIMPLE ICON	● ● ●	● ? H L ●	● H ●	● L ●	● H ●	● L ●	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

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 94.9% against a target of 90%. For the Trust derived indicators, as of March 2024, disability is at 47.5%, sexual orientation 59.9% and postcode is at 99.8%. 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 and there has been a slight increase in recording over the last month.
• 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 to ensure that our approach is fair and does not present needless barriers or disadvantage any protected groups of people. No policy is agreed without an equality impact assessment in place and therefore we have investigated why the performance is under 100%. This is a decrease since last month's reporting figures due to high number of EIAs expiring in the same month of March and April. The EI team will be contacting EIA owners so they can dedicate time to update these in the next 2 weeks. Work is progressing to ensure we move back into a green position by early May.

Quality

NHS England Indicators (national)
The Trust continues to perform well against the majority of national metrics. The following under-performance should be noted:
• Continued service improvement work supports the overall use of inappropriate out of area bed days however, there was an increase in March compared to the last five months with 138 days used. This slight increase in keeping with previous years at this point in the year. The use of out of area beds continues to be an improved position when compared to the first six months of the year and for the full 2023/24 year (3184 days) compared to 2022/23 (4965 days). Need for use of these beds mainly relates to the requirement for gender specific psychiatric intensive care (not commissioned locally), increased acuity and capacity issues due to challenges to timely discharge. Workforce pressures also impact the successful management of acuity. 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 waiting for a diagnostic appointment (paediatric audiology) within 6 weeks decreased to 66.3% in March, this continues to remain below the national threshold of 99%. This metric relates to the Trust's Paediatric Audiology service only. The small in month decline was due to school holidays resulting in staff taking annual leave and parental choice to change appointments. The team continue delivering the improvements on the action plan and have a service review booked in May '24 which will assess the progress against this.

Quality continued

Care planning and risk assessments

• The March data for care planning shows a drop in the sustained performance to under 80% for the first time since April '23, at 73.6%. This was an unexpected drop based upon the improvement work but has been observed seasonally in previous years linked to increased annual CPA review activity. Performance is expected to improve in April.

For risk assessments, the March data shows a slight increase in performance from the previous month within inpatient services 91.7% this means that 110 service users had a risk assessment within 24 hours, 10 service users had a completed risk assessment but this was outside the 24 hours. For community services, performance for March has increased slightly to 79.2% - 38 people are showing to not have a risk assessment – all service users without a risk assessment are followed up individually in the care group to maintain patient safety.

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.

• 'While you wait' offers are in place or in development for children on waiting lists, teams maintain contact with children and families while they wait to ensure appropriate action can be taken in case risks escalate.

• Waiting times and waiting numbers for neurodevelopmental services within CAMHS remain high, with a specific risk noted where additional capacity is no longer available in Kirklees. 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 challenging due to staffing/operational pressures in community learning disability services, with 76.7% - (35 out of 46) 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. During March the LD team have focussed on people with the longest waits and this has had an impact on staffing capacity to meet the 18 weeks. Improvement work, including recruitment, additional training for staff in specific skills for example dysphagia and pathway development continue.

• Adult Attention Deficit Hyperactivity Disorder (ADHD) and autism referrals continue to be at levels significantly higher than commissioned – cases, where agreed with commissioners, are triaged and prioritised according to need. As demand is significant the care remains with the referrer until accepted by the service.

Patient Safety Indicators

95% of incidents reported in March 2024 resulted in no or low harm or were not under the care of the Trust, an overview of key indicators is below:

• The number of restraint incidents increased to 188 (165 in February). Statistical analysis of data since April 2018 shows that the number of restraint incidents month on month remain static – all incidents are reviewed and learning is shared.

• Positively, 92.3% of prone restraint incidents were for a duration of three minutes or less – this related to 13 incidents for the month of March. The circumstances where prone is used will be influenced by the level of concern during the incident. Improvement work is underway with regards to minimising prone restraint during seclusion exit or when administering intra-muscular medication. All incidents of prone restraint are now reviewed for learning in the Patient Safety Oversight Group.

• There were five information governance personal data breaches during March which is a significant reduction on previous months (20 reported in February). Following the spike last month, an urgent communications campaign is in progress, and items will be issued via the intranet, the Headlines and the Brief. The appropriate Quality & Governance Leads have also been advised, and the Information Governance team will work with them to ensure improvements are made.

• The number of inpatient falls in March was 45 which is in line with numbers over the last quarter. All falls are reviewed to identify measures required to prevent reoccurrence. and more serious falls are investigated. There have been no red or amber Datix incident reported (falls with injury) during the month.

• The number of responses provided within six months of the date a complaint remains under the Trust threshold of 100%. Improvement work continues and this is reflected in the overall improvement of this metric since April '23.

Our People

• Supervision data is included in the report at Trust level and by care group and inpatient ward. The data for March is 73.0% which is an improvement from the refreshed performance for February which is 68.7%. This means that more staff have had access to a supportive conversation about their practice. The improvement work continues. Supervision is monitored monthly by the operational management group.

• The Trust had 23 violence and aggression incidents against staff on mental health wards involving race during March - incidents are monitored by the Patient Safety Team, and Equity Guardians are alerted to all race related incidents against staff. Recognising that this has an impact on 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.

• For the full year, we have had 692.8 new starters and 460.8 leavers.

• At the end of March 2024, our Trust growth rate has increased further to 7.7% (staff in post) as a result of targeted recruitment activity over the year. This has exceeded our annual forecasted growth rate of 4%. As the new financial year approaches our teams need to refocus on keeping our workforce numbers static throughout 2024/25 to meet our planned workforce targets.

• Overall, our 12-month turnover rate in March has dropped slightly again this month to 11.0% which is a reflection of the low number of leavers and increase in new starters over the year. This means that more skills and experience have been retained.

• In March 2024 we have seen a drop in sickness overall to 4.4%. This is seen as a positive and the Trust does not appear to have been impacted excessively by winter seasonal absence.

• The combination of reduced turnover, successful recruitment and an overall reduction in sickness along with improved appraisal compliance should be considered to be related as working with regular staff in supportive teams contributes to a great place to work.

• Sickness absence year-to-date in March remains at 5.0% which is above local threshold. This remains the lowest sickness rate since April 2023.

• Estates and Facilities sickness absence continues to be high at 8.92%. This staff group have seen a consistent monthly rise since April (Apr 6.15%). Further work is being done with our Business Partners to help support Estates and Facilities, along with an internal audit.

• We have increased our rolling appraisal compliance rate again in March, which saw an increase from 82.9% 84.2%. This is the second month the compliance of 80% has been reached. Actions remain in place to address hotspot areas in care groups and support services and the focus continues across the Trust to prioritise appraisals.

• Although our overall mandatory training compliance has increased slightly to 91.9%, we have seen a drop in some areas. Reducing Restrictive Physical Interventions (RRPI) has dropped again this month to 73.0% however our learning and development team and RRPI team are working together to maximise the training places available and are taking a targeted approach to booking staff onto refresher training.

• Information governance training has reduced slightly to 91.5%. Whilst Cardiopulmonary Resuscitation has increased to 77.8% this also remains below the Trust targets - 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). Individuals will be contacted directly by a member of the learning and development team when a place is available to ensure as many staff as possible are able to complete their learning. Weekly e-mail reminders are going out to all staff.

Care Groups

The care group summary section describes the “hotspot” performance areas and mitigating actions for the month of March, and we have also provided a breakdown of the 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, particularly whilst focussing on reducing reliance on out of area bed use. Capacity to meet demand for beds remains challenging.

• Although recruitment has been positive, there is increased pressure on the wards from the number of learners that require support, for example student nurses, internationally recruited nurses and newly registered staff, creating additional pressures.

• The Trust currently has higher than usual levels of vacancies in some mental health community teams for qualified practitioners. Work continues to review establishments and create proactive and innovative solutions to the workforce.

• Demand into the Single Point of Access (SPA) continues. SPA continues to prioritise 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 March performance data indicates that the routine access for assessment target is being achieved in Calderdale and Kirklees and Wakefield whilst performance is below target in Barnsley. Barnsley performance remains below target in March which requires specific measures for improvement in addition to current business continuity plans and improvement work. This will include further consideration of systems and processes within the team, workforce modelling, pathways with core and enhanced, improving pathways with primary care and talking therapies to provide timely assessment and the most appropriate intervention to meet individual need.

• Access to tier 4 beds and specialist residential care for children remains a risk and currently more challenging due to pressures within the 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. Concerns have been escalated by the executive trio to the CAMHS inpatient provider collaborative executive trio.

• There were two patients under 18 years old in an adult bed during March. Whilst this is measured clearly, other children will wait in other settings, for example acute hospital beds or home, for inpatient care. 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 mental health care group have seen an increase in the number of physical violence (patient on staff) in March. Almost half of incidents related to two service users and the intervention of staff have stopped these from becoming more serious incidents. Staff teams have liaised with RRPI team for specialist advisor input as needed. Recognising the impact of violence upon staff support is offered after an incident.

Finance

• The Trust agreed to a revised surplus position in February 2024. This has been achieved with a surplus of £0.5m (which is £0.5m better than the breakeven target).

• Agency spend has continued to reduce in March 2024 with total spend of £8.3m in year. This is a £1.7m (17%) reduction from the prior year. Work continues to maintain, and improve, this run-rate into 2024/25.

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

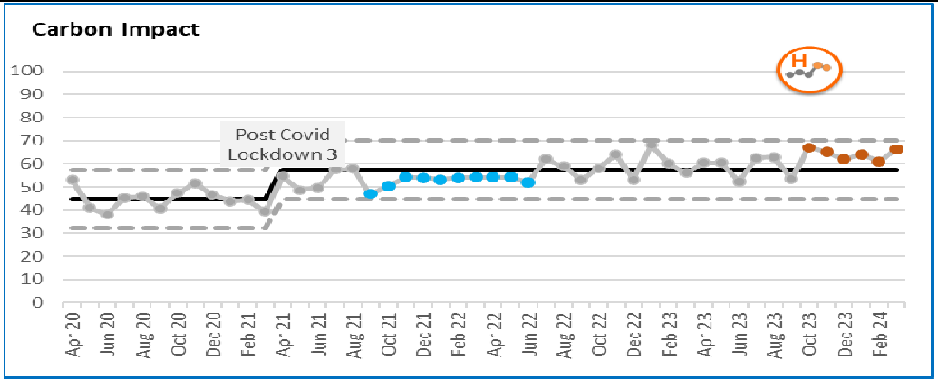
• The Trust cash position remains strong, although this has reduced to under £70m in March 2024. This was forecast in line with expected revenue and capital payments.

• Performance against the Better Payment Practice Code is 98%.

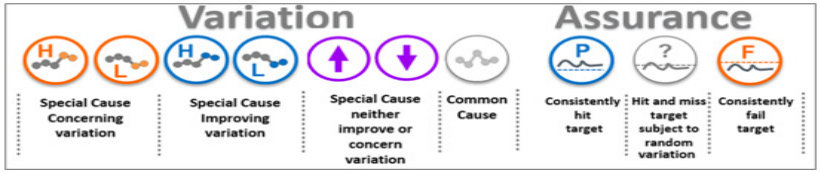
Improving health

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance	Notes
Percentage of service users who have had their equality data recorded - ethnicity	90%	96.6%	95.6%	94.9%		
Percentage of service users who have had their equality data recorded - disability	50%	46.4%	47.4%	47.5%		A statistical approach is being undertaken in order to work out a target that will be adjusted based on actual performance each month. The current threshold is 50%. Please note that from January 2024 service users under 16 years of age have been excluded from the sexual orientation calculation.
Percentage of service users who have had their equality data recorded - sexual orientation		59.4%	59.7%	59.9%		
Percentage of service users who have had their equality data recorded - deprivation (postcode)	90%	99.8%	99.8%	99.8%		
Timely completion of equality impact assessments (EIAs) in services and for policies	Service timely completion - 75%	88.5% Service	91.7% Service	91.7% Service		All services have an EIA in place. Expired EIAs (or EIAs not reviewed and graded within the 12-month cycle) expired in March and have all been offered support to complete. Our approach is to change the submission and review of EIAs to April-February cycle ensuring March gives the Trust a final position statement.
	Policy - 95%	95.8% Policy	95.5% Policy	96.1% Policy		
Completion of equality mandatory training	>=80%	95.1%	95.6%	95.6%		
Number of job start/work retention outcomes during month by individual placement and support service	Trend monitor	Reported from Feb '24	7	12		New metric added March 2024. A single client could have multiple job starts
Number of new people accessing Individual placement and support service during month	Trend monitor	Reported from Feb '24	50	44		New metric added March 2024. First contact and work started on vocational profile
Carbon Impact (tonnes CO2e) - business miles	76	64	61	66	H	Data showing the carbon impact of staff travel / business miles. In March staff travel contributed 66 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 May 2024				Q1 - 65%, Q2 - 66%, Q3 - 68%. A weighted average is used given there are different targets in different service areas.

What the data is telling us. Statistical process control charts will be inserted here to alert the reader to charts which identify improvement or that require further work or investigation



The SPC chart 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. Although we remain under threshold, we have recently entered a period of special cause concerning variation. Levels are not expected to return to those seen pre-Covid-19 as a more blended approach to working is expected to continue.



Improve Care

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance	Notes
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95%	93.4%	90.1%	91.7%		March data shows a slight decrease in performance from the previous month within inpatient services to 89.7%. This is the second month where a decrease in performance has been recorded, this equates to a very small number of service users, there are no themes in learning. For community services, performance for March has increased slightly to 79.2%.
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%	71.8%	74.7%	79.2%		The Care Plan and Risk Assessment Improvement Group review challenges with performance and review for improvement opportunities. Opportunities include making the data easier to review for performance figures and adding pop up reminders to the system, both of which are being explored. Communications and narrative about the importance of risk assessments and timeliness of this is being developed to share. .
% Service users on CPA offered a copy of their care plan	80%	88.5%	88.7%	73.6%		The Care Plan and Risk Assessment Improvement Group continue to look at performance as well as quality of care planning and risk assessments. The March data for care planning shows a drop in the sustained performance to under 80% for the first time since April '23, at 73.6%. This was an unexpected drop based upon the improvement work but has been observed seasonally in previous years linked to increased annual CPA review activity . Other learning suggests there is a need to review the terminology used to prevent clinician confusion, this is forming part of the changes to the care plan.
Registered substantive staff in post mental health and learning disabilities services	Establishment	1088	1094	1109		
Registered substantive staff in neighbourhood teams	Establishment	171	174	176		
Number of violence and aggression incidents against staff on mental health wards involving race	Trend monitor	23	25	23		Any increases will be monitored by the Patient Safety Team.
Inappropriate out of area bed placements (days)	Q1 - 455, Q2 - 368, Q3 - 276, Q4 - 0	104	74	138		The Q4 target shown is a National target and whilst we remain above this threshold we have seen a notable improvement in the number of out of area bed days which is down to an average of 95 days in the past 5 months from an average of 335 days in the 5 months prior to that. Out of area bed placements continues to be a Trust priority programme to address the operational and financial pressures that this causes and to ensure that services users receive care closer to their home. See statistical process chart in National Metrics section for further detail. Please note, this is an in month position and may not reflect the quarterly outturn.
% service users clinically ready for discharge	<=3.5%	4.3%	2.9%	2.5%		Performance in month has improved to 2.5% and below threshold. However, there are still a significant number of people who are delayed which may impact on performance in future months. 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. Further work taking place to review this as the improved position for this does not reflect what we believe is happening in practice.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Calderdale	126	636	702	683		Neurodevelopment waits remain a concern, especially given the additional capacity has stopped at the end of March 2024. This is in keeping with the national picture and forms part of the system wide work. These metrics calculate length of wait in days for those discharged that month. Children and young people 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 and there is still a backlog of individuals who will have waited a long time for assessment from referral.
CAMHS - Average wait (days) to neurodevelopmental assessment from referral - Kirklees	126	633	636	611		Calderdale - The longest wait for those seen in the month was 749 days, the shortest was 605 days. Number on waiting list at end of March - 232. The longest waiter on the waiting list had waited 717 days. Kirklees - The longest wait for those seen in the month was 651 days, the shortest was 394 days. Number on waiting list at end of March - 1959. The longest waiter on the waiting list had waited 675 days.
Learning Disability - % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	83.8% 62/74	87.5% 42/48	76.7% 35/46		This remains a key concern and actions are underway as part of the improving access priority programme. Where waits breached 18 weeks (11 in total in March) the service understand why and are taking appropriate action. A report in relation to waits will be discussed in the Executive Management Team meeting. During March the LD team have focussed on people with the longest waits and this has had an impact on staffing capacity to meet the 18 weeks.
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	80%	88.7%	92.0%	87.5%		
Community health services two hour urgent response standard	70%	86.3%	87.8%	88.2%		
Referral to assessment within 2 weeks (external referrals)	75%	80.5%	81.8%	89.3%		

Improve resources

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance	Notes
Surplus/(deficit) against plan (monthly)	Breakeven	(£144k)	(£149k)	(£53k)		Overall the Trust has reported a surplus of £540k for 2024 / 25. This is higher than the planned breakeven plan. A deficit of £53k has been reported in March 2024. Although a deficit this is £363k higher than planned.
Capital spend against plan (monthly)	£8.8m	(£16k)	£1,033k	£2,766k		Spend in March 2024 was £3.2m which was £2.8m more than plan. Total capital spend, excluding leases, was £8.2m which is £0.1m less than the Trust capital allocation. The target of £8.8m originally included a 5% aspiration, as set by West Yorkshire Integrated Care Board, but this was reset back to allocation in November 2023.
Agency spend managed within the overall workforce (Monthly)	3.5% £8.7m	£581k	£483k	£438k		The reduction in run rate, when compared to the first half of the year, continues. The Trust scrutiny group continues to review the detail and the progress made to date to ensure that this is maintained and maximised.
Financial sustainability and efficiencies delivered over time (monthly)	£12m	£1,312k	£1,175k	£1,126k		The cumulative savings to date are £12m in line with target.
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	8				Eight RIDDOR notifications to the Health & Safety Executive were made during Q4. All eight cases were spread around services & teams - no hotspot areas identified. Three slips trips & falls resulted in over seven day work related absences. The Unintended/Accidental Staff Injury category covered a range of injuries. There were no enquiries from either the Health and Safety Executive or CQC related to any RIDDOR notifications during Q4.
Estates Urgent Response Times - Service level agreement (SLA)	95%	96.9%	96.9%	96.9%		Service level agreement 1 & 2 are the priorities given to emergency and urgent work which has a two 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%	100.0%	100.0%	100.0%		Estates senior management have reviewed this metric and from August '23 only jobs screened as category SLA 2 are included due to some inconsistencies in the categorisation of jobs when initially logged.

Make SWYPFT a great place to work

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance	Notes
Turnover external (12 month rolling)	>12% - 13%<	11.6%	11.2%	11.0%		
Registered workforce growth	3% (by March 24)	7.7%				
Sickness absence - rolling 12 months	<=4.8%	5.1%	5.0%	5.0%		Absence rate in month dropped to 4.4%. Further detail is provided in the relevant section of this report.
Workpal appraisals - rolling 12 months	May >=78% March >=90% Overall >=95%	79.6%	83.4%	84.2%		For the month of March, the percentage rate increased but continues to remain below threshold. Work is taking place to understand the relation between supervision and appraisal uptake, in particular where the same staff have missed both an appraisal and supervision and whether there are any specific reasons.
% staff recommending the Trust as a place to work	65%	N/A	70.5%			Results from national staff survey.
% staff recommending the Trust as a place to receive care and treatment	65%	N/A	72.2%			
Staff supervision rate	80%	69.4%	68.7%	73.0%		As part of the review of the supervision of the workforce policy, an improvement programme is underway to use the learning from the Forensic care group to increase uptake and recording of supervision within the clinical workforce. This includes making further changes to the systems and reporting practice. (Band 4 and above, all supervision)
Mandatory training - Cardiopulmonary resuscitation	80%	77.5%	76.1%	77.8%		In order to maintain a safe environment, inpatient services ensure access to appropriately cardiopulmonary resuscitation trained staff on each shift. 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).
Mandatory training - Reducing restrictive physical interventions	80%	77.0%	74.0%	73.0%		Performance has dropped again this month to 73.0% however our learning and development team and RRPI team are working together to maximise the training places available and are taking a targeted approach to booking staff onto refresher training. Successful recruitment will improve team capacity.
Mandatory training - Fire	80%	90.5%	89.6%	89.2%		
Mandatory training - Information governance (IG)	95%	92.7%	91.8%	91.5%		Reminders circulated regarding IG training compliance. See People section for further detail.

Quality Headlines

Section	KPI	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Year End Forecast*
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	TBC	76.0%	81.0%	84.0%	84.0%	81.0%	80.0%	82.4%	85.8%	84.2%	80.9%	78.8%	79.9%	N/A
Complaints	% of feedback with staff attitude as an issue [12]	< 20%	17% 4/23	11% 2/17	16% 3/19	19% 3/16	17.6% (3/17)	10% (1/10)	9% (1/11)	8% (2/24)	17% (4/23)	8% (2/24)	14% (1/7)	18% (4/22)	1
	Complaints - Number of responses provided within six months of the date a complaint received	100%	27% (4/15)	38% (3/8)	17% (2/12)	29% (4/14)	38% (5/14)	38.9% (7/18)	42.9% (9/21)	44.1% (12/27)	44.4% (4/9)	70.0% 7/10	62.5% (10/16)	66.7% (8/12)	
Service User Experience	Friends and Family Test - Mental Health	84%	82%	85%	91%	90%	90%	95%	89%	88%	94%	89%	92%	92%	1
	Friends and Family Test - Community	95%	94%	97%	96%	93%	97%	96%	95%	97%	98%	97%	97%	97%	1
Quality	Number of compliments received	N/A	50	66	33	35	22	17	18	35	16	2	8	6	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) [4]	Trend monitor	26	34	25	24	35	24	30	19	15	17	16	17	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions [4]	Trend monitor	1	2	3	3	5	4	6	3	1	0	0	0	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches [4]	0	0	1	1	0	0	0	0	1	3	0	0	0	1
	% Service users on CPA offered a copy of their care plan	80%	85.0%	85.7%	86.6%	87.5%	87.4%	87.5%	87.5%	87.7%	87.6%	88.5%	88.7%	73.6%	1
	Number of Information Governance breaches [3]	<12	12	9	14	13	16	8	9	11	8	14	20	5	2
	% of inpatients clinically ready for discharge	3.5%	2.4%	2.1%	4.6%	4.8%	5.7%	5.7%	5.2%	5.8%	5.7%	4.3%	2.9%	2.5%	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%	90.6%	87.7%	86.7%	87.2%	88.0%	87.5%	89.9%	92.5%	94.1%	93.4%	90.1%	91.7%	3
	The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		80.7%	65.0%	66.1%	74.0%	72.2%	71.3%	71.1%	76.4%	70.0%	71.8%	74.7%	79.2%	2
	Total number of reported incidents	Trend monitor	1198	1327	1258	1159	1206	1150	1315	1321	1185	1286	1342	1394	
	Total number of patient safety incidents resulting in moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	18	30	19	21	28	23	25	20	17	25	33	41	
	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	2	5	1	4	1	4	1	1	5	4	2	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Trend monitor	5	2	1	2	3	1	3	2	2	2	0	1	
	Safer staff fill rates	90%	123.5%	123.5%	123.7%	123.9%	123.8%	124.1%	123.5%	128.8%	128.7%	129.6%	127.6%	128.5%	1
	Safer Staffing % Fill Rate Registered Nurses	80%	94.4%	95.7%	93.1%	93.6%	92.1%	91.4%	91.3%	97.5%	96.2%	102.2%	100.8%	101.6%	1
	Number of pressure ulcers which developed under SWYPFT care (1)	Trend monitor	29	42	40	36	43	43	28	33	27	45	58	41	
	Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care (2)	0	2	1	3	1	2	0	3	6	6	2	2	0	
	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%	90.0%	86.6%	89.5%	95.2%	90.0%	90.0%	91.7%	66.6%	100.0%	100.0%	100.0%	92.3%	1
	Number of Falls (inpatients)	Trend monitor	34	41	43	32	33	36	50	46	42	48	45	45	
	Number of restraint incidents	Trend monitor	192	186	201	145	146	92	198	153	193	121	165	188	
	% of staff receiving supervision within policy guidance [15]	80%	Reporting to start from Sept 23					65.8%	66.0%	70.1%	67.8%	69.4%	68.7%	73.0%	2
	Potential under-reporting of patient safety incidents														
	% people dying in a place of their choosing [14]	80%	87.5%	92.1%	87.8%	83.8%	81.8%	90.6%	91.3%	66.7%	95.1%	97.4%	88.9%	94.1%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	6	0	0	0	0	0	0	0	0	1	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 Information Governance 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 4 and above clinical staff who have received supervision in the previous 90 days.

Quality Headlines

The following section provides insight into key quality issues identified in the dashboard for the month of March.

• Although there has been an increase in the number of reported incidents in March, it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. Further detail is provided in the relevant section of this report.
• The overall number of restraint incidents in March was 188 which is within acceptable range. Further detail is provided in the relevant section of this report. The Trust's ongoing ambition is for a reduction in all restraint incidents, and reducing restrictive physical interventions training has a clear focus on interventions to prevent escalation of a situation to the point where restraint is required.
• Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care - There were no instances in March.
• Clinically ready for discharge (previously delayed transfers of care) - This has decreased to 2.5% and remains below threshold. However, there are still a significant number of people who are delayed which may impact on performance in future months.
• Number of Falls (inpatients) - All falls incidents are reviewed regularly by the Trustwide falls coordinator to ascertain any themes or actions required . In March there were 45 inpatient fall incidents. Further detail is provided in the relevant section of this report.
• % Service users on CPA offered a copy of their care plan - performance has dropped below the 80% threshold this month for the first time in the financial year, however this dip in March, at the end of the financial year has been seen before historically and is linked to the annual review dates of clients on CPA and we therefore anticipate an improvement next month.
• The number of information governance breaches in relation to confidentiality breaches has decreased to 5 during the month and is now below threshold. The Information Commissioner's Office has notified the Trust of two complaints they have received, pertaining to the Trust's alleged failure to uphold their information rights. The Data Protection Office is investigating and will respond before the advised deadlines
• 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, as part of the Trust's focus on clinical safety and quality, and staff wellbeing.

Patient Safety

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. The Trusts PSIRF plan and policy went live date of the 1st December 2023. On the 9th April the patient safety team have some time out to look at continuous improvement.

Since launching PSIRF on 1 December 2023, we have been:
• Reviewing linked policies and procedures
• Refining our guidance for learning responses using PDSA
• Reviewing incidents against our PSIRF Plan
• Supporting services with considering if incidents meet the plan and if so what improvement work is already in place
• Developing the format of the Patient safety oversight group (PSOG) (formerly clinical risk panel) to align with PSIRF
• Updated Datix to reflect our processes for PSIRF

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)
Following a further upgrade of the Datix system (on 29/01/24), incident form configuration and thorough testing, the Trust went live with LFPSE on 14th February. This means that we no longer report to the National Reporting and Learning System from 14th February. Since launching LFPSE the team have been working on providing training to staff and developing monitoring processes.

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 became mandatory from March 2024. This is currently progressing well at 95% completed.

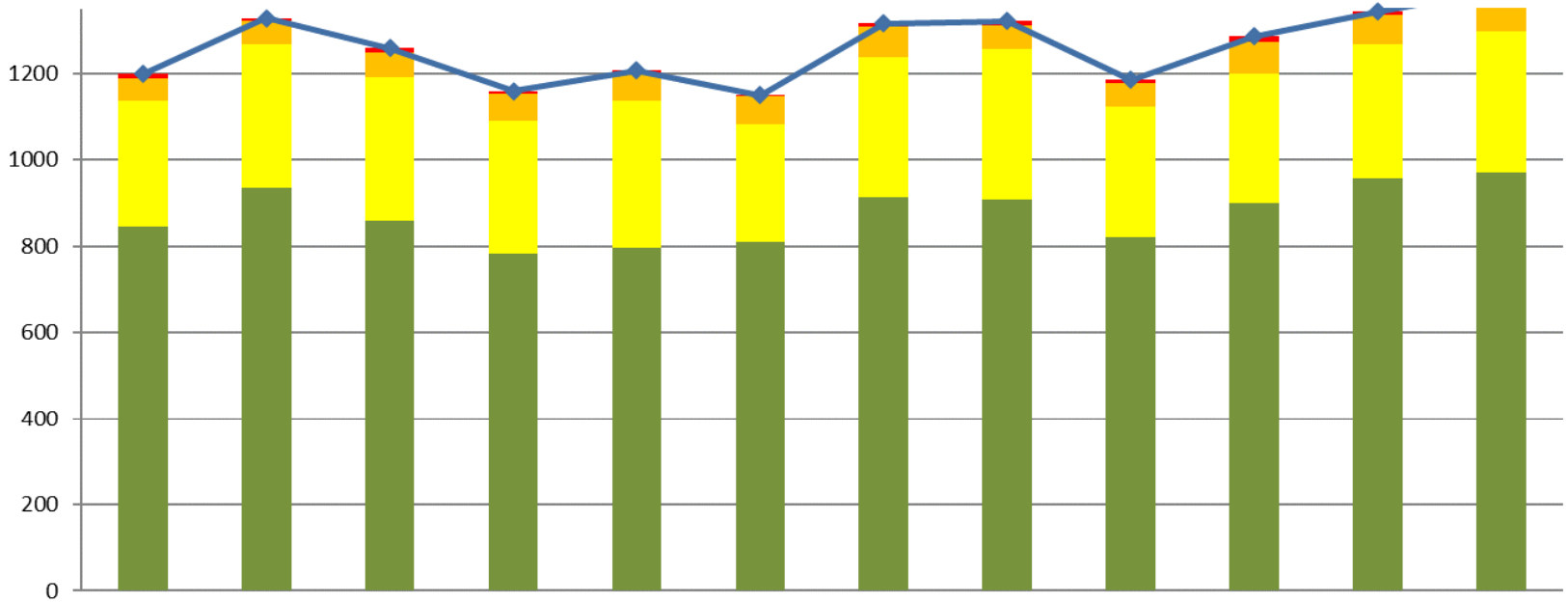
Patient Safety Partners
The three patient safety partners (this is a volunteer role) was inducted into the patient safety team in February 2024. The next steps are for the PSPs to meet again and discuss work allocations.

Safety First

Summary of Incidents

Incidents may be subject to re-grading as more information becomes available

95% of incidents reported in March 2024 resulted in no harm or low harm or were not under the care of SWYPFT.
No never events reported in March 2024



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Red (should not be compared with SIs)	11	6	10	7	9	3	8	9	9	14	8	14
Amber	51	55	58	63	60	65	69	56	54	73	67	83
Yellow	291	330	330	307	342	272	324	349	301	300	310	327
Green	845	936	860	782	795	810	914	907	821	899	957	970
Total	1198	1327	1258	1159	1206	1150	1315	1321	1185	1286	1342	1394

Safety First cont…

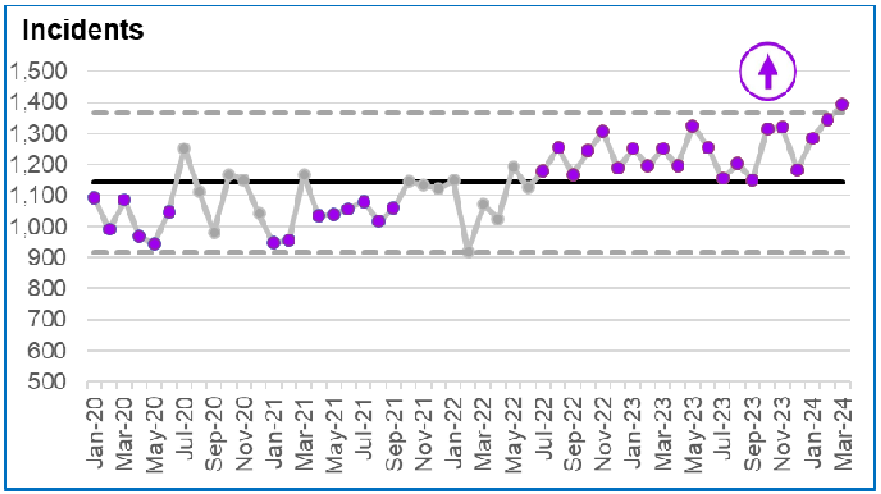
Summary of Patient Safety Incidents resulting in moderate or severe harm or death

Breakdown of incidents in March 2024
42 moderate harm incidents:
The most common incidents were pressure ulcers, self harm and falls.

2 Severe harm incidents:
These include pressure ulcers and self harm.

Sadly, there was also one patient safety related death.

Incidents



We remain in a period of special cause variation (something is happening and this should be investigated) in March due a sustained increase in the number of incidents, though it should be noted that an increase in the reporting of incidents is not necessarily a cause for concern. We encourage reporting of incidents and near misses. An increase in reporting is a positive where the percentage of no/low harm incidents remains high as it does which is evidenced on the previous page. All incidents are reviewed by the care group management team and then by the Patient Safety Datix team to review the actual degree of harm to ensure consistency with national reporting. All amber and red incidents are monitored through the weekly Trust Clinical Risk Panel and all serious incidents are investigated using systems analysis techniques. Learning is shared via a number of routes; care group learning events following a Serious Incident, specialist advisor forums, quarterly trust wide learning events, briefing papers and the production of Situation Background Assessment Recommendation (SBARs).

Learning Library

The learning library has been developed as a way to gather and share examples of learning from experience.
Further examples can be found on the SWYPFT intranet page.

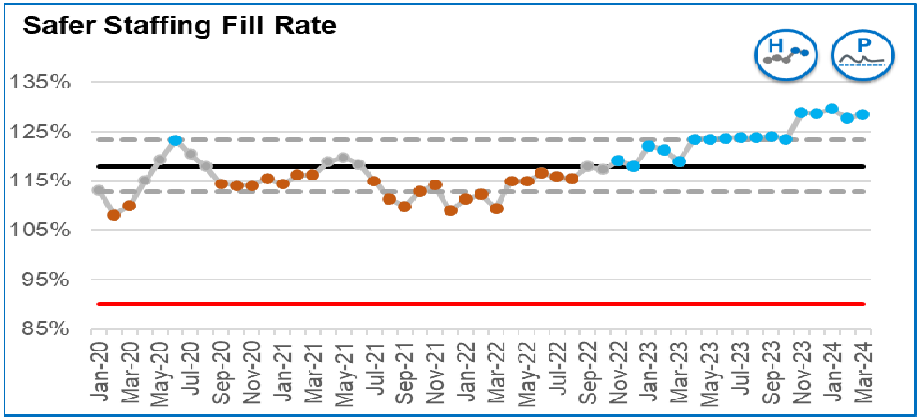
If you would like to attend or share your learning from experience with the learning network, please email learninglibrary@swyt.nhs.uk.

Patient Safety Alerts

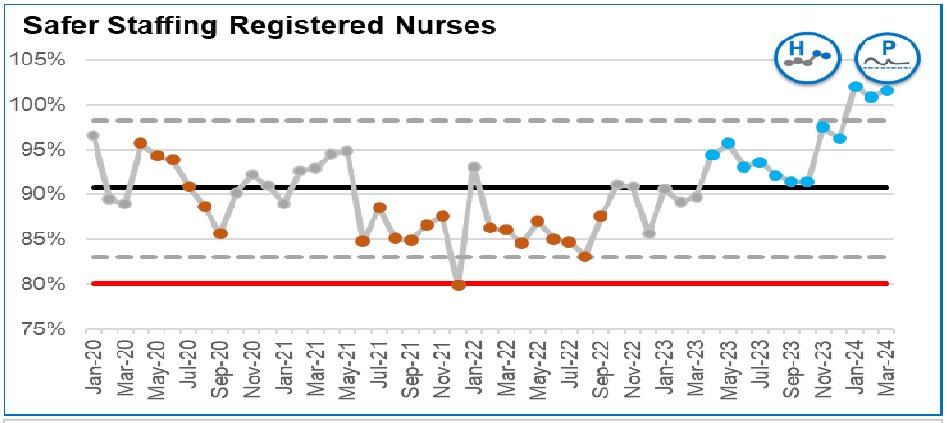
There were no patient safety alerts issued in March 2024

Patient Safety alerts not completed by deadline of March 2024 - zero.

Safer Staffing Inpatients



The chart above shows that as at March 2024 due to the continued increasing staffing fill rate, we remain in a period of special cause improving variation.



The chart above shows that in March 2024, due to the continued increase in the registered nurses fill rate, we remain in a period of special cause improving variation.

- There was a significant increase in March on demand, mainly due to decreased vacancies and annual leave being taken by substantive staff, of the flexible staffing pool with a total of 751 more shift requests with the overall fill rate remaining high. This is historically reflective of March.
- All figures within the care groups indicate a slight increase in overall demand to deal with acuity given the increase in requests correlating with the increase in fill rates and we will closely monitor this trend.
- All international educated nurses have started on their wards.
- Vacancy control groups are being established to ensure that targeted local recruitment replaces the centralised process.
- The safer staffing reports are under review to ensure that we are receiving a narrative that is reflective of the current situation within teams.
- We continue to work around issues within the collaborative bank with around 1500 expressions of interest within the three trusts to join.
- SafeCare is continuing to be pushed to ensure it becomes embedded and a corner stone of discussions around staffing and template reviews with Thornhill providing a good example of how this works.
- We have dedicated time and resource to the roll out of the health roster to accelerate the Programme and introduce check and challenge to realise efficiencies within its usage.
- The overall fill rate has increased by 0.9% to 128.5% with the day fill rate for RNs continuing to improve. Consistent with last month 13 wards have fallen below the 90% RN day fill rate.
- In March no ward fell below the 90% overall fill rate threshold, which was a decrease of one.

Safer Staffing Inpatients cont…

Registered Nurses Days
Overall registered Day fill rates have increased by 1.8% to 94.5% in March compared with the previous month.

Registered Nurses Nights
Overall registered Night fill rates have decreased by 0.3% in February to 108.6% compared with the previous month.

Overall Registered Rate: 101.6% (increased by 0.8% on the previous month)
Overall Fill Rate: 128.5% (increased by 0.9% on the previous month)

Fill Rate	Jan-24	Feb-24	Mar-24
Adults and Older People	136%	136%	138%
Barnsley Integrated Services	111%	110%	114%
Forensic and LD	122%	117%	116%
Grand total	**130%**	**128%**	**129%**

Registered day rate	Jan-24	Feb-24	Mar-24
Adults and Older People	89%	91%	95%
Barnsley Integrated Services	103%	105%	99%
Forensic and LD	94%	93%	93%
Overall shift fill rate	**92%**	**93%**	**94%**

Registered night rate	Jan-24	Feb-24	Mar-24
Adults and Older People	113%	108%	106%
Barnsley Integrated Services	90%	80%	85%
Forensic and LD	116%	114%	116%
Overall shift fill rate	**113%**	**109%**	**109%**

- Bank staff filled 68.26% (increased by 5.65% on the previous month) of RN requests for flexible staffing and 85.17% (decreased by 1.05% on the previous month) of HCA requests.
- Agency staff filled 11.21% (a decrease of 2.08% on the previous month) of RN requests for flexible staffing and 10.34% (an increase of 0.01% on the previous month) of HCA requests.
- Health Care Assistants showed a decrease in the day fill rate for March of 5.6% to 146.8% and the night fill rate increased by 4.25% to 154.6%.

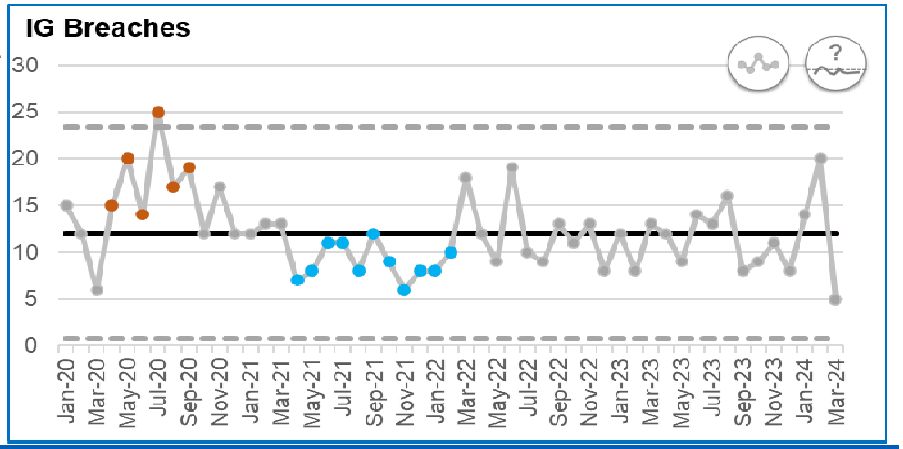
Information Governance (IG)

There were five personal data breaches were reported during March which is the lowest number reported during the 2023/24 financial year. Due to the increased number of incidents reported during February, relevant services have created action plans to prevent a recurrence. A comms campaign continues using a variety of channels to raise awareness of personal responsibility and the consequences of an incident.

All five incidents in March involved information being disclosed in error. They were due to:
- correspondence sent to wrong recipient or address
- sharing information with callers where service user had not consented to the share

The Information Commissioner's Office has notified the Trust of two complaints they have received, pertaining to the Trust's alleged failure to uphold their information rights. The Data Protection Office is investigating and will respond before the advised deadlines.

This SPC chart shows that as at March 2024 we remain in a period of common cause variation.



Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes are 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.

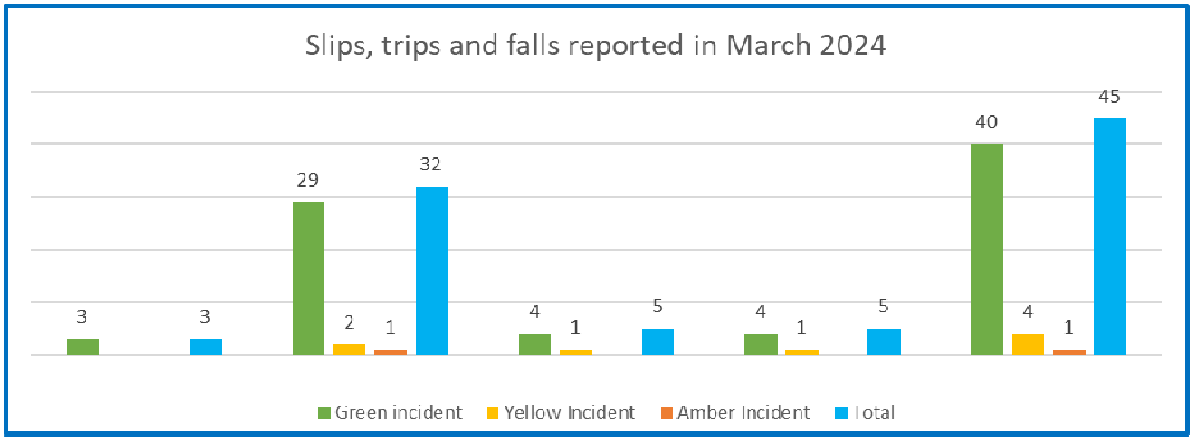
There are some new indicators in this years scheme and the Trust's CQUIN leads group are monitoring progress against the thresholds. The quarter 4 submission is due by the end of May 24. Some risk has been associated with full achievement of the following metrics: staff flu vaccinations and outcome monitoring in adults and older people and children and young people and community perinatal mental health services - actions plans have been in place to mitigate this as far as possible throughout the year and performance monitored via the CQUIN leads group.

National contract guidance states that the CQUIN schemes are to be paused during 2024/25.

Trustwide Falls

March 2024: A total of 45 slips, trips and falls were reported.

The current rate of falls in March is 2.68 per 1000 bed days. We are below the national average of 3-5 falls per 1000 bed days.

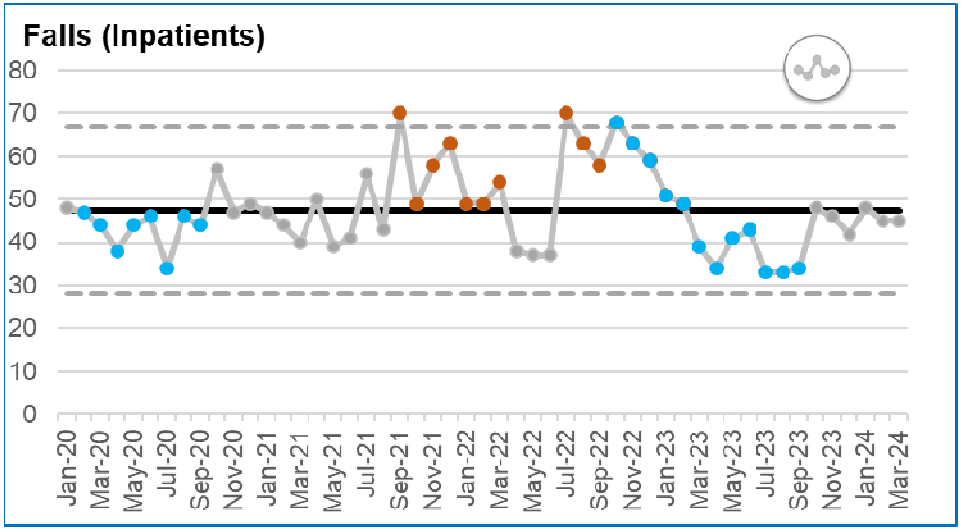


Incident Grading
Amber: 1 (2%) reported incident, younger person fell on an inpatient ward
Yellow: 4 (9%) reported incidents. No significant injuries reported
Green: 40 (89%) reported incidents had low or no harm recorded

Falls by location
• We continue to monitor falls in bedroom areas. This remains consistent with previous months. A meeting to review and discuss this is being arranged.

Falls (Inpatient)

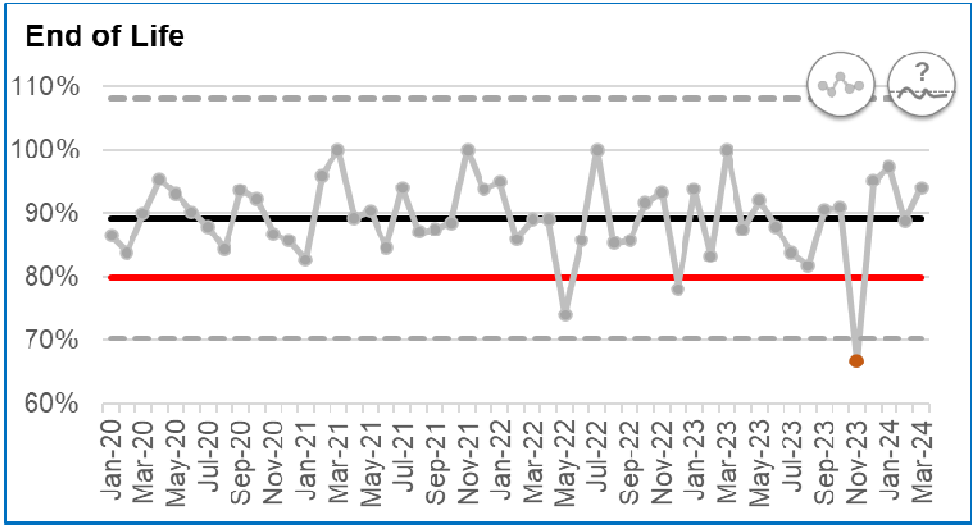
The total number of inpatient falls was 45 in March.



The SPC chart above shows that in March 2024 we remain in a period of common cause variation (no concern). All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

End of Life

The total percentage of people dying in a place of their choosing was 94.1% in March. As is noted in the Quality Headlines Dashboard, performance against this metric remains above threshold this month. This metric relates to the Macmillan service, end of life pathway.



The chart above shows that in March 2024 the performance against this metric remains in common cause concerning variation (no concern). 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 (FFT) shows

- 97% would recommend community services
- 92% would recommend mental health services

	Target	January	February	March
Mental health community	85%	90%(183)	94% (298)	92% (299)
Mental health inpatient	85%	87% (31)	89% (72)	83% (40)
Learning Disabilities	85%	100% (7)	100% (16)	100% (25)
ASD/ ADHD	85%	60% (5)	67% (6)	100% (1)
CAMHS	75%	90% (41)	86% (29)	93% (29)
Forensic	60%	100% (7)	67% (3)	100% (4)
Mental health overall	84%*	**89% (275)**	**92% (426)**	**92% (399)**
Barnsley Gen ops	95%	**97% (318)**	**97% (295)**	**97% (315)**
Trustwide	**85%**	**93% (593)**	**94% (730)**	**94% (715)**

** weighted for 2023/24*

Satisfaction in mental health inpatient and community has declined. ADHD, forensic and CAMHS have seen an increase in satisfaction and learning disabilities has remained the same.

All service lines remain above target except for mental health inpatients which has dipped just below target for the first time in four months.

The number of responses has declined for ADHD, and this will be discussed at the next ADHD Project Group in April 2024.

	Top three positive themes	Top three negative themes
Trustwide	1. Staff	1. Staff
	2. Communication	2. Access & waiting times.
	3. Patient Care	3. Admission & discharge
Community	1. Staff	1. Access & waiting times.
	2. Communication	2. Admission & discharge
	3. Patient care	3. Staff
Mental Health	1. Staff	1. Staff
	2. Communication	2. Patient Care
	3. Patient care	3. Access & waiting times

Safeguarding

Safeguarding Adults:
In March 2024, there were 23 Datix categorised as safeguarding adults. Thirteen of these were graded as green, one were graded as yellow, one was an amber and there were no red Datix. The most common subcategories were emotional/psychological abuse, self neglect and sexual abuse.

In addition to the Safeguarding Adults Datix, there were 15 sexual safety Datix of which two were amber, two yellow and 11 green. In all cases reviewed appropriate actions were taken, including Police, local authority safeguarding referrals and support from specialist services were made where required.

Safeguarding Children:
In March 2024 there were 20 Datix categorised as safeguarding children; ten of these were graded as green, nine were graded as yellow, one was an amber and there were no red Datix. The most common subcategory of these Datix was physical abuse. In all of the Datix submitted, SWYPFT safeguarding advice was sought as appropriate.

Complaints

- Acknowledgement and receipt of the complaint within three working days – 20/21 (95% of formal complaints)
- Number of responses provided within six months of the date a complaint received – 8/12 (66%)
- Number of complaints waiting to be allocated to a customer service officer – 0
- 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 – N/A
- There were 22 new formal complaints in March 2024
- 6 compliments were received
- 12 formal complaints were closed in March 2024
- Number of concerns (informal issues) raised and closed in March 2024 – 41
- Number of enquiries responded to in March 2024 – 93
- Number of complaints referred to the Parliamentary Health Service Ombudsman and upheld this financial year to date and how many upheld = 3

Infection Prevention Control (IPC)

Mandatory training: figures for hand hygiene and, infection, prevention and control remain healthy and above Trust 80% threshold.

Outbreaks - March 2024
- One norovirus outbreak on inpatient wards
- One Influenza A outbreak on inpatient ward

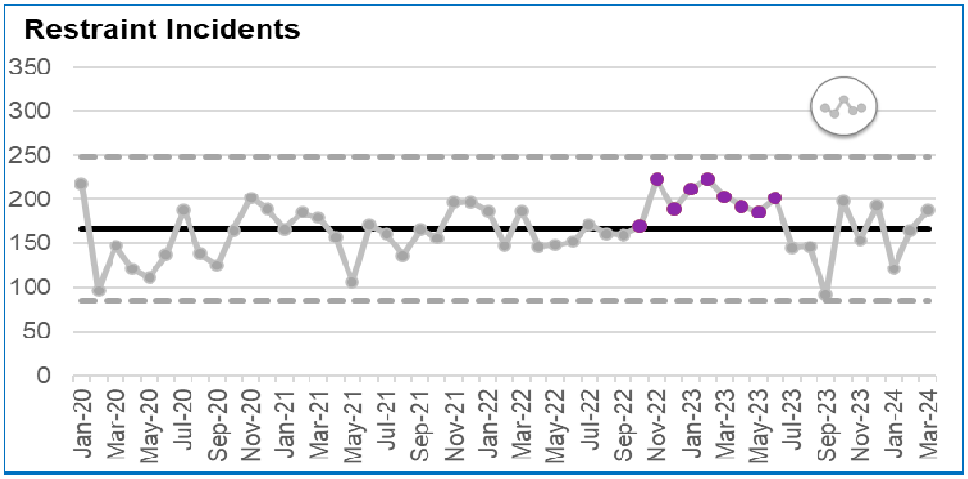
Reducing Restrictive Physical Intervention (RRPI)

- There were 188 reported incidents of Reducing Restrictive Physical Interventions used in March 2024.
- 92.3% of Prone Restraints in March 2024 lasted under 3 minutes.

Restraint Position	Total Restraint Positions Used	Percentage of Use
Standing	108	37.2%
Safety Pod	54	18.6%
Seated	52	17.9%
Supine - held on their back, regardless of surface	20	6.8%
Restricted escort	20	6.8%
Prone descent then remained in chest down position	13	4.4%
Side	9	3.0%
Prone descent then immediately rolled	8	2.7%
Kneeling	7	2.4%

Team Using Prone Restraint	Total
Nostell Ward, Wakefield	4
136 Suite - Unity Centre, Wakefield	1
Ashdale Ward	1
Beamshaw Ward	1
Chippendale, Forensic	1
Clark Ward - Barnsley	1
Newhaven Forensic Learning Disabilities Unit	1
Stanley Ward, Wakefield	1
Walton PICU	1
Ward 18, Priestley Unit	1

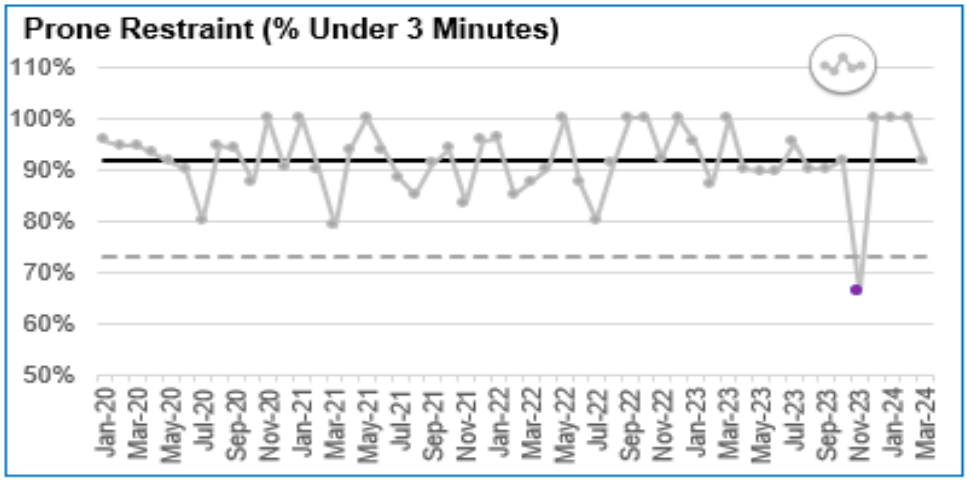
Duration of Prone Restraint	Total
0 - 1 minute	6
1 - 2 minutes	5
2 - 3 minutes	1
3 - 4 minutes	1

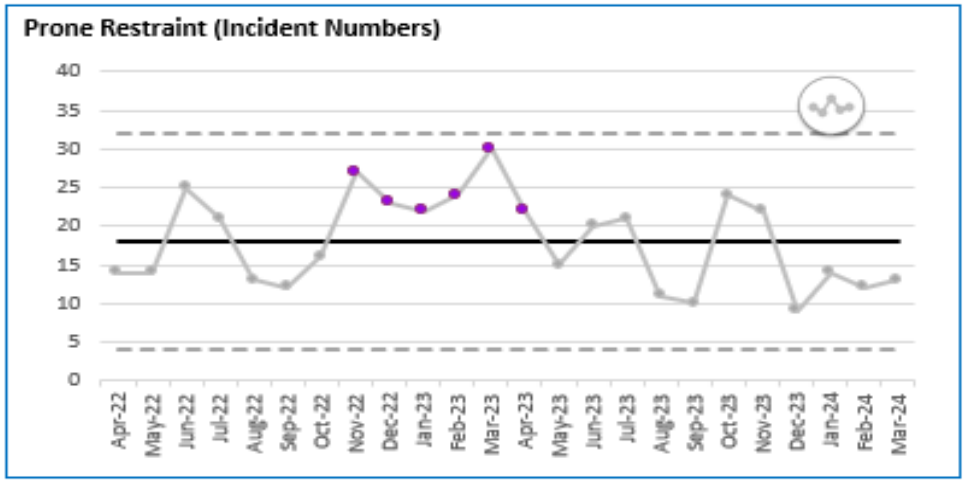


This SPC chart shows that in March 2024 we remain in a period of common cause variation (no concern).

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

Reducing Restrictive Physical Intervention (RRPI)





The circumstances where prone is used will be influenced by the level of concern during the incident. Improvement work is underway with regards to minimising prone restraint during seclusion exit or when administering intra-muscular medication. Use of prone restraint continues to be below the year average of 21, and from now on all incidents of prone restraint will be reviewed for learning in the Patient Safety Oversight Group.

People - Performance Wall

Trust Performance Wall

	Objective	CQC Domain	Threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Establishment	Improving Resources	Well Led	-	5,157.4	5,174.0	5,193.8	5,196.6	5204.8	5321.0	5323.3	5329.5	5341.4	5412.1	5415.1	5422.1
Contracted Staff In Post (Ledger)			-	4,338.5	4,352.0	4,375.4	4,400.5	4,432.7	4453.2	4425.9	4442.5	4471.3	4535.6	4574.5	4605.2
Vacancies			-	818.9	822.0	818.4	796.1	772.1	867.8	897.4	887.0	870.1	876.6	840.6	817.0
Turnover external (12 month rolling)			>12% - <13%	13.0%	12.2%	13.1%	13.0%	13.1%	12.1%	12.4%	12.0%	12.0%	11.6%	11.2%	11.0%
Starters			-	45.8	54.9	57.5	53.9	64.0	63.3	69.4	61.6	42.8	91.4	49.8	38.3
Leavers			-	39.4	36.5	41.1	51.3	45.2	35.2	51.8	31.9	27.6	30.3	32.8	37.7
International Nurse Starters in Month			-	0	0	0	0	9	10	10	10	5	5	0	0
% Bank Fill Rates - Registered Nurses			-	Reporting commenced August 23				47.8%	49.6%	52.0%	59.1%	52.3%	60.3%	62.6%	68.3%
% Bank Fill Rates - Health Care Assistants			-					69.8%	70.2%	75.9%	80.3%	80.8%	82.2%	86.2%	85.2%
Overall Temporary Staffing Fill Rate (Bank & Agency fill inclusive)			-					90.9%	90.3%	90.6%	93.4%	91.6%	92.2%	92.2%	92.6%
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				199 (14.7%)	203 (14.9%)	206 (14.9%)	209 - All staff (15.1%) 86 - excl medics (7.21%)	217 - All staff (16.0%) 90 - excl medics (7.7%)	217 - All staff (15.9%) 89 - excl medics (7.6%)	220 - All staff (16.2%) 92 - excl medics (7.9%)	222 - All staff (16.3%) 94 - excl medics (8.0%)
Proportion of staff in senior leadership roles who are women (relates to staff in posts band 7 and above, excludes bank staff)			-					931 (69.8%)	942 (69.3%)	962 (69.5%)	963 (69.7%)	946 (69.8%)	947 (69.8%)	952 (69.9%)	953 (70.0%)
Sickness absence - Rolling 12 month			<=4.8%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.2%	5.2%	5.1%	5.1%	5.0%	5.0%
Sickness absence - Month			<=4.8%	5.0%	4.6%	4.6%	5.1%	4.7%	4.9%	5.2%	4.9%	5.1%	5.1%	4.8%	4.4%
Employees with long term sickness over 12 months			-	1	0	0	0	0	2	2	0	1	1	0	0
Appraisals - rolling 12 months			May >=78% Overall >=95%	74.4%	74.9%	78.5%	76.5%	74.5%	72.5%	69.7%	73.1%	74.3%	79.6%	82.9%	84.2%
Employee Relations - Suspensions (over 90 days)			-	0	0	0	3	3	3	4	2	2	2	2	3
Mandatory Training - TOTAL	Improving Care		>=80%	90.5%	90.9%	92.0%	92.1%	92.5%	92.1%	92.5%	92.1%	91.9%	91.9%	91.8%	91.9%
Mandatory Training - Reducing Restrictive Practice Interventions				73.8%	73.8%	76.7%	76.2%	82.6%	82.8%	82.9%	85.0%	81.8%	77.0%	74.0%	73.0%
Mandatory Training - Cardiopulmonary Resuscitation				75.5%	79.2%	81.3%	81.0%	79.9%	80.0%	79.7%	78.5%	77.0%	77.5%	76.1%	77.8%
Mandatory Training - Clinical Risk				95.6%	95.4%	95.4%	95.2%	94.8%	94.0%	92.6%	91.3%	91.0%	90.6%	91.8%	92.5%
Mandatory Training - Display Screen Equipment				96.5%	96.8%	97.0%	97.1%	97.4%	97.4%	97.4%	97.1%	97.0%	95.2%	96.1%	96.4%
Mandatory Training - Equality & Diversity				96.0%	96.2%	96.2%	96.0%	95.9%	96.1%	95.4%	94.9%	94.9%	95.1%	95.3%	95.4%
Mandatory Training - Fire Safety				90.2%	91.2%	92.8%	92.0%	91.4%	91.2%	91.0%	90.6%	90.8%	90.5%	89.6%	89.2%
Mandatory Training - Food Safety				78.0%	83.4%	86.4%	87.8%	89.4%	89.3%	88.1%	89.0%	89.4%	90.0%	90.4%	90.2%
Mandatory Training - Freedom To Speak Up (FTSU)				93.2%	93.7%	94.0%	94.3%	94.7%	94.9%	95.0%	94.9%	95.0%	95.2%	95.2%	95.6%
Mandatory Training - Infection Control & Hand Hygiene				91.5%	92.4%	94.1%	94.3%	94.3%	95.6%	94.2%	93.6%	93.1%	93.7%	93.7%	92.8%
Mandatory Training - Information Governance (Data Security)			>=95%	90.6%	95.9%	96.8%	96.9%	95.3%	94.8%	94.5%	93.4%	94.0%	92.7%	91.8%	91.5%
Mandatory Training - Moving & Handling			>=80%	95.5%	94.9%	95.2%	95.1%	95.6%	94.8%	96.5%	96.9%	96.9%	97.3%	97.5%	97.6%
Mandatory Training - Nat Early Warning Score 2 (New S2)				92.5%	92.1%	93.8%	94.7%	95.2%	96.2%	96.0%	94.6%	94.1%	93.5%	93.6%	94.1%
Mandatory Training - Mental Capacity Act/Dols				91.6%	93.6%	93.7%	93.4%	94.0%	96.7%	99.6%	99.2%	99.0%	99.1%	99.2%	99.4%
Mandatory Training - Mental Health Act				91.6%	91.3%	91.2%	91.1%	92.2%	99.8%	91.2%	90.5%	90.2%	90.7%	89.6%	89.1%
Mandatory Training - Oliver McGowan Training on Learning Disability and Autism			10%	Reporting commenced February 2024										66.6%	74.4%
Mandatory Training - Prevent			>=80%	95.4%	95.5%	92.1%	94.1%	94.2%	91.7%	93.7%	92.1%	92.3%	92.9%	91.9%	92.6%
Mandatory Training - Safeguarding Adults				90.0%	89.7%	89.3%	89.5%	89.7%	93.9%	90.7%	89.6%	89.4%	88.4%	88.3%	88.2%
Mandatory Training - Safeguarding Children				90.0%	90.7%	91.1%	91.2%	91.7%	89.7%	95.1%	94.4%	94.0%	92.9%	93.6%	93.3%

Notes:

- Contracted Staff In Post (Ledger) - this has replaced the previously reported Staff in Post (ESR Last Day of the month)
- 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 vs Staff in Post – Whilst our starters and leavers figures give us a true account of turnover growth it will not exactly match the overall staff in post movement from month to month as this also includes any contracted hours changes of existing staff in that same month.
- 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
- .Bank fill rates - We are continuing to successfully recruit to band 2 and bank 5 posts for both substantive posts and bank. Our use of agency is under constant scrutiny, with bank being used as opposed to agency as much as possible, including for block bookings, and this is seeing a positive impact on agency spend.

Stability of the Workforce

Turnover

• Our Turnover for 23/24 has seen an overall reduction compared to 22/23 (22/23= 13.5% / 23/24=11.0%).

Stability

• The stability rate has increased on a month by month basis across the year (from 85.4% - 90.5%). This is as a result of our employees being in a great place to work. This can be evidenced by the improvements in our staff survey results where there have been several areas of improvement. Please see Supportive Teams section for further information.

Starters and Leavers / Net Growth

• The Trust has seen ongoing net growth across the year of 232 employees which equates to a net growth percentage of 7.67%. As the new financial year approaches our teams need to refocus on keeping our workforce static throughout 24/25 to meet our planned workforce targets.

• We have recruited a total of 86 International Nurses since April '23. Cohorts in December and January have been reduced (5 per month) and future cohort delivery in February and March has been paused.

Vacancies

• Despite the establishment figures growing across the year (5267 full time equivalents (FTE) – 5422 FTE) we have maintained a static vacancy rate 23/24 (818.9 FTE - 8170 FTE). This means our vacancy rate has dropped overall for the year 15.1% (Apr 23=15.9%).

Recruitment

We are pleased to provide an update on the development of our new recruitment dashboard, leveraging PowerBI to enhance our data visualisation capabilities and streamline our recruitment analytics processes. The development of the dashboard was led by our People & Performance colleagues, with valuable contributions from Integrated Change colleagues and members of the recruitment team. This collaborative effort ensured that the dashboard meets the diverse needs of stakeholders across the different care groups and aligns with our strategic objectives. We will focus on enhancing usability, expanding data sources, and incorporating feedback from users. We remain committed to leveraging data-driven insights to drive improvements in recruitment processes, support Equality, Diversity, and Inclusion (EDI) initiatives, and optimise workforce planning. Key Features:

• Integration with NHS Jobs data to provide comprehensive time-to-hire metrics for external substantive staff.

• Measurement of time from advert published to applicant start date, and from advert published to offer accepted, offering valuable insights into recruitment efficiency and effectiveness.

• Inclusion of vital protected characteristic data to support our EDI measures, ensuring alignment with trust values and WRES reporting requirements.

• Visibility of number of advertised roles, number of applications received, number invited to interview, and the number of conversations to offer. This data is also shown by Agenda for Change grade and location, facilitating targeted recruitment strategies and resource allocation.

Keep fit and Well

Absence

Our People Relations staff have been supporting line managers in all areas to actively manage long term sickness cases i.e. following process to review cases, have appropriate meeting etc. to either bring people back to work (or redeploy them) or end their employment on the grounds of medical capability. As a result we have seen the overall sickness rate drop and the lowest absence in month since April 2023. In addition to this our People Business Partners have been working closely with care group leaders to highlight hotspots and provide more guidance for managers.

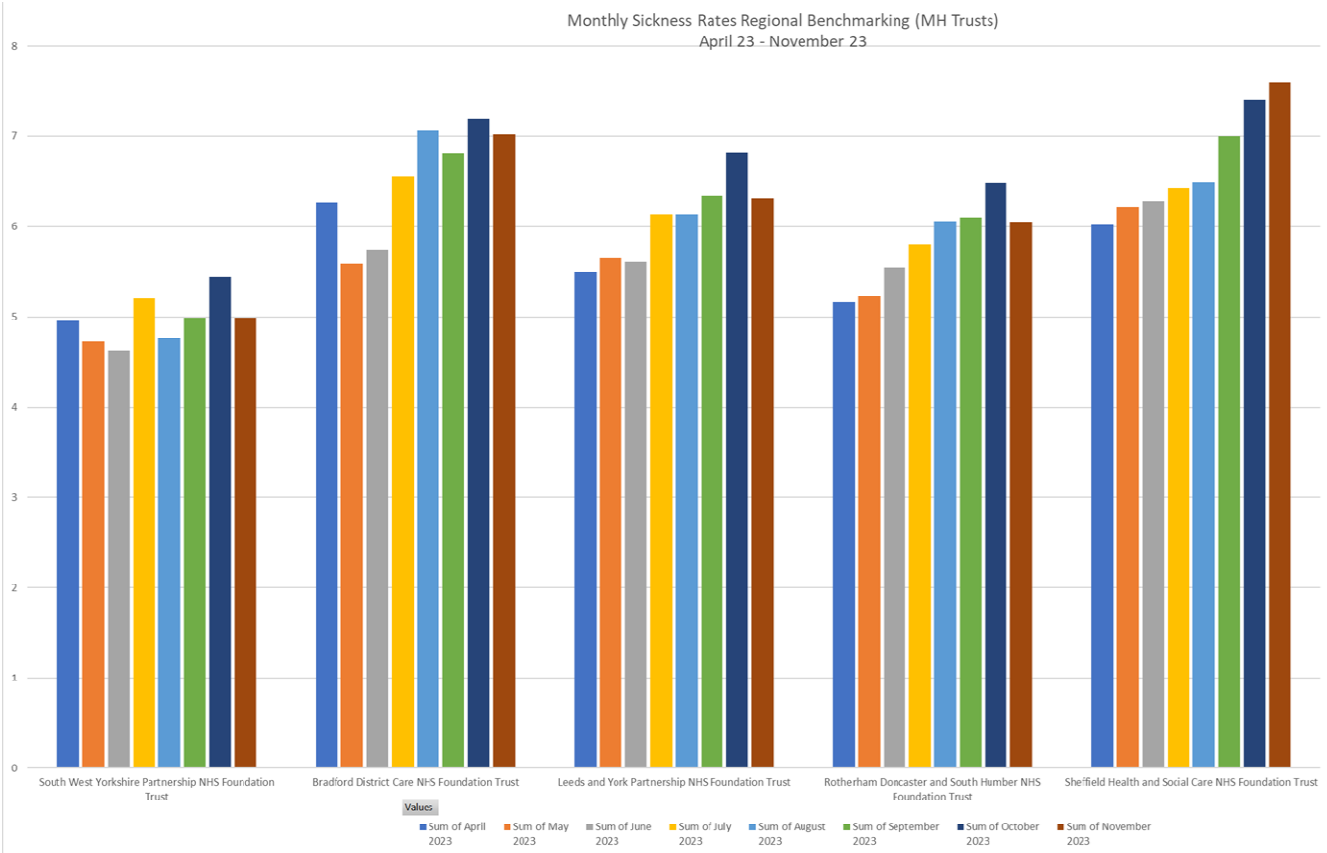
• Our People Business Partners are supporting care groups in providing insightful information regarding areas where high anxiety and stress is applicable. This is allowing managers to focus more attention on these employees to support them back into work,

• Our final overall sickness figure for the year is at it's lowest point at 4.97%.

• Estates and Facilities sickness absence continues to be high at 8.9%. This staff group have seen a consistent monthly rise since April (Apr 6.2%). Further work is being done with our Business Partners to help support Estates and Facilities, along with an internal audit.

- The number of people on long term sick has reduced from 17 to 10 since Jan 2024
- Further investigation into long term and short-term sickness analysis is underway.
- Anxiety/stress, back problems, and other musculoskeletal sickness are the top sickness reasons which the rapid improvement plan will aim to address.

Regional Sickness Benchmarking – April 23 – November 23

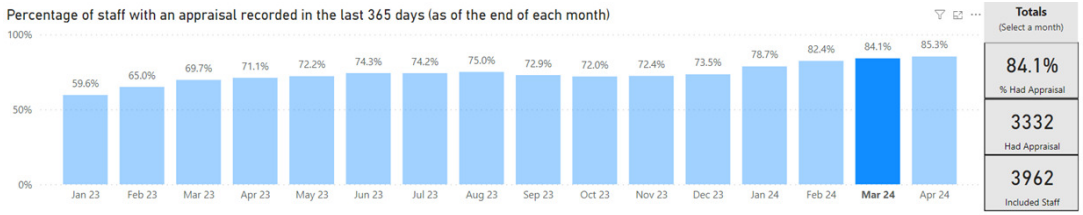


When compared to the April - November 23 published data by NHS England (latest data). we have the lowest sickness absence compared with other regional Mental Health Trusts (See graph).

Supportive Teams

Appraisals

• The new online reporting system for appraisals has been very positive and is reflected in the appraisal compliance.
• Although we are seeing significant improvements in appraisal compliance we have still identified there are some managers not adding their appraisals to the system. Further work has been done between our Learning and Development (L&D) team and managers to provide support in using the system to update appraisals,
• We have increased our rolling appraisal compliance rate again in March '24, which saw an increase, from 82.4% to 84.1%. Our L&D team continue to work towards hitting our Trust Target of 95%, with a milestone target of 90%.



Percentage of staff who have had an appraisal in the last 365 days

Month / Care Group/Level 3/Team	Mar 24 Appraised	Total	%
Barnsley PH	872	996	87.6%
CYP and Families	257	297	86.5%
Forensic	276	347	79.5%
LD Adult ASD ADHD	128	163	78.5%
Mental Health	1224	1480	82.7%
Support Services	575	679	84.7%
Total	**3332**	**3962**	**84.1%**

Training

• Our overall mandatory training compliance remains above target at 91.9%.
• An interim training compliance report has been developed and published to support our managers in improving training compliance. This report will remain in place until the fully developed version is finalised (expected by May '24). Feedback regarding the interim report has been positive.
• RRPI has dropped again this month to 73.0% however our learning and development team and RRPI team are working together to maximise the training places available for RRPI training and are taking a targeted approach to booking staff onto refresher training. Individuals will be contacted directly by a member of the learning and development team when a place is available to ensure as many staff as possible are able to complete their learning.
• IG has also dropped from 91.8% to 91.5. Communications are sent across the Trust to raise more awareness of the importance of completing IG training. The importance of completing IG training is also highlighted as part of the Team Brief.
• Care group operational and quality leads have established a working group with specialist advisors for CPR and RRPI and Nursing Quality and Professions representatives to collaboratively address issues around compliance, course availability and attendance.

Staff Survey

The NHS Staff Survey response rate increased in 2023 to 51%, from 50% in 2022. This is slightly below the national sector average of 52%. Throughout the survey period the people experience team, working with service leaders, encouraged colleagues to complete the survey using drop-in sessions, visits to Trust locations, use of a prize draw to win an iPad, and sharing work undertaken during 2023 on the staff survey actions.

In the 2023 survey our staff engagement theme score improved to 7.3 from 7.1 in 2022, 2023 sector average score 7.1. SWYPFT's staff engagement score is the best score for our sector in the region and 8th best nationally. Levels of staff engagement vary across the Trust and the OD team is looking at these results and working with services to improve engagement across the Trust. Our staff engagement score has been improving since 2019.

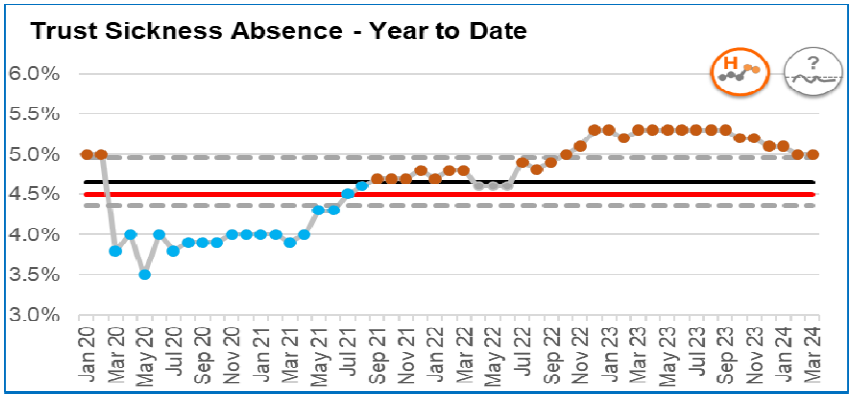
Bullying, harassment and abuse, from service users/public, SWYPFT 23%, this is down from 28% in 2022, 2023 sector average 24%. Bullying, harassment and abuse from managers to staff 6% down from 7% in 2022, 2023 sector average 8%. Bullying, harassment and abuse from other colleagues 12%, down from 13% in 2022, 2023 sector average 14%. For the Trust as a whole, the staff survey results show a reduction in bullying since 2019. However, of concern is the 2023 workforce race equality scheme results which show an increase in harassment, bullying and abuse to Black, Asian and minority ethnic colleagues from staff from 18% in 2022 to 25% in 2023, sector average 21%. This will be a priority in our survey action plan.

Leadership culture. 'Compassionate leadership' sub scale score 7.6, up from 7.4 in 2022, 2023 sector average 7.6. Our compassionate leadership sub scale score has been improving since 2021 (7.3). Compassionate leadership will be a key element of leadership and management development offer in future. 'Line management' sub scale score, which asks questions about satisfaction with line management support 7.5, up from 7.2 in 2022, 2023 sector average 7.4. Our line management sub scale score has been improving since 2021 (7.2).

The Trust has improved in many areas this year. Some further examples of these are below:

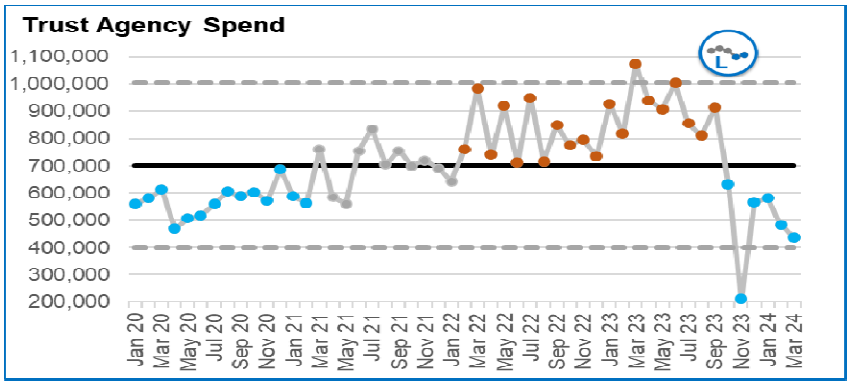
- 70% of our employees think SWYPFT is a great place to work in 2023. This is a 5% improvement from last year (65%)
- Our staff feel safer in their workplace with a reduction in violence and aggression. This is now at 13% (last year 15%)
- Further analysis is currently underway between the people experience team and the people performance team to further examine the output of the staff survey results, it is also in the plan to share this with operational teams to see where improvements can be made or achievements can be celebrated and learnings can be applied.

Statistical process control charts



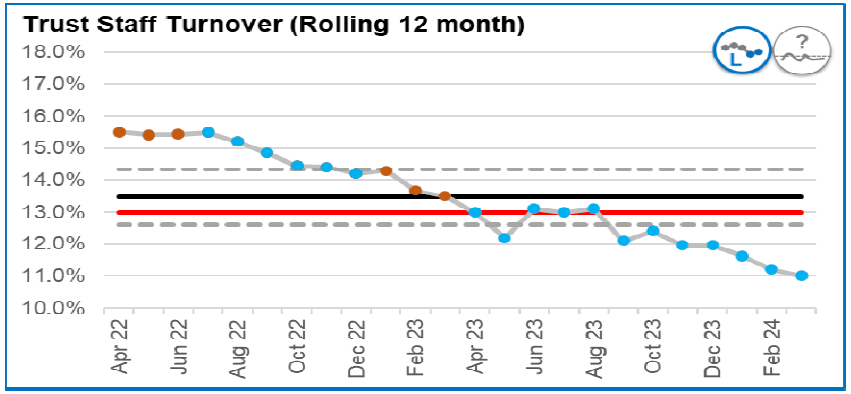
The SPC chart shows that in March 2024 we remain in a period of special cause concerning variation (something is happening and this should be investigated). See Finance Appendix for further information.

From July 2022 this data also includes absence due to Covid-19.



The SPC chart shows that in March 2024, as anticipated after the VAT savings incorporated in November 2023, we remain a period of common cause variation (no concern).

Please see finance appendix for further detail on agency spend.



The SPC chart shows that in March 2024, we remain a period of special cause improving variation (something is happening and this should be investigated) following a sustained decrease in the turnover percentage over the past 9 months.

MEDICAL APPRAISALS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of doctors due to have an appraisal meeting in the reporting period	37	32	48	48
Number undertaken in period	34	29	42	43
Number not undertaken for which the RO accepts postponement is reasonable	2	3	6	5
Percentage of appraisals taken place and submitted on time	92%	91%	88%	90%

MEDICAL REVALIDATIONS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of revalidation recommendations due in period	5	6	12	9
Number of positive recommendations	5	6	11	9
Number of deferrals	0	0	1	0
Number of non-engagements	0	0	0	0
Percentage of revalidation recommendations made	100%	100%	92%	100%

RESPONDING TO CONCERNS	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of active cases under Maintaining High Professional Standards procedures	0	0	0	0

National Metrics

Data as of : 24/04/2024 14:32:06

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	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
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	L	434	545	435	589	400	187	66	75	85	104	74	138
M3	Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops		60%	?		87.1%	87.8%	88.6%	90.3%	93.1%	70%	81.8%	83.8%	83.3%	81.6%	87.2%	83.8%
M4	Talking Therapies - proportion of people completing treatment who move to recovery		50%	?		52.5%	53.4%	53.2%	50.4%	51.5%	51.6%	52.7%	51.6%	54.7%	50.2%	53.9%	53.0%
M5	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	P	H	97.9%	99.0%	99.6%	99.0%	99.5%	99.9%	100%	100%	99.7%	99.8%	99.9%	99.9%
M6	Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)		99%	?	L	59.7%	53.6%	83.1%	67.1%	64.4%	74.9%	74.2%	63.0%	64.3%	55.9%	69.2%	66.3%
M7	72 hour follow-up from psychiatric in-patient care		80%	?	H	92.5%	90.6%	92.6%	87.7%	90.7%	88.6%	90.8%	89.0%	91.2%	88.7%	92%	87.5%
M8	Total bed days of Children and Younger People under 18 in adult inpatient wards		0	?		15	11	29	9	18	8	2	9	23	30	28	8
M9	Total number of Children and Younger People under 18 in adult inpatient wards		0	?		3	1	1	1	2	2	1	1	1	1	1	2
M10	Talking Therapies - Treatment within 6 Weeks of referral		75%	P	H	97.8%	98.6%	99.4%	99.2%	98.3%	98.3%	99.0%	98.8%	98.6%	98.8%	98.7%	99.0%
M11	Talking Therapies - Treatment within 18 weeks of referral		95%	P		99.8%	99.8%	100%	99.8%	99.8%	100%	99.9%	99.8%	99.8%	100%	100%	99.8%
M13	Children & Younger People with eating disorder - % URGENT cases accessing treatment within 1 week		95%	?		50%	80%	100%	70%	66.7%	100%	100%	100%	75%	100%	66.7%	100%
M14	Children & Younger People with eating disorder - % ROUTINE cases accessing treatment within 4 weeks		95%	?	H	77.8%	95.8%	100%	92%	91.3%	96.6%	91.7%	93.5%	88.6%	97.1%	97.2%	97.1%
M15	Data Quality Maturity Index		95%	P	H	99.4%	99.2%	99.5%	98.8%	99.3%	99.3%	99.5%	99.5%	99.5%	99.5%	99.4%	99.4%
M19	Talking Therapies - number of people receiving advice/signposting or starting a course.					1306	1603	1578	1470	1403	1477	1745	1713	1315	1621	1416	1357
M23	Talking Therapies - Completion of outcome data for appropriate Service Users		90%	P		98.9%	98.4%	99.0%	99.2%	99.7%	99.0%	99.1%	99.4%	99.2%	99.7%	99.4%	98.6%
M24	Number of people accessing individual placement and support (IPS) services during the month		13	?	H	23	33	26	37	38	34	35	38	25	48	50	44
M25	Number of individuals accessing specialist community perinatal or maternity mental health services					51	67	53	64	61	70	68	45	38	82	61	56

National Metrics

Data as of : 26/04/2024

NHS South West Yorkshire Partnership NHS Foundation Trust

Metric	MetricName	Data Quality Rating	Target	Assurance	Variation	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
M30	Number of detentions under the Mental Health Act (MHA)					93	101	93	101	100	97	96	86	98	92	82	99
M31	Proportion of people detained under the Mental Health Act (MHA) who are of black or minority ethnic (BAME) origin					20.4%	17.8%	12.9%	24.8%	19%	22.7%	21.9%	18.6%	18.4%	19.6%	18.3%	18.2%
M33	% Service users on Care Programme Approach (CPA) having formal review within 12 months		95%			98.9%	97.3%	98.9%	99.4%	98.4%	96.6%	97.8%	97.8%	97.7%	97.7%	96.9%	97.7%
M34	% Clients in settled accommodation	⚠	60%			84.2%	84%	84.3%	83.8%	84.3%	84.3%	84.8%	85%	84.5%	84.6%	84.2%	83.5%
M35	% Clients in employment	⚠	10%			11.2%	11.5%	11.7%	12.0%	12.3%	12.6%	12.2%	12.3%	12.6%	13.2%	13.0%	13.5%
M41	Completion of a valid NHS number		99%			99.8%	99.8%	99.7%	99.8%	99.6%	99.6%	99.6%	99.7%	99.7%	99.8%	99.7%	99.7%
M42	Completion of ethnicity coding for all service users		90%			99.4%	99.5%	99.4%	99.4%	99.5%	99.4%	99.5%	99.4%	99.4%	99.4%	96.9%	100.0%
M43	Community health services two hour urgent response standard		70%			87.3%	86.6%	86.1%	88.0%	89.5%	88.6%	88.1%	87.4%	85.3%	86.2%	87.8%	88.2%
M44	The number of completed non-admitted RTT pathways in the reporting period		1500			1523	1719	2335	1509	1667	1656	1726	1844	1303	1700	1559	1336
M45	The number of incomplete Referral to Treatment (RTT) pathways		2000														2598
			2100													2216	
			2200												2285		
			2300									2009	2289	2019			
			2400						1782	1982	2168						
			2500			1933	1835	1592									
M46	Count of 2-hour urgent community response first care contacts delivered					826	953	910	935	1019	1003	929	862	929	1102	1005	1171
M47	Virtual ward occupancy		80%			82.9%	44.3%	92.9%	51.4%	57.1%	60%	57.5%	78.8%	64.3%	81.4%	95.7%	101%
M48	Community services waiting list		5198												4767	5068	5414
			5430						5024	5170	5048						
			5469									4952	4886	4808			
			5652			5420	5298	5131									
M171	% Admissions gate kept by crisis resolution teams		95%			100%	99%	100%	96.6%	100%	99.1%	100%	97.9%	100%	98.1%	98.8%	95.7%

National Metrics

Data as of : 26/04/2024 12:36:06

NHS South West Yorkshire Partnership NHS Foundation Trust

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 87.5%.

• The percentage of service users waiting for a diagnostic appointment for less than 6 weeks in the paediatric audiology service remains below threshold and has seen a small decline in March due to school holidays, resulting in staff taking annual leave and parental choice to change appointments. The team continue delivering the improvements on the action plan and have a service review booked in May which will assess the progress against this. Not all appointments are for diagnosis. Overall the average waiting time for an appointment in audiology is 4.4 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 has increased to 100%. The routine access to treatment measure has increased in March to 97.1% which is over the 95% threshold. Please see narrative in the Strategic Objectives & Priorities section of this report for further detail.

• Virtual ward: increased demand in frailty pathway has meant over occupancy in month. As pathways within virtual ward are being further established we are continuing to see a steady increase in both acute respiratory infection and frailty patients. We are currently monitoring this increased level against staff capacity, in addition to managing the roll out of digital technology and assessing the impact this has on the pathway.

• Community services waiting list - This metric reports the total number of people waiting across a range of physical health and wellbeing services in Barnsley (aligned to the national community services SitRep). There has been a significant increase in demand for musculoskeletal services in March compared to previous month which is also reflected in the number of incomplete Referral to Treatment (RTT) pathways (Metric 45) and this has impacted the increase for this measure this month. It is important to note that although there has been an increase in numbers waiting, this does not mean they are waiting longer than the threshold.

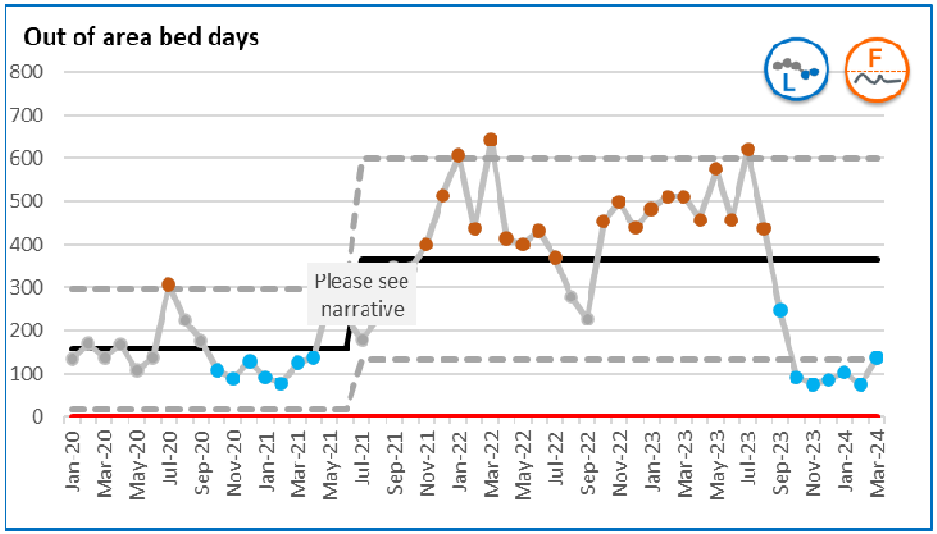
• During March, there were two service users aged under 18 years placed in an adult inpatient ward with a total length of stay in the month of 8 days. Although the Trust has robust governance arrangements in place to safeguard young people, it is concerning that young people continue to need admission into adult beds. This has been escalated by the executive trio to the provider collaborative executive trio and work is ongoing.

• The percentage of clients in employment and percentage of clients in settled accommodation - there are some data completeness issues that may be impacting on the reported position of these indicators however both are above their respective thresholds.

• Data quality maturity index - the Trust has been consistently achieving this target. This metric is in common cause variation and we are expected to meet the threshold.

• NHS Talking Therapies - proportion of people completing treatment who move to recovery remains above the 50% target at 53% for March. 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 at 96.7% during the month of March. 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.



The SPC chart shows that there has been a marginal increase in the number of inappropriate out of area bed days in March 2024 and we remain in a period of special cause improving variation (something is happening and this should be investigated). We are still not estimated to meet the target of zero bed days though we are closer to this than we have been for over 2 years.

The process limits were recalculated in June 2021 due to a conscious increase in out of area bed usage which in turn was due to staffing pressures across the wards, increased acuity, Covid-19 outbreaks and challenges to discharging people in a timely way.

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.

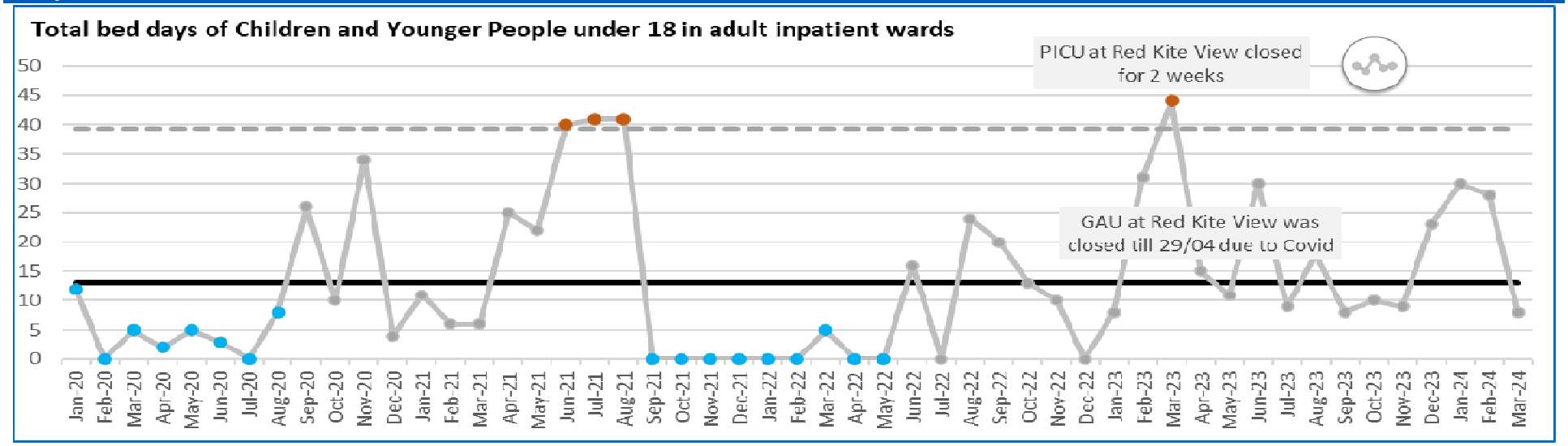
Summary	Actions	Assurance
The Trust remains in a period of special cause improving variation following a significant decrease in the number of bed days used.	The culmination of the work of the improvement programme which has focussed on: - Addressing barriers to discharge and reducing delays for people 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 metrics 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 March the following data quality issue has been identified in the reporting:

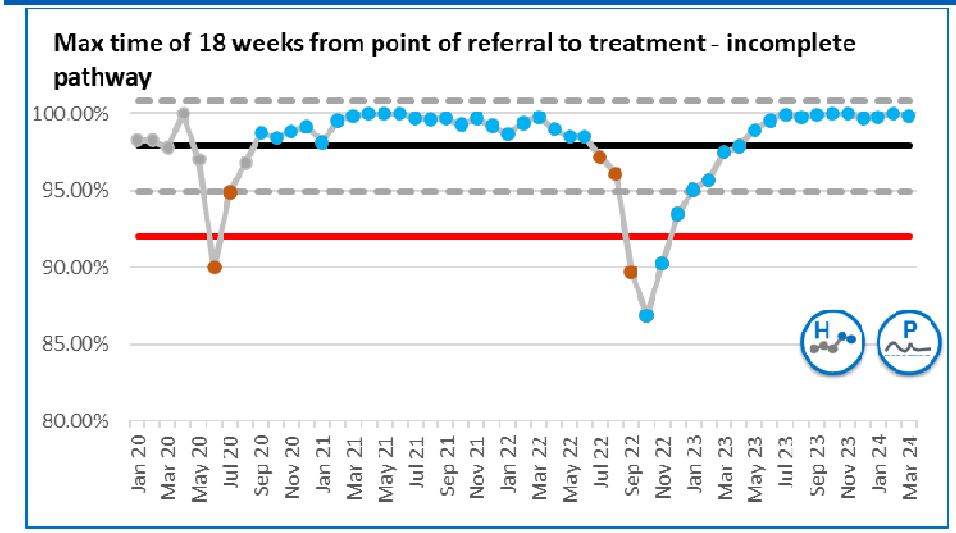
- The reporting for employment and accommodation shows 18.4% of records have missing employment and/or accommodation status with a further 1.4% that have an unknown employment status and 1.0% with an unknown accommodation status. This has been flagged as a data quality issue and work is taking place within care groups as part of their data quality action plans to review this data and improve completeness.

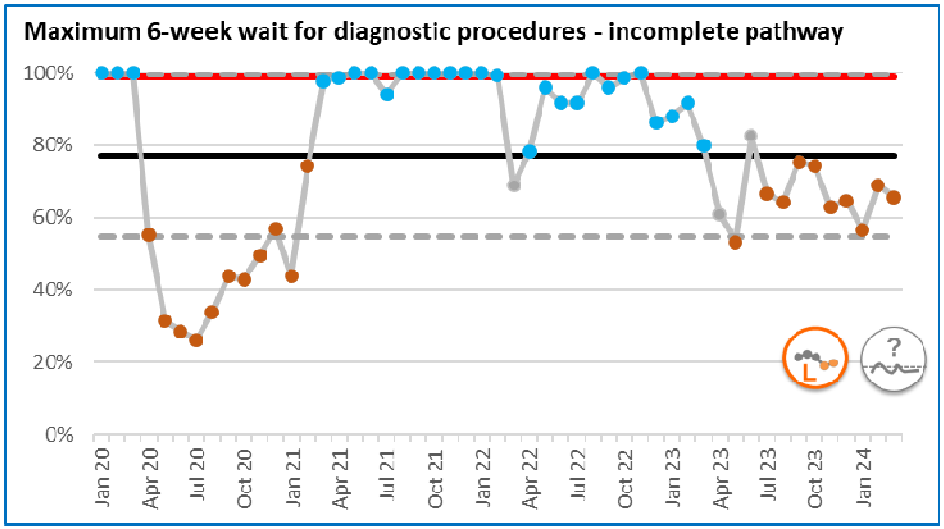
Analysis



The statistical process control chart (SPC) above shows that in March 2024 we remain in a period of common cause variation (no concern) regarding the number of beds days for children and young people in adult wards.

Analysis





The SPC charts above show that in March 2024 we remain in a period of special cause improving variation (something is happening and this should be investigated) for clients waiting a maximum of 18 weeks from referral to treatment and we are estimated to achieve the target against this metric. As we have seen a continued and sustained achievement of the target and indeed over 10 months over the mean, a recalculation of the process limits should be considered. For clients waiting for a diagnostic procedure we remain in a period of special cause concerning variation (something is happening and this should be investigated) 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.

Overall Headlines

Appraisals remain a priority. These are being booked, with work to address reporting underway.
Actions are in place to address underperformance in mandatory training. Staff rostering for inpatient wards ensures the availability of appropriately trained staff at all times.
Positive recruitment, particularly to band 5 roles has not yet had a commensurate impact on substantive staffing capacity on wards as recruits are still undergoing preceptorship, training and induction.
Overall, improved appraisal compliance, improved supervision, reduced sickness and reduced turnover interlink to have a positive impact on staff wellbeing.

Current average OPEL level

2.56

Key
OPEL Level 1
OPEL Level 2
OPEL Level 3
OPEL Level 4

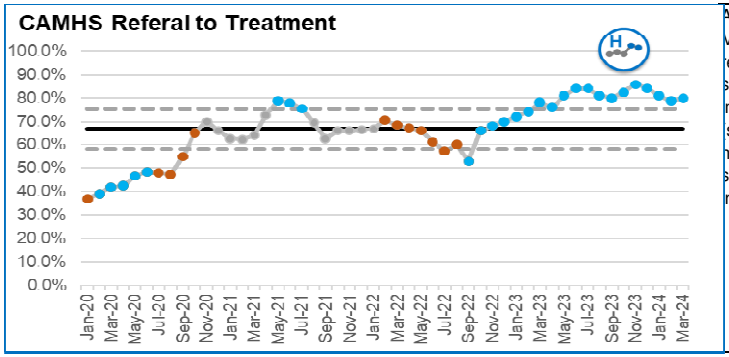
Child and adolescent mental health services (CAMHS)

Headlines

Neurodevelopment waits remain a concern particularly in Kirklees particularly as the additional capacity ends in March 2024.
Access to specialist provision for inpatient care is challenging. This has been escalated within the provider collaborative.
Work is underway to address underperformance in mandatory training.

CAMHS

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance
% Appraisal rate	>=95%	84.1%	84.6%	88.4%	
% Complaints with staff attitude as an issue	< 20%	0% 0/4	0% 0/1	0% 0/2	
% of staff receiving supervision within policy guidance	80%	75.6%	74.6%	75.7%	
CAMHS - Crisis Response 4 hours	N/A	98.3%	95.2%	95.1%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.0%	75.2%	78.7%	
Eating Disorder - Routine clock stops	95%	97.1%	97.2%	97.1%	
Eating Disorder - Urgent/Emergency clock stops	95%	100.0%	66.7%	100.0%	
Information Governance training compliance	>=95%	92.6%	92.6%	90.4%	
Reducing restrictive physical interventions training compliance	>=80%	68.6%	70.6%	75.3%	
Sickness rate (Monthly)	4.5%	4.5%	4.0%	4.9%	
% rosters locked down in 6 weeks					



As you can see in March 2024, we remain in a period of special cause improving variation (something is happening and this should be investigated).

Alert/Action

- Work to address all underperformance in mandatory training continues. Improvements have been noted in all areas of mandatory training except Information Governance and actions have been taken to remind teams to address this. The new Trust wide reporting system will make it easier to monitor and manage training at team level.
- Calderdale CAMHS continue to see increasing numbers waiting for services, reaching the highest since July 2023, plans are ongoing to manage the referrals and numbers waiting. Kirklees CAMHS has seen a slight increase in the numbers waiting for services, reaching the highest since September 2023.
- Waiting numbers for autistic spectrum condition (ASC) / attention deficit hyperactivity disorder (ADHD) (neuro-developmental) diagnostic assessment in Calderdale/Kirklees remain problematic. A robust action plan is in place but a shortfall between commissioned capacity and demand remains and additional waiting list resources have now ceased causing further impact on the numbers waiting. This has been recorded on the risk register.
- The shortage of specialist residential and specialist inpatient bed places leading to inappropriate stays for young people on acute hospital wards and in Trust in-patient beds. This is noted on the Trust risk register and has been escalated through the provider collaborative. Work continues with the provider collaboratives to improve patient flow

Advise

• Crisis response times are generally met, however when there is a breach, a review of the circumstances is undertaken and learning shared within the team as appropriate.
• The number of referrals into the service has remained stable and average wait times from referral to first contact have reduced or been maintained within all areas. Efforts continue to reduce these further alongside the development of a 'while you wait' offer to support people to wait well.
• The number of cases waiting for a service in Barnsley continues to remain stable, conversations are taking place about pathways and resource optimisation alongside conversations about funding with commissioners.
• The number of cases waiting for partnership work over six months has increased in Barnsley, Kirklees and Calderdale. These are small numbers and this will continue to be reviewed.
• Kirklees have not met the threshold for routine clock stops in Eating disorders for 1 young person, MDT and managerial oversight is always in place for any breach, these are often due to family requests or changes in circumstances. All urgent cases have been seen within the expected timeframes.
• There has been a slight increase in reporting of incidents, these are all monitored for learning through the children's services governance group. An increase in incidents being reported does not necessarily cause concern as this is an indication of a learning and reporting culture.
• There has been a reduction in ethnic coding in Barnsley and this will be explored to understand any learning and training needs.
• Appraisal rates are continuing to improve and performance and are expected to be 90% by the next reporting period, continuing to aim for the 95% target.
• Clinical supervision remains an ongoing are of improvement and the care group are working with the nursing directorate to improve processes and recording of data.
• There has been an increase in sickness with the exception of secure CAMHS, the reason of stress and anxiety has been a theme – this is reflected in the staff survey where work pressures and expectations are impacting on wellbeing due to vacancies in teams and waiting times for families causing distress.

Assure

• Barnsley mood and emotional pathways have seen a significant drop in the average number of days wait from referral to treatment, this is the lowest it has been in the last 12 months.
• Friends and family test results remain positive with Calderdale and Wakefield both receiving 100%
• Secure CAMHS sickness has reduced and recruitment to vacant posts is going well.
• Recruitment to vacant posts is going well in all areas, the teams are looking forward to new starters joining the services.
• Partnership working is going well and we are proactively engaged with provider collaboratives in South and West Yorkshire to strengthen interface with inpatient providers and improve access to specialist beds.

Adults and Older People Mental Health

Headlines

The improvement work continues to contribute to reduced reliance on out of area bed use. The Trust is a positive outlier and has shared learning and actions with neighbouring Trusts, whilst still recognising that this is an ongoing challenge.
The data shows a reduction in the number of people who are clinically ready for discharge, but this does not accord with operational understanding. Further work is underway to clarify this position.
High acuity and high occupancy on wards is directly linked to the work on reducing reliance on out of area beds, the work underway in the intensive home based treatment teams to gatekeep admissions and support people at home significantly helps to manage the overall position.
Wards continue to reporting an increased pressure from the number of learners who require support. Support has been drawn from retired, experienced nurses.
Where the sickness rate is above the Trust threshold on some wards and is due to a combination of long-term absence, pregnancy related illness and seasonal illness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
Under-performance in mandatory training, supervision and appraisal is being addressed through line management support and oversight.

Mental Health Community (Including Barnsley Mental Health Services)

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance
% Appraisal rate	>=95%	77.2%	79.9%	82.8%	
% Assessed within 14 days of referral (Routine)	75%	80.5%	81.8%	89.3%	
% Assessed within 4 hours (Crisis)	90%	93.4%	99.0%	98.1%	
% Complaints with staff attitude as an issue	< 20%	9% (1/11)	0% 0/2	22% (2/9)	
% of staff receiving supervision within policy guidance	80%	71.0%	64.7%	68.0%	
% service users followed up within 72 hours of discharge from inpatient care	80%	88.7%	92.0%	87.5%	
% Service Users on CPA with a formal review within the previous 12 months	95%	97.1%	96.8%	96.4%	
% Treated within 6 weeks of assessment (routine)	70%	96.3%	97.0%	97.8%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.9%	77.0%	77.0%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	73.5%	74.7%	73.7%	
Information Governance training compliance	>=95%	91.2%	91.1%	92.0%	
Reducing restrictive physical interventions training compliance	>=80%	70.1%	72.8%	74.2%	
Sickness rate (Monthly)	4.5%	5.0%	5.0%	3.8%	
% rosters locked down in 6 weeks					

Mental Health Inpatient

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance
% Appraisal rate	>=95%	77.7%	89.0%	91.3%	
% bed occupancy	85%	87.1%	87.8%	90.6%	
% Complaints with staff attitude as an issue	< 20%	33% (1/3)	0% 0/2	25% (1/4)	
% of staff receiving supervision within policy guidance	80%	87.4%	88.5%	89.6%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.9%	76.3%	74.7%	
% of clients clinically ready for discharge	3.5%	5.6%	3.6%	3.1%	
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	93.4%	90.1%	91.7%	
Inappropriate Out of Area Bed days	92	104	74	138	
Information Governance training compliance	>=95%	89.6%	91.0%	92.2%	
Physical Violence (Patient on Patient)	Trend Monitor	18	22	21	
Physical Violence (Patient on Staff)	Trend Monitor	55	62	107	
Reducing restrictive physical interventions training compliance	>=80%	77.9%	78.3%	75.8%	
Restraint incidents	Trend Monitor	65	87	***55***	
Safer staffing (Overall)	90%	135.7%	135.5%	137.6%	
Safer staffing (Registered)	80%	97.3%	97.1%	98.9%	
Sickness rate (Monthly)	4.5%	6.2%	6.4%	5.2%	
% rosters locked down in 6 weeks					

Alert/Action

• Acute wards have continued to manage high levels of acuity.
• There are high occupancy levels across wards and capacity to meet demand for beds remains a challenge. Plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
• Workforce challenges have continued with continued use of agency and bank staff.
• The work to maintain effective patient flow continues, with the use of out of area beds being closely managed, the numbers are at a minimum and are essential to meet a person's needs. We are monitoring the impact of reduced out of area beds on inpatient wards, Intensive Home Based Treatment Teams, and community teams.
• The care group are working actively with partners to reduce the length of time people who are clinically ready for discharge (CRFD) spend in hospital and to explore all options for discharge solutions / alternatives to hospital, underpinned by the new national guidance on Discharge from mental health inpatient settings. There has been a reduction in % CRFD on a number of wards in March. However, some wards have a higher number of people who are waiting for discharge due to the requirement for specialist placements for people with complex needs, for others the percentage of those delayed is due to the small numbers of patients on the ward, and in other cases judicial processes are required which can be lengthy. Work is ongoing to ensure the categorisation of CRFD is applied consistently.
• There is increased pressure on the wards from the number of learners that require support, for example student nurses, internationally recruited nurses and newly registered staff, which is creating patient safety concerns. In most cases the support is being provided to learners by two to three 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. There has been successful recruitment in Wakefield and Barnsley SPAs and staff are expected to be in post by the end of March 24.
• 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 March performance data indicates that the routine access for assessment target is being achieved in Calderdale and Kirklees and Wakefield whilst performance is below target in Barnsley. Barnsley performance remains below target in March which requires specific measures for improvement in addition to current business continuity plans and improvement work. This will include further consideration of systems and processes within the team, workforce modelling, pathways with core and enhanced, improving pathways with primary care and talking therapies to provide timely assessment and the most appropriate intervention to meet individual need.
• The Talking Therapies recovery rate for March is 52.91% for Kirklees and 50.53% for Barnsley, both achieving the national standard of 50%. The recovery rate 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.
• All areas are focussing on continuing to improve performance for FIRM risk assessments. There has been some improvement for community mental health services. Inpatient performance for those admitted who have had a staying-well plan within 24 hours is working towards achieving and sustaining improvement against trajectory. The percentage compliance is significantly impacted due to the relatively small number of admissions. There is a high level of scrutiny when a staying safe care plan is not completed within 24 hours and this is generally due to high acuity, bed occupancy or when an agency nurse is in charge of the ward. At the point of admission a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed.

Advise

• Senior leadership from matrons and general managers remains in place across 7 days.
• Intensive work is underway to consider how quality and safety is maintained on inpatient wards. In addition there is a focus on improving the well-being of staff and service users and focussing on recruitment and retention.
• The care group is actively expanding creative approaches to enhance service user experience and the general ward environments. Challenges and priorities are being identified and included in 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 provision of robust gatekeeping, trauma informed care and effective intensive home treatment.
• The care group is participating in the Trustwide work on measuring and managing waits in terms of consistent data and performance measurement.
• Work continues in collaboration with our places to implement community mental health transformation.
• Progress has been made in all areas on ensuring care plans are produced collaboratively and shared with service users. Achievement of the target is being maintained with continued support from Quality and Governance Leads.
• Care Programme Approach (CPA) review performance is above target in all areas, action plans and support from Quality and Governance Leads remain in place.
• The care group recognises the key role of supervision and appraisal in staff wellbeing and are ensuring time is prioritised for these activities and there is a commitment for acute inpatient wards to achieve the target of all appraisals being completed. Data cleansing is underway to ensure that WorkPal and Trust performance data reflect actual appraisal activity in service areas.
• 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. Furthermore, there has been particular focus at ward level to understand and address where supervision levels are low. For example, on Ashdale and Elmdale there has been a number of band 6 vacancies impacting on supervision capacity.
• The sickness rate is above the Trust target on some wards which is due to a combination of factors such as long-term absence, pregnancy related illness and seasonal illness. General Managers have a firm grip on absence with staff being supported and managed in line with Trust policies.
• There is a focus on performance with respect to Friends and Family Tests both in content of responses and numbers completed. Action plans for improvement are in place with all areas now above threshold.
• All team managers have been contacted where compliance rates are below expected thresholds for mandatory training (this includes Reducing Restrictive Physical Interventions/ Cardio-Pulmonary Resuscitation and Information Governance). Inpatient General Managers have also discussed how the service manager might support with monitoring this moving forward.
• Work continues towards meeting required concordance levels for Cardio Pulmonary Resuscitation (CPR) training and RRPI (Reducing Restrictive Physical Interventions) training - this has been impacted by some issues relating to access to training and levels of did not attends. There are issues with course cancellations in addition to changes in CPR course times not aligning with shift patterns.
• The care group is working closely with specialist advisors and have plans in place across inpatient services to ensure appropriately trained staff are on duty across all shifts at all times.
•The care group has seen an increase in the number of physical violence (patient on staff) in March. Almost half of incidents related to two service users and have been near misses by intervention. Staff teams have liaised with RRPI team for specialist advisor input as needed.

Assure

• Intensive Home Based Treatment teams are performing well in gatekeeping admissions to our inpatient beds.
• The care group is performing well in 72 hour follow up for all people discharged into the community.
• The use of out of area beds remains low following intensive work as part of the care closer to home workstream

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) / Learning Disability (LD) Services

Headlines

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic Spectrum disorder (ASD) services:
In line with the national picture, ADHD demand continues to exceed commissioned capacity.
Referral rates remain high across both pathways and the service try to minimise waiting times as far as possible.

Learning disability services:
Key concern remains the number of people who are seen, assessed and commence their plan within 18 weeks. During March the LD team have focussed on people with the longest waits and this has had an impact on staffing capacity to meet the 18 weeks. The data relates to 11 breaches out of 46 people. Work is underway as part of the Improving Access priority program. Each locality has an action plan and there have been some demonstrable improvements to date and waiting lists will be monitored on a weekly basis. A high proportion of inpatients within the Horizon centre remain clinically ready for discharge and awaiting a suitable placement - work continues with partners to encourage flow.

LD, ADHD & ASD

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance
% Appraisal rate	>=95%	77.8%	76.3%	78.5%	
% Complaints with staff attitude as an issue	< 20%	0% (0/2)	100% (1/1)	17% (1/6)	
% of staff receiving supervision within policy guidance	80%	75.5%	77.5%	84.7%	
Bed occupancy (excluding leave) - Commissioned Beds	N/A	56.5%	50.0%	50.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	74.9%	75.8%	75.5%	
% of clients clinically ready for discharge	3.5%	57.8%	50.0%	50.0%	
Information Governance (IG) training compliance	>=95%	94.7%	97.2%	94.9%	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks	90%	83.8%	87.5%	76.7%	

LD, ADHD & ASD

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance
Physical Violence - Against Patient by Patient	Trend Monitor	0	0	0	
Physical Violence - Against Staff by Patient	Trend Monitor	38	30	19	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	75.6%	76.5%	76.8%	
Safer staffing (Overall)	90%	166.6%	164.2%	162.1%	
Safer staffing (Registered)	80%	123.2%	108.5%	116.7%	
Sickness rate (Monthly)	4.5%	3.1%	2.5%	2.7%	
Restraint incidents	Trend Monitor	27	36	***19***	
% rosters locked down in 6 weeks					

Attention Deficit Hyperactivity Disorder (ADHD) / Autistic spectrum disorder (ASD) services:

Alert/Action

- Friend & Family Test – ↑ 67%, efforts continue to improve service user experience and feedback. Service is looking to use chat pads to aim to improve engagement with service users.
- ICB West Yorkshire Neurodiversity project – Work ongoing across West Yorkshire
- Appraisal 89%↓. The service is seeking to understand why this has reduced and address undercompliance.

ADHD Pathway
- Referral rates remain high and waiting lists continue to grow. There are currently over 4000 people waiting for an ADHD assessment. This is a national challenge.
- The service has invited 800 people to appointments since April.

Autism Pathway
- Referral rates remain high but there are minimal waits for assessment across Barnsley, Kirklees and Wakefield. There are approximately 20 people currently waiting from these areas and the longest wait for assessment is 16 weeks from referral date (although this person has faced a delay following a period of non-engagement).
- Calderdale continues to progress the Any Qualified Provider (AQP) model.

Advise

The service has had discussions with commissioners to find the best solutions to challenges in Places pending a West Yorkshire solution for Calderdale, Kirklees and Wakefield.
- Wakefield Place has already invested in a pilot project to implement ADHD screening and triage from April 2024.
- Kirklees Place has invested in an all-age neurodiversity referral unit, submitted jointly with Kirklees CAMHS. This clinical unit will determine appropriateness for ADHD and autism assessments.
- These developments have also created an opportunity to review the referral process for adults and an electronic referral process is being explored.

Assure

- All training not above the target have plans in place to address. This applies to RRPI (Reducing Restrictive Physical Interventions) and Information Governance.
- Relationship with Bradford working very well.
- Excellent levels of supervision (100%) and appraisal (93%).
- Excellent staff survey results.

Learning disability services:

Alert/Action

LD (Learning Disability)
• Appraisal performance remains a focus. Plans are in place to ensure compliance across the Care Group. Current compliance is 80%↑ (this is based on local data). The service is working with People Performance to reconcile the local data with the electronic staff record.
• The focused work has led to an increase in supervision to 80.9%↑ Further work is taking place to embed supervision in practice.
• Plans are in place to address mandatory training hotspots in cardiopulmonary resuscitation, information governance and reducing restrictive physical interventions. In the inpatient ward, staff rostering is used to ensure the availability of appropriately trained staff at all times.

Community Services
• Waiting Lists – Improvement work continues with action plans in place for each locality. Weekly progress meetings will track progress and detailed updates will be provided to OMG/EMT.
• The focus on addressing longer waits has had an impact on staff capacity to address 18 weeks waits and this is noted in the reduction in performance in March 2024. The actions are under review.

ATU (Assessment & Treatment Unit)
• Speech and Language post remains vacant and now back out to recruitment.
• We continue to progress on improvement actions and the service is self-assessing 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.
• Appointed an Occupational Therapist following several recruitment drives.

Advise

Greenlight Toolkit
• Work continues to progress.

Community
• Challenges continue with the recruitment of specialist in Speech and Language, Psychology and Occupational Therapy.
• Locality trios are improving their clinical pathways locally including crisis, behavioural and dementia.
• Business cases for additional ADHD resource now being revised following commissioner feedback.
• Liaising with ICB's regarding community accommodation that meets the needs of service users both in terms of environment and skills of staff.

ATU (Assessment & Treatment Unit)
• Improvement work continues to be embedded into the service.
• Internal staff training programme continues re Positive Behaviour Support, Trauma Informed Care, Active Support and Autism.
• Service users Clinically Ready for Discharge continues to be at 50%, which means that 2 people are experiencing delays in leaving hospital to an appropriate community placement. Whilst plans are now in place for these people, the availability of appropriate placements for people with a learning disability is recognised as a system wide pressure.

Assure

• Friends and Family Test 100%
• Increase in appraisal rates and supervision.
• Sickness on target and well being plans have good levels of engagement from staff.
• Staff survey results demonstrate improvements.
• All localities have exceeded 75% target for annual health checks.

Barnsley General Community Services

Headlines

Paediatric audiology waits remain a significant concern, with increased demand outstripping capacity. Action and recovery plans are in place for the waiting times for diagnostic procedures and an audit action plan is in place and agreed by integrated care board (ICB). A request for assurance from the CQC following the national audit is being responded to.
Staffing in the neuro rehabilitation unit remains a concern with temporary staffing solutions in place to maintain safe staffing levels. The business and service model is being reviewed.
Clinical supervision uptake and recording has improved with the targeted action, but remains a concern and is being addressed through line management support and oversight.

Barnsley General Community Services

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance
% Appraisal rate	>=95%	81.5%	85.8%	86.9%	
% Complaints with staff attitude as an issue	< 20%	0% (0/3)	0% (0/1)	0% (0/1)	
% people dying in a place of their choosing	80%	97.4%	88.9%	94.1%	
% of staff receiving supervision within policy guidance	80%	47.3%	53.6%	62.6%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	77.6%	79.1%	80.1%	
Clinically Ready for Discharge (Previously Delayed Transfers of Care)	3.5%	0.0%	0.0%	0.0%	
Information Governance (IG) training compliance	>=95%	93.6%	94.0%	95.7%	

Barnsley General Community Services

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance
Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	99.8%	99.9%	99.9%	
Maximum 6 week wait for diagnostic procedures	99%	56.5%	69.0%	65.7%	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	75.0%	100.0%	80.0%	
Safer staffing (Overall)	90%	110.6%	110.1%	113.6%	
Safer staffing (Registered)	80%	98.7%	96.9%	94.0%	
Sickness rate (Monthly)	4.5%	3.8%	4.2%	4.1%	
% rosters locked down in 6 weeks					

Alert/Action

- NRU (Neurological Rehabilitation Unit) safer staffing figures continue to show mostly green with a dip to amber this month at 79.8% for Registered Staff on NRU. Ongoing challenge to fill trained staff shifts; we continue to supplement with untrained staff. Work ongoing with Finance and Contracting colleagues to revise the service / business model. This issue has been logged on Datix and is also on the local risk register. In addition, a meeting with Safer Staffing Project Manager is planned for April 2024.
- The CQC has requested from all providers, information and assurance in relation to Paediatric Audiology and that this is shared with Trust Boards. This is being compiled and will be provided to a future Trust Board, in line with the CQC request.

Advise

- Clinical supervision continues to receive a special focus with a drive to improve recording and a further 9% increase has been seen from February to March.
- Appraisals - many of our 32 service lines are at 100% and we continue to work on data cleansing linked to ESR. Overall figure as at end March has increased to 86.9%.
- Yorkshire Smokefree Wakefield tender submitted – currently awaiting decision.
- Changes to the structures in the Care Group now require work to the reporting portfolios so that the People Directorate, Patient Safety etc. are all reporting on correctly aligned service line portfolios. Changes to the portfolio may impact on the data being reported in terms of overall care group statistics.
- Paediatric Audiology 6-week waits are at 65.7% as at March 2024 with work ongoing to address this.

Assure

- Paediatric Audiology – following the national audit, a visit from integrated care board (ICB) colleagues is planned for 8 May 2024 with a Teams call booked before the end of April 2024.
- Urgent Community Response Service 2-hour target is 88.2% as at March 2024 which is well above the 70% threshold. The team are also working on data quality in order to improve statistical information further. This supports people to avoid admission to the acute hospital.
- Musculo Skeletal Service (MSK) are seeing a continued achievement against the national target of 92% for 18-week RTT (Referral to Treatment) – 99.9% as at March 2024.
- Friends and Family Test (FFT) 97% of people would recommend community services.
- Over 5% increase to 94.12% of people dying in their place of choosing as at March 2024
- Sickness across all Yorkshire Smoke Free (YSF) and Live Well Wakefield (LWW) is showing as 3.95% overall. Managing this through return-to-work interviews.
- Mandatory training overall scores this month has shown an increase for YSF and LWW currently showing as 96.85% compliant.
- CPR training now 80.1% compliant as a care group. To note: Resus Lead has advised that the process for CPR training recording is that they send the signature sheets to L&D. These are inputted by L&D but at irregular intervals once per month. Therefore there is a potential for up to a 6-week lag before the updated training statistics are showing.
- Information Governance training now 95.7% compliant as a care group.
- No 'Areas for Improvement' (previously known as Lapse in Care) to report for March 2024, for pressure sores.

Forensic Services

Headlines

Sickness is a significant concern, particularly in low secure. The people directorate business partner is leading a deep dive into sickness and actions are underway in line with the policy. Individual ward sickness performance is also impacted by the allocation of staff with long term conditions into less acute areas. There has been some improvement in February with the overall performance.
Work on pathways with the collaborative is underway to address the underoccupancy in medium secure services.
Liaison with the collaborative is underway to find appropriate solutions for the patients waiting for high secure placements.
Positive recruitment to band 5 roles has not yet had a commensurate impact on staffing capacity as training, preceptorship and induction is still underway.

Forensic

Metrics	Threshold	Jan-24	Feb-24	Mar-24	Variation/ Assurance
% Appraisal rate	>=95%	76.5%	79.1%	79.8%	
% Bed occupancy	90%	83.2%	81.2%	81.9%	
% Complaints with staff attitude as an issue	< 20%	0% (0/0)	0% (0/0)	0% (0/0)	
% of staff receiving supervision within policy guidance	80%	92.6%	90.0%	90.9%	
% Service Users on CPA with a formal review within the previous 12 months	95%	97.3%	100.0%	100.0%	
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	71.8%	75.6%	80.4%	
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%	
FIRM Risk Assessments - Staying safe care plan in 7 working days	95%	N/A	N/A	N/A	
Information Governance (IG) training compliance	>=95%	91.2%	92.2%	93.4%	
Physical Violence (Patient on Patient)	Trend Monitor	1	3	6	
Physical Violence (Patient on Staff)	Trend Monitor	15	10	8	
Reducing restrictive physical interventions (RRPI) training compliance	>=80%	77.8%	76.1%	75.0%	
Restraint incidents	Trend Monitor	29	29	***13***	
Safer staffing (Overall)	90%	115.7%	105.8%	105.5%	
Safer staffing (Registered)	80%	99.2%	97.4%	96.1%	
Sickness rate (Monthly)	5.4%	6.5%	5.3%	6.3%	
% rosters locked down in 6 weeks					

Alert/Action

• Bed Occupancy – Newton Lodge 85.91%↑, Bretton 77.59%↓, Newhaven 63.96%↑.
•Waiting list for medium secure has increased over the last few months. However, 2 service users in Trust forensic services are waiting for High Secure beds and utilising long periods in seclusion. This impacts their overall wellbeing and impacts capacity in the service. Service liaising directly with commissioning hub and NHSE to find alternative solutions.
• Sickness absence – continues to be a concern across the service with year to date data indicating Newton Lodge 6.7%↓ , Bretton Centre 11.7%↓ and Newhaven 7.6%↑.
• Vacancies & Turnover –Service continues to focus on recruitment and retention. Band 5 vacancies have reduced although many of these are preceptees or internationally educated nurses who are not yet able to undertake their full Band 5 roles therefore the impact on reducing bank and agency is yet to be fully realised. Turnover has reduced across the care group.

Advise

• The West Yorkshire Provider Collaborative are planning two events to explore future bed modelling options.
• The West Yorkshire Provider Collaborative continue to develop future intentions for the women's pathways.
• Mandatory training overall compliance:
  Newton Lodge – 91.6%
  Bretton – 90.2%
  Newhaven –87.9%

The above figures represent the overall position for each service. Hotspots in reducing restrictive physical interventions, cardiopulmonary resuscitation and information governance training are being managed and monitored closely.
• Local appraisal data shows 93%. Work, supported by the people directorate business partner is being undertaken with the people performance team to reconcile this data with Trust data.
• NHS survey results are being used to develop an action plan within the service, with a specific focus on addressing issues regarding equality.

Assure

• High levels of Data Quality across the Care Group (100%).
• 100% compliance for HCR20 (historical clinical risk management) being completed within 3 months of admission.
• The friends and family test feedback remains green and this is supported by other activities within the care group that focus on service user feedback.
• 25 Hours of meaningful activity is 100%.
• All Equality Impact Assessments across Forensic Services have been completed for 23/24 and are scheduled to be reviewed shortly.

Inpatients - Mental Health - Working Age Adults

Ward Level Headlines - Working Age Adults, Older Peoples (WAA and OPS) and Rehab Services

Appraisal
• Improvement on a number of wards
• Targeted work underway, particularly on Enfield Down and Poplars, to ensure outstanding appraisals are booked and that WorkPal and Trust performance data reflect actual appraisal activity in service areas.

Sickness
• Improvement on Clark, Ashdale and Ward 18 due to return of staff from long term sickness absence. Each individual sickness/return has a high percentage effect on Clark due to the small staff group.
• Increase on Lyndhurst, Ward 19, Stanley and Enfield Down due to a combination of long-term sickness absence and unrelated short term absence including pregnancy related illness and seasonal illness.
• Specific challenges on Elmdale relate to recent serious incidents. Occupational Health are involved and support is in place.

Supervision
• Ward specific improvement plans in place where required, for example on Stanley where supervision is particularly low.

Mandatory Training
• CPR (Cardiopulmonary Resuscitation) course cancellations and changes in course times not aligning with shift patterns have impacted on compliance. This has been a particular issue for staff on Beamshaw, Stanley, Lyndhurst, Ward18 and Ward19F.
• RRPI (Reducing Restrictive Physical Interventions) compliance has been impacted by course cancellations and exacerbated by staff then needing to attend the full 4-day course as they have missed the timeframe for the refresher due to course cancellation. This has been the case for Beamshaw, Walton, Nostell, Ashdale, Elmdale, Willow, Wd19, Crofton, Enfield Down and Lyndhurst. Compliance on Crofton has also been impacted by a number of new starters requiring the 4-day course.
• Rota planning and oversight from ward managers ensures adequate numbers of RRPI and CPR trained staff on each shift.
• IG is a particular area of focus and staff are having protected time on shift to complete. Absences on Lyndhurst and Elmdale are impacting on compliance.

Bed Occupancy
• Where the bed occupancy exceeds target plans are in place to mitigate any impact on quality of high occupancy such as increased staffing levels.
• Occupancy levels in rehabilitation units are affected by the fact that within the overall commissioned bed base the service model offers a flexible usage of beds and community packages of care at any one time depending on service user need. Occupancy calculations are based on the full commissioned bed base, not accounting for the agreed flexible usage.

Safer Staffing
• Elmdale did not meet the safer staffing (registered) target in March due to the sickness absence of 5 registered staff. There was a minimum of 1 registered member of staff with additional Health Care Assistants to ensure overall safe staffing.
• Enfield Down had 3 registered staff on long term sick in March. The safer staffing target does not take account of the reduction in occupancy due to the flexible bed base.

Clinically Ready For Discharge (CRFD)
• High percentage affect due to small numbers of patients on the ward, 20% CRFD on Poplars relates to 3 people, 1 person is now discharged.
• CRFD remains high on some wards which reflects the complexities of the service user population and is impacted by availability of specialist placements for people with complex needs.
• CRFD categorisation includes more individuals than previous DTOC (Delayed Transfer of Care), however the threshold of 3.5% for DTOC has remained for CRFD. The threshold is under review.
• Work is ongoing to ensure the categorisation of CRFD is applied consistently.

FIRM Risk assessments
• Percentage compliance is significantly impacted by small number of admissions. Beamshaw, Clark, Walton, Ashdale, Ward 18, Willow and Ward 19 are all red. Each ward has had 1 breach in March.
• At the point of admission a risk assessment on the immediate safety needs of the person is conducted and appropriate observation levels are prescribed

Restraint Incidents
• Higher incidence of restraint on Clark and poplars is reflective of current patient population & presentation and risk profile of service users.
• All restraint incidents are reviewed by the RRPI (Reducing Restrictive Practice Interventions) team and no areas of concern have been identified.

Inpatients - Mental Health - Working Age Adults

Beamshaw Suite

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	82.6%	95.8%	100.0%
Sickness	4.5%	7.5%	4.8%	4.0%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	92.9%	90.0%	90.6%
Reducing restrictive physical interventions training compliance	>=80%	67.9%	70.0%	71.9%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	82.1%	56.7%	53.1%
Bed occupancy	85%	109.0%	106.2%	111.1%
Safer staffing (Overall)	90%	153.0%	132.7%	132.8%
Safer staffing (Registered)	80%	126.9%	136.6%	139.8%
% of clients clinically ready for discharge	3.5%	6.6%	4.2%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	87.5%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	1
Physical Violence (Patient on Staff)	Trend Monitor	0	2	2
Restraint incidents	Trend Monitor	1	1	***2***
Prone Restraint incidents	Trend Monitor	0	1	***1***
Unfilled Shifts	Trend Monitor	19	10	8

Clark Suite

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	88.9%	87.5%	100.0%
Sickness	4.5%	7.1%	12.7%	5.1%
Supervision	80%	55.6%	50.0%	44.4%
Information Governance training compliance	>=95%	90.0%	84.2%	95.2%
Reducing restrictive physical interventions training compliance	>=80%	95.0%	89.5%	90.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	85.0%	73.7%	71.4%
Bed occupancy	85%	92.2%	92.1%	89.6%
Safer staffing (Overall)	90%	129.3%	159.7%	149.1%
Safer staffing (Registered)	80%	99.8%	100.5%	98.7%
% of clients clinically ready for discharge	3.5%	15.5%	7.0%	2.5%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	77.8%	50.0%	75.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	1	3
Physical Violence (Patient on Staff)	Trend Monitor	4	5	11
Restraint incidents	Trend Monitor	7	8	***12***
Prone Restraint incidents	Trend Monitor	0	1	***0***
Unfilled Shifts	Trend Monitor	19	14	20

Melton Suite

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	68.2%	87.0%	87.0%
Sickness	4.5%	6.5%	3.6%	0.1%
Supervision	80%	100.0%	90.0%	100.0%
Information Governance training compliance	>=95%	92.0%	96.2%	96.2%
Reducing restrictive physical interventions training compliance	>=80%	80.0%	96.2%	96.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	73.1%	76.9%
Bed occupancy	85%	103.8%	110.3%	98.4%
Safer staffing (Overall)	90%	165.9%	160.8%	160.2%
Safer staffing (Registered)	80%	89.3%	98.3%	97.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	85.7%
Physical Violence (Patient on Patient)	Trend Monitor	0	2	0
Physical Violence (Patient on Staff)	Trend Monitor	0	2	1
Restraint incidents	Trend Monitor	2	9	***4***
Prone Restraint incidents	Trend Monitor	1	0	***0***
Unfilled Shifts	Trend Monitor	6	3	23

Nostell

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	92.6%	96.3%	100.0%
Sickness	4.5%	2.7%	0.8%	1.8%
Supervision	80%	83.3%	88.2%	94.4%
Information Governance training compliance	>=95%	93.5%	96.8%	96.8%
Reducing restrictive physical interventions training compliance	>=80%	80.0%	80.0%	76.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.3%	90.0%	93.3%
Bed occupancy	85%	97.1%	94.4%	88.7%
Safer staffing (Overall)	90%	118.5%	139.3%	151.6%
Safer staffing (Registered)	80%	102.5%	100.8%	100.6%
% of clients clinically ready for discharge	3.5%	13.1%	13.4%	5.5%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	85.7%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	2	1
Physical Violence (Patient on Staff)	Trend Monitor	1	6	5
Restraint incidents	Trend Monitor	3	11	***3***
Prone Restraint incidents	Trend Monitor	2	1	***1***
Unfilled Shifts	Trend Monitor	4	7	17

Inpatients - Mental Health - Working Age Adults

Stanley

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	84.0%	84.6%	92.0%
Sickness	4.5%	4.6%	8.6%	5.4%
Supervision	80%	88.2%	81.3%	86.7%
Information Governance training compliance	>=95%	92.3%	100.0%	89.7%
Reducing restrictive physical interventions training compliance	>=80%	84.6%	83.9%	82.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.8%	77.4%	69.0%
Bed occupancy	85%	97.1%	97.8%	106.0%
Safer staffing (Overall)	90%	162.5%	158.4%	131.7%
Safer staffing (Registered)	80%	114.5%	118.4%	115.7%
% of clients clinically ready for discharge	3.5%	8.0%	3.8%	4.6%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	3	1
Physical Violence (Patient on Staff)	Trend Monitor	2	1	2
Restraint incidents	Trend Monitor	8	5	***0***
Prone Restraint incidents	Trend Monitor	3	1	***0***
Unfilled Shifts	Trend Monitor	13	11	12

Walton

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	88.9%	97.1%	100.0%
Sickness	4.5%	6.3%	4.7%	3.5%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	97.4%	88.6%	94.4%
Reducing restrictive physical interventions training compliance	>=80%	73.7%	79.4%	71.4%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	81.6%	88.2%	85.7%
Bed occupancy	85%	93.1%	98.3%	97.2%
Safer staffing (Overall)	90%	127.9%	125.4%	128.9%
Safer staffing (Registered)	80%	92.7%	101.0%	107.2%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	6.8%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	80.0%
Physical Violence (Patient on Patient)	Trend Monitor	1	3	2
Physical Violence (Patient on Staff)	Trend Monitor	2	1	5
Restraint incidents	Trend Monitor	13	11	***2***
Prone Restraint incidents	Trend Monitor	5	1	***1***
Unfilled Shifts	Trend Monitor	7	8	6

Ashdale

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	84.6%	92.9%	92.6%
Sickness	4.5%	9.9%	10.2%	4.4%
Supervision	80%	90.9%	93.3%	75.0%
Information Governance training compliance	>=95%	90.0%	93.9%	97.0%
Reducing restrictive physical interventions training compliance	>=80%	80.0%	69.7%	66.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	80.0%	78.8%	75.8%
Bed occupancy	85%	99.7%	99.0%	98.9%
Safer staffing (Overall)	90%	115.9%	125.3%	121.4%
Safer staffing (Registered)	80%	92.9%	82.8%	87.9%
% of clients clinically ready for discharge	3.5%	4.2%	3.9%	2.5%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	91.7%
Physical Violence (Patient on Patient)	Trend Monitor	3	1	1
Physical Violence (Patient on Staff)	Trend Monitor	0	2	3
Restraint incidents	Trend Monitor	1	3	***1***
Prone Restraint incidents	Trend Monitor	1	0	***1***
Unfilled Shifts	Trend Monitor	1	5	0

Ward 18

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	63.0%	89.3%	100.0%
Sickness	4.5%	3.4%	5.6%	1.8%
Supervision	80%	50.0%	77.8%	87.5%
Information Governance training compliance	>=95%	88.2%	85.7%	90.6%
Reducing restrictive physical interventions training compliance	>=80%	79.4%	82.9%	81.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.5%	74.3%	68.8%
Bed occupancy	85%	95.9%	99.4%	99.3%
Safer staffing (Overall)	90%	125.3%	125.3%	130.1%
Safer staffing (Registered)	80%	84.2%	87.5%	82.4%
% of clients clinically ready for discharge	3.5%	8.3%	5.3%	8.3%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	83.3%
Physical Violence (Patient on Patient)	Trend Monitor	1	0	1
Physical Violence (Patient on Staff)	Trend Monitor	4	0	11
Restraint incidents	Trend Monitor	5	*6*	***5***
Prone Restraint incidents	Trend Monitor	0	0	***1***
Unfilled Shifts	Trend Monitor	2	4	3

Inpatients - Mental Health - Working Age Adults

Elmdale

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	85.7%	94.4%	85.0%
Sickness	4.5%	9.3%	17.0%	14.6%
Supervision	80%	75.0%	50.0%	81.8%
Information Governance training compliance	>=95%	78.3%	75.0%	85.7%
Reducing restrictive physical interventions training compliance	>=80%	87.0%	80.0%	76.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	63.6%	68.4%	70.0%
Bed occupancy	85%	100.3%	96.6%	96.8%
Safer staffing (Overall)	90%	137.2%	144.5%	128.5%
Safer staffing (Registered)	80%	81.6%	70.9%	69.3%
% of clients clinically ready for discharge	3.5%	0.0%	1.1%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	88.9%	93.3%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	4	5	6
Physical Violence (Patient on Staff)	Trend Monitor	9	10	6
Restraint incidents	Trend Monitor	14	*8*	***3***
Prone Restraint incidents	Trend Monitor	2	1	***0***
Unfilled Shifts	Trend Monitor	6	0	2

Inpatients - Mental Health - Older People Services

Crofton

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	73.7%	95.7%	91.7%
Sickness	4.5%	6.5%	5.8%	0.2%
Supervision	80%	88.9%	90.0%	90.9%
Information Governance training compliance	>=95%	96.2%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	76.0%	80.8%	66.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	92.0%	92.3%	96.3%
Bed occupancy	85%	82.5%	80.0%	94.6%
Safer staffing (Overall)	90%	185.9%	166.2%	175.1%
Safer staffing (Registered)	80%	161.2%	147.1%	150.5%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	90.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	4	1	0
Restraint incidents	Trend Monitor	1	2	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	27	38	22

Poplars CUE

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	91.7%	88.0%	84.0%
Sickness	4.5%	2.4%	1.1%	0.7%
Supervision	80%	81.8%	81.8%	100.0%
Information Governance training compliance	>=95%	96.4%	96.4%	89.7%
Reducing restrictive physical interventions training compliance	>=80%	84.6%	84.6%	81.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	88.5%	84.6%	77.8%
Bed occupancy	85%	72.0%	68.5%	78.9%
Safer staffing (Overall)	90%	210.2%	205.2%	231.7%
Safer staffing (Registered)	80%	115.2%	111.4%	111.2%
% of clients clinically ready for discharge	3.5%	14.6%	9.7%	20.4%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	0.0%	N/A
Physical Violence (Patient on Patient)	Trend Monitor	2	2	2
Physical Violence (Patient on Staff)	Trend Monitor	10	16	35
Restraint incidents	Trend Monitor	8	20	***16***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	39	42	52

Inpatients - Mental Health - Older People Services

Willow

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	85.0%	100.0%	100.0%
Sickness	4.5%	1.1%	0.3%	2.9%
Supervision	80%	100.0%	100.0%	90.0%
Information Governance training compliance	>=95%	100.0%	96.0%	96.0%
Reducing restrictive physical interventions training compliance	>=80%	78.3%	80.0%	76.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	65.2%	76.0%	72.0%
Bed occupancy	85%	47.4%	45.5%	84.2%
Safer staffing (Overall)	90%	136.3%	119.9%	188.0%
Safer staffing (Registered)	80%	98.7%	86.1%	96.9%
% of clients clinically ready for discharge	3.5%	34.7%	22.0%	11.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	66.7%	100.0%	75.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	1
Restraint incidents	Trend Monitor	0	2	***2***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	13	11	11

Beechdale

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	100.0%	91.3%	91.7%
Sickness	4.5%	10.3%	7.5%	4.0%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	91.7%	91.7%	92.0%
Reducing restrictive physical interventions training compliance	>=80%	83.3%	83.3%	84.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.3%	91.7%	84.0%
Bed occupancy	85%	97.8%	96.3%	94.2%
Safer staffing (Overall)	90%	139.8%	138.3%	124.8%
Safer staffing (Registered)	80%	93.4%	97.0%	91.6%
% of clients clinically ready for discharge	3.5%	0.4%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	2	0	0
Physical Violence (Patient on Staff)	Trend Monitor	5	4	0
Restraint incidents	Trend Monitor	1	0	***1***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	9	5	9

Ward 19 - Male

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	93.8%	93.8%	100.0%
Sickness	4.5%	2.2%	5.8%	6.1%
Supervision	80%	87.5%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	95.2%	91.7%
Reducing restrictive physical interventions training compliance	>=80%	69.6%	75.0%	65.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	87.0%	90.0%	82.6%
Bed occupancy	85%	91.8%	94.0%	97.6%
Safer staffing (Overall)	90%	117.6%	126.3%	135.7%
Safer staffing (Registered)	80%	76.5%	70.7%	94.7%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	80.0%	50.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	3	2	2
Physical Violence (Patient on Staff)	Trend Monitor	5	8	16
Restraint incidents	Trend Monitor	0	1	***4***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	4	1	4

Ward 19 - Female

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	81.3%	94.1%	94.4%
Sickness	4.5%	7.0%	8.4%	5.6%
Supervision	80%	100.0%	100.0%	90.0%
Information Governance training compliance	>=95%	89.5%	94.4%	90.5%
Reducing restrictive physical interventions training compliance	>=80%	66.7%	72.2%	75.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	55.6%	52.9%	50.0%
Bed occupancy	85%	94.8%	95.9%	95.1%
Safer staffing (Overall)	90%	108.7%	111.9%	110.8%
Safer staffing (Registered)	80%	77.4%	85.9%	86.9%
% of clients clinically ready for discharge	3.5%	7.0%	1.1%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	100.0%	100.0%	100.0%
Physical Violence (Patient on Patient)	Trend Monitor	3	2	2
Physical Violence (Patient on Staff)	Trend Monitor	5	8	16
Restraint incidents	Trend Monitor	0	**0**	***0***
Prone Restraint incidents	Trend Monitor	0	**0**	***0***
Unfilled Shifts	Trend Monitor	2	1	0

Inpatients - Mental Health - Rehab

Enfield Down				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	69.6%	72.7%	72.7%
Sickness	4.5%	5.5%	6.4%	7.6%
Supervision	80%	94.7%	94.1%	94.4%
Information Governance training compliance	>=95%	82.7%	91.8%	92.2%
Reducing restrictive physical interventions training compliance	>=80%	76.5%	72.9%	72.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.9%	79.5%	73.9%
Bed occupancy	85%	49.3%	57.2%	54.1%
Safer staffing (Overall)	90%	87.8%	89.1%	92.0%
Safer staffing (Registered)	80%	70.6%	76.3%	78.9%
% of clients clinically ready for discharge	3.5%	0.4%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	0.0%	0.0%	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	2	0	1
Restraint incidents	Trend Monitor	1	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	0	1	2

Lyndhurst				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	95.2%	95.5%	95.0%
Sickness	4.5%	4.7%	5.8%	14.7%
Supervision	80%	83.3%	92.3%	85.7%
Information Governance training compliance	>=95%	85.2%	92.6%	92.0%
Reducing restrictive physical interventions training compliance	>=80%	59.3%	59.3%	64.0%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	70.4%	70.4%	68.0%
Bed occupancy	85%	64.1%	69.0%	73.0%
Safer staffing (Overall)	90%	127.6%	95.7%	95.1%
Safer staffing (Registered)	80%	108.4%	102.4%	93.9%
% of clients clinically ready for discharge	3.5%	5.8%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	100.0%	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	1	1
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	0	0	0

Inpatients - Forensic - Medium Secure

Ward Level Headlines - Forensics
Performance for all wards is being addressed through regular meetings with Ward Managers and the General Manager. Remedial work continues on appraisals and the service is confident that compliance is just above 90% further work is now being undertaken to update the Trust system so this is reflected more accurately.

Medium Secure
• Supervision remains a focus for the service Waterton and Priestley are the only wards failing to achieve compliance focused interventions will seek to address this.
• Waterton's performance has been affected by sickness/absence and vacancies in the Band 6 group. Additional support is being offered to the ward.
• Sickness variable across medium secure. Management of sickness absence is a focus across the care group. The service is currently being supported by the People Directorate to undertake more detailed analysis to inform future actions. An audit is being undertaken to assess compliance with the sickness absence policy across all wards. It is noted that staff with underlying medical conditions tend to be directed to Wards that are a part of the rehabilitation pathway not the acute pathway by occupational health as part of supportive measures to keep staff in work.
• Compliance for reducing restrictive physical interventions (RRPI) remains challenging for the service with particular challenges accessing courses.
• Bed occupancy in Appleton is lower due to an overall reduction in referrals for learning disability beds in medium secure. Bed occupancy in general remains under constant review with work on flow and pathways progressing.
• Cardio pulmonary rehabilitation compliance is the focus of targeted improvement work. All wards with the exception of Bronte have made some improvement. The service is currently booking staff on available courses and monitoring closely. In Newton Lodge all wards are now compliant except for Bronte, Priestley and Waterton but all are showing an upward trajectory from last month
• Priestley is currently experiencing challenges with overall performance due to recent high sickness rates and high levels of staff on amended duties (40%). The service is working closely with the People Directorate to address ongoing issues.

Low Secure
• Sickness across all wards monitored closely significant improvement in Thornhill and Newhaven's position. Sandals sickness has reduced but remains higher than target. Sickness levels on Ryburn are currently 24.8% due to long term sickness (this relates to 4 staff). The service is currently being supported by the People Directorate to address these issues and is anticipating a reduction in this figure imminently.
• Cardio pulmonary rehabilitation compliance on all 4 Low Secure wards remains a focus with all staff now either completed or booked on courses, System in place to ensure there are CPR trained staff on all shifts.
• Bed occupancy in low secure apart from Ryburn is below expected targets. This is similar to other low secure services across West Yorkshire. The reduction in Thornhill's occupancy is due to recent discharges. The care group is monitoring bed occupancy closely and liaising with the commissioning hub.
• Supervision is excellent across all 3 wards at the Bretton Centre but has dropped significantly in Newhaven for February and March, acuity on the ward is affecting performance.
• The number of prone restraints on Newhaven has fallen this has been supported by quality improvement work undertaken by the service and supported by the reducing restrictive physical interventions team.

Appleton

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	90.5%	85.7%	90.5%
Sickness	5.4%	3.1%	4.4%	3.0%
Supervision	80%	90.0%	81.8%	91.7%
Information Governance training compliance	>=95%	95.7%	95.7%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	82.6%	87.0%	95.5%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	83.3%	79.2%	82.6%
Bed occupancy	90%	56.5%	62.5%	60.5%
Safer staffing (Overall)	90%	96.7%	97.3%	96.1%
Safer staffing (Registered)	80%	108.7%	104.3%	113.0%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	1	0
Physical Violence (Patient on Staff)	Trend Monitor	1	2	1
Restraint incidents	Trend Monitor	1	16	***2***
Prone Restraint incidents	Trend Monitor	0	2	***0***
Unfilled Shifts	Trend Monitor	0	0	1

Bronte

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	100.0%	100.0%	100.0%
Sickness	5.4%	0.4%	0.3%	4.4%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	91.3%	87.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	78.3%	78.3%	70.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	73.9%	65.2%	75.0%
Bed occupancy	90%	99.5%	98.0%	91.2%
Safer staffing (Overall)	90%	99.7%	99.2%	100.8%
Safer staffing (Registered)	80%	101.1%	94.6%	98.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	3	0	0
Restraint incidents	Trend Monitor	1	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	0	1	1

Chippendale				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	90.9%	90.9%	95.2%
Sickness	5.4%	3.7%	3.8%	2.3%
Supervision	80%	88.9%	90.9%	100.0%
Information Governance training compliance	>=95%	87.5%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	79.2%	81.8%	79.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	75.0%	90.9%	95.8%
Bed occupancy	90%	91.7%	91.7%	90.1%
Safer staffing (Overall)	90%	145.3%	147.1%	151.4%
Safer staffing (Registered)	80%	117.8%	119.6%	132.4%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	5	4	1
Restraint incidents	Trend Monitor	4	7	***4***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	8	3	5

Hepworth				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	92.0%	92.0%	91.7%
Sickness	5.4%	7.9%	4.1%	4.7%
Supervision	80%	93.8%	100.0%	94.1%
Information Governance training compliance	>=95%	93.1%	89.3%	96.6%
Reducing restrictive physical interventions training compliance	>=80%	75.9%	82.1%	79.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.6%	74.1%	89.3%
Bed occupancy	90%	98.1%	94.7%	85.8%
Safer staffing (Overall)	90%	96.3%	94.2%	95.7%
Safer staffing (Registered)	80%	86.2%	86.0%	82.3%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	1	0	0
Restraint incidents	Trend Monitor	7	1	***1***
Prone Restraint incidents	Trend Monitor	5	0	***0***
Unfilled Shifts	Trend Monitor	3	1	4

Inpatients - Forensic - Medium Secure

Johnson				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	89.3%	82.8%	92.9%
Sickness	5.4%	6.4%	2.5%	1.0%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	93.8%	87.5%	90.3%
Reducing restrictive physical interventions training compliance	>=80%	87.5%	75.0%	67.7%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.1%	87.5%	90.3%
Bed occupancy	90%	80.4%	79.3%	71.6%
Safer staffing (Overall)	90%	140.2%	136.5%	122.5%
Safer staffing (Registered)	80%	105.8%	116.1%	109.0%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	0	0	***1***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	5	6	6

Priestley				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	50.0%	73.7%	77.8%
Sickness	5.4%	15.5%	10.1%	10.2%
Supervision	80%	78.6%	66.7%	75.0%
Information Governance training compliance	>=95%	90.5%	95.2%	95.0%
Reducing restrictive physical interventions training compliance	>=80%	70.0%	50.0%	52.6%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	70.0%	75.0%	78.9%
Bed occupancy	90%	89.8%	90.7%	92.2%
Safer staffing (Overall)	90%	94.1%	97.9%	97.3%
Safer staffing (Registered)	80%	69.1%	96.0%	90.6%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	2
Restraint incidents	Trend Monitor	1	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	1	1	0

Waterton				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	45.0%	42.1%	40.0%
Sickness	5.4%	4.6%	4.9%	7.5%
Supervision	80%	81.8%	63.6%	60.0%
Information Governance training compliance	>=95%	90.5%	91.3%	89.3%
Reducing restrictive physical interventions training compliance	>=80%	85.7%	69.6%	64.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	61.9%	69.6%	71.4%
Bed occupancy	90%	75.0%	80.2%	91.1%
Safer staffing (Overall)	90%	122.1%	121.6%	128.7%
Safer staffing (Registered)	80%	98.5%	92.0%	100.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	1	1
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	1	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	4	2	8

Inpatients - Forensic - Low Secure

Thornhill				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	86.4%	83.3%	82.6%
Sickness	5.4%	1.0%	0.8%	5.2%
Supervision	80%	92.9%	92.9%	93.3%
Information Governance training compliance	>=95%	95.8%	100.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	83.3%	70.8%	69.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	62.5%	70.8%	73.1%
Bed occupancy	85%	59.8%	57.9%	64.7%
Safer staffing (Overall)	90%	106.9%	99.1%	96.5%
Safer staffing (Registered)	80%	106.3%	92.4%	96.4%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	0
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	5	4	2

Sandal				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	66.7%	70.8%	69.6%
Sickness	5.4%	8.0%	6.1%	6.8%
Supervision	80%	100.0%	90.9%	100.0%
Information Governance training compliance	>=95%	76.0%	92.3%	89.3%
Reducing restrictive physical interventions training compliance	>=80%	80.0%	65.4%	64.3%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	52.0%	73.1%	71.4%
Bed occupancy	85%	87.3%	88.8%	76.8%
Safer staffing (Overall)	90%	127.4%	103.0%	101.6%
Safer staffing (Registered)	80%	101.1%	105.7%	103.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	1	2
Restraint incidents	Trend Monitor	3	0	***1***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	3	1	0

Inpatients - Forensic - Low Secure

Ryburn				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	100.0%	100.0%	87.5%
Sickness	5.4%	36.8%	26.1%	24.8%
Supervision	80%	100.0%	100.0%	100.0%
Information Governance training compliance	>=95%	100.0%	90.0%	100.0%
Reducing restrictive physical interventions training compliance	>=80%	62.5%	66.7%	77.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	50.0%	55.6%	100.0%
Bed occupancy	85%	100.0%	96.1%	95.9%
Safer staffing (Overall)	90%	104.7%	98.6%	99.1%
Safer staffing (Registered)	80%	109.7%	96.0%	99.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	0	1	0

Newhaven				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	76.2%	81.8%	81.0%
Sickness	5.4%	6.3%	3.9%	9.5%
Supervision	80%	100.0%	81.8%	78.6%
Information Governance training compliance	>=95%	89.3%	92.9%	88.5%
Reducing restrictive physical interventions training compliance	>=80%	78.6%	71.4%	69.2%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	78.6%	67.9%	76.9%
Bed occupancy	85%	73.0%	63.4%	65.9%
Safer staffing (Overall)	90%	126.3%	112.0%	109.3%
Safer staffing (Registered)	80%	112.0%	101.5%	87.9%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	1	1	4
Physical Violence (Patient on Staff)	Trend Monitor	4	0	7
Restraint incidents	Trend Monitor	11	5	***4***
Prone Restraint incidents	Trend Monitor	0	0	***1***
Unfilled Shifts	Trend Monitor	6	4	4

Inpatients - Non-Mental Health

Headlines

Appraisal rate:

• NRU rate is showing as 29.2% - Significant focus during March and further staff are booked for April. Critical staffing levels mean that it has been difficult to release staff from clinical duties (see AAA re NRU staffing levels). However, the Appraisal Dashboard is showing 53.6% as at 16 April. There continues to be some data quality issues / data lags which management team are currently investigating.
• SRU rate has increased from 85.5% to 87.7%. This ward has been impacted by LTS in terms of management/senior staff. The Appraisal Dashboard is showing 91.2% compliant as at 16 April. To Note: 2 appraisals completed and input on 15.4.24 are not yet showing within these statistics; therefore this percentage will increase further when dashboards update.

Supervision:

• NRU figures have reduced from 85.7% to 78.6%. This has been impacted by staffing as noted earlier but we expect this to improve from April.
• SRU figures have increased from 70.4% to 73.1% despite this ward being impacted by LTS in terms of management /senior staff.

Cardiopulmonary resuscitation CPR:

• NRU – reduced from 76.7% to 69.7% as at March 2024. This remains below compliance, however, the critical staffing levels noted earlier in care group narrative are contributing to this position.
• SRU – reduced from 74.6% to 70.5% as at March 2024.
• To note: Resus Lead has advised that the process for CPR training recording is that they send the signature sheets to L&D. These are inputted by L&D but at irregular intervals once per month. Therefore there is a potential for up to a 6-week lag before the updated training statistics are showing.
• Recovery improvement plan has been in place for IG and CPR within NRU and SRU – see above.

Information Governance (IG):

• NRU – Increased to 97.1% as at March 2024 - remains compliant.
• SRU – slight reduction from 93.5% to 90.8% as March 2024. This is slightly below target.

Sickness:

• NRU – significant improvement for March - reduced from 10.3% in February to 6.8%. This is being managed via HR processes and sickness reviews and a number of staff have returned to work during March.
• SRU – a further significant reduction in sickness for March – reduced from 8.3% in February to achieve 3.2% compliancy. The unit continues to have some long-term sickness which management are aware is likely to continue for an extended period due to nature of illness.

Bed Occupancy:

• NRU 71.2% against target of 80% - since the last week in March, occupancy has dipped and a reduced number of 5 out of the 8 beds have been in use.
• SRU 96.2% - against target of 80%

Neuro Rehabilitation Unit (NRU)				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	50.0%	29.2%	29.2%
Sickness	4.5%	6.6%	10.3%	6.8%
Supervision	80%	69.2%	85.7%	78.6%
Information Governance training compliance	>=95%	87.1%	96.8%	97.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	76.7%	76.7%	69.7%
Bed occupancy (Barnsley Commissioned beds only)	80%	109.7%	107.8%	71.2%
Safer staffing (Overall)	90%	114.2%	113.2%	120.4%
Safer staffing (Registered)	80%	87.0%	84.7%	79.8%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	2
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	10	5	1

Stroke Rehabilitation Unit (SRU)				
Metrics	**Threshold**	**Jan-24**	**Feb-24**	**Mar-24**
Appraisal rate	>=95%	92.3%	85.5%	87.7%
Sickness	4.5%	8.3%	5.9%	3.2%
Supervision	80%	60.0%	70.4%	73.1%
Information Governance training compliance	>=95%	98.3%	93.5%	90.8%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	69.6%	74.6%	70.5%
Bed occupancy	80%	77.7%	96.8%	96.2%
Safer staffing (Overall)	90%	107.9%	107.8%	108.6%
Safer staffing (Registered)	80%	108.7%	107.4%	106.1%
% of clients clinically ready for discharge	3.5%	0.0%	0.0%	0.0%
Physical Violence (Patient on Patient)	Trend Monitor	0	0	0
Physical Violence (Patient on Staff)	Trend Monitor	0	0	0
Restraint incidents	Trend Monitor	0	0	***0***
Prone Restraint incidents	Trend Monitor	0	0	***0***
Unfilled Shifts	Trend Monitor	12	16	14

Inpatients - Mental Health - Learning Disability

Headlines

• Improvements to supervision levels have been made with supervision now being rostered in for all staff. Appraisal is being monitored locally and is 80% but further work needs to be undertaken to align that on the Trust system.

• Cardiopulmonary resuscitation training is currently a hotspot with remedial actions in place and staff being booked on available courses. There is a system in place to ensure CPR trained staff are on duty at all times which is achieved through effective roster planning.

• Focused attention on information governance training has been successful in achieving compliance.

• High levels of service users who are clinically ready for discharge is due to service users requirements for complex packages of care to be sourced within the community. This has been escalated through the assessment and treatment unit delivery group and is being picked up by Bradfords Chief Operating Officer. The 50% figure relates to two service users, one with a package in place and a tentative discharge date of May and the other service user is currently being assessed by services who can offer the bespoke package required.

Horizon

Metrics	Threshold	Jan-24	Feb-24	Mar-24
Appraisal rate	>=95%	73.1%	71.4%	73.3%
Sickness	4.5%	4.2%	3.3%	3.2%
Supervision	80%	60.0%	83.3%	100.0%
Information Governance training compliance	>=95%	100.0%	97.4%	97.3%
Reducing restrictive physical interventions training compliance	>=80%	80.0%	80.6%	77.1%
Cardiopulmonary resuscitation (CPR) training compliance	>=80%	60.0%	61.1%	62.9%
Bed occupancy	N/A	56.5%	50.0%	50.0%
Safer staffing (Overall)	90%	166.6%	164.2%	162.1%
Safer staffing (Registered)	80%	123.2%	108.5%	116.7%
% of clients clinically ready for discharge	3.5%	60.7%	50.0%	50.0%
FIRM Risk Assessments - Staying safe care plan in 24 hours	95%	N/A	N/A	N/A
Physical Violence (Patient on Patient)	Trend Monitor	0	30	0
Physical Violence (Patient on Staff)	Trend Monitor	38	0	18
Restraint incidents	Trend Monitor	27	36	***19***
Prone Restraint incidents	Trend Monitor	1	0	***0***
Unfilled Shifts	Trend Monitor	18	8	19

The following section highlights the performance against the Trust's strategic objectives and priority change and improvement programmes for 2023/24.
The Trust has in place a robust system for the development, agreement and governance of these priority areas of work: Framework for governance and assurance.
Programme plans are in place with key agreed milestones identified and reporting against these will be provided at the identified date or by exception.
Progress against milestones and other updates by exception are reported in this section.

Progress key	
G	On track against plan and/or on schedule with/in agreed timescales
A	Needs additional action to stay on track and/or on schedule
R	Not on track and/or at risk of not delivering within agreed timescales. Requires review
B	Completed

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving health	Address inequalities involvement and equality in each of our places with our partners	Work continues with partners in each of our four places to address inequalities. Examples include our work on physical health checks for people with a Learning Disability and work to improve understanding of the people who are waiting for services. Internal work on data and metrics is supporting this work and developing our understanding of the impact of services on different cohorts of people. Examples include our work with the alliance and the acute hospital in Barnsley to see how we can collectively support people who are waiting for orthopaedic procedures or MSK services.	
Improving care	Transform our Older People inpatient services	Public consultation has now concluded with over 1500 responses in total. Through March, further consultation activity was completed with a series of roadshows being held. Final survey data has been sent to external providers for analysis with initial data findings and theming due back before the end of April and full report at end of May. The Travel, Transport and Parking working group held its first meeting in March, with further meetings scheduled to focus on solutions to support people with transport needs. Finance, estates, quality, and equality activity all to be taken forward to inform options appraisal. The governance timetable for decision making is being established.	
	Improve our mental health services so they are more responsive, inclusive, and timely	**1. Waits for CAMHS Neurodevelopmental Services in Kirklees and Calderdale:** Wait time to complete the referral appointment in Kirklees is now within 4 weeks (6 months at outset of project). Aim is to reduce further going forward. Continues to be a stabilisation of the caseload size since Feb 2023, any impact of the loss of commissioned funding for additional assessment capacity is being closely monitored as evidence suggests there is likely to be no improvement for the assessment wait without additional capacity to undertake assessment. SWYPFT continues to be involved in discussions with the ICB and WY collaborative on implementation of Choice agenda in Calderdale for Adult ADHD and neurodevelopment services. Transition work with Adult ADHD services in both localities continues to be sustained, with greater equity for others on the waiting list. There are no further large-scale complex change or improvement initiative scheduled for this project. A report of the impact of change and improvement activity undertaken to date has been produced for EMT with the recommendation to support the removal of this project from IATC programme and into operational management. **2. Waits for Community LD (CLD) services:** Phase 2 work has commenced: Training for more staff to complete autism assessments. Business case to resource ADHD diagnostic assessments has been submitted to commissioners for consideration. Locality trios are leading on reviews and improvements of clinical pathways. Each team manager has a full action plan in place to reduce the waits to 17 weeks and under within the next 6 months. The plans target the longest waits and set out the expected number of discharges and allocations within specific time scales to ensure improvement. The operational manager meets with team managers weekly to review progress. EMT support the implementation of phase 2 actions to continue through operational management and governance and removal from IATC programme. **3. Improving Access to Core Psychological Therapies:** Work has commenced on initial qualitative and quantitative data collection and developing a baseline understanding of current activity to inform the Project. A narrative detailing the longest wait times has been provided to enhance comprehension regarding why certain individuals are experiencing extended delays. This has also given insight into variations across areas. Process Mapping has commenced in some localities with Lead Psychologist and Admin team manager to understand the current 'as is' position and understand variations in the ways of working across different localities. Engagement with General Managers has taken place, and a way forward has been agreed. Rapid improvement event to be conducted to identify and action immediate next steps and 3–5 year plan to be included in strategy development. **4. Mental Health Single Point of Access (SPA) Review:** Project initiation activity completed which included initial qualitative and quantitative data collection and baseline understanding of current activity. SPA Core Principles have been defined and recommendations developed for improvement work. A report is being drafted which summarises findings and proposals for next steps. **Care Closer to Home (CC2H) Programme** • Work continuing to sustain the reduction in OoA admissions during a challenging first quarter of the year • Action plan agreed from the outputs of the two staff engagement events • Barnsley engagement event planned for 15th April • Further Calderdale engagement event planned for 29th April • IHBTT SOP work progressing	

Strategic Objective	Priority Programme	Highlights (progress against milestones and other updates by exception)	Progress
Improving Care	Improve our mental health services so they are more responsive, inclusive, and timely	**Inpatient Priority Programme** Discharge Initiatives continue to track progress in alignment with NHSE principles New standards relaunch for the Barriers to Discharge meeting have been rolled out to all localities Therapeutic Inpatient care improvement plan is in development with leads/timescales Workforce – Ongoing development of Preceptorship support package – to be implemented from April 24 Data - Outcome & Measures Dashboard drop-in training sessions successfully ran to the first cohort of ward staff **Community Transformation (MH)** Care Pathway review task and finish group report on commonality and difference within SWYPFT Pathways aligned to review of Core Services SOP and Enhanced Services SOP. On track May 2024 A subgroup is reviewing the role of Trusted Assessor within the Primary Care Pathway. On track July 2024 Review SMI/PHC Templates and SNOMED coding on templates within SWYPFT and Ardens templates used in Primary Care. May 2024 Analysis of the impact of the Client Activation Tool for EMIS GP Practices in other SWYPFT Services experiencing technical issues. Rescheduled completion date set to May 2024. Higher level Communications Intranet Page. Complete NICHE West Yorkshire CMHT Evaluation draft report has been produced and reads favourably for SWYPFT as an integral partner.	
Improving care	Improve safety and quality	**Care planning and risk assessment** Work is progressing in line with the improvement plan. An improvement workshop was held with frontline colleagues in March to co-design the new look care plan and another is scheduled for 26th April to look at the development of a good practice guide, training, performance and quality metric dashboard. The April workshop will also include feedback on the new care plan design. The monthly Care Planning and Risk Assessment Improvement Group continues and the group reviews challenges with performance and opportunities for improvement at each meeting. Ideas for improvement are monitored through the improvement plan. Communications and narrative about the importance of care plans and risk assessments and timeliness of these is being developed to share during June 2024. **Personalised care (moving on from Care Programme Approach)** Steering Group members continue to engage in national, regional, and local network meetings to progress development of national guidance and best practice. Working with Voluntary Action Calderdale and ICB colleagues to develop awareness of the changes to personalised care provision for communication across WY VCSFE networks. June 2024 Continue to engage with Local authorities. A second session with Kirklees Local Authority is set for May 2024. Progress is communicated trust wide via intranet and to service users and partners via internet. On track April 2024. Development of PROMS measures and co-production with staff of a Care Plan Template. On track April 2024. Principles for key worker and multi-disciplinary team (MDT) functions have been drafted and seeking wider staff views through the service line meetings. June 2024.	
Improving use of resources	Spend money wisely and increase value	**Value for money** Confirmation of value for money (VFM) target 23/24 has been achieved. This is going to be subject to an internal audit. Concerns to deliver the value for money sustainability target for 24/25 escalated at Finance OMG. Weekly VFM meetings to commence with DoS to be chaired by COO and report / update to OMG. Key lines of enquiry previously shared including workforce and non-pay schemes, limited progress and pace, meetings continue monthly; supporting scoping of resources and capacity required to deliver key schemes. Continue to explore the management of culture and behaviours of those involved in delivering the VFM schemes and initiatives with a focus on increasing pace and accountability.	
	Make digital improvements	**Digital Dictation** The tender exercise has been completed and a new supplier (Lexacom) appointed to supply a Trust wide single digital dictation solution. The contract was signed in March. A benefits realisation workshop has been held and further ones will be scheduled during April. A digital graduate started in post on 15th April to support the project. The first mobilisation meeting is scheduled for 19th April. Work continues to identify priority services to roll out the solution to initially based on need.	
Great place to work	People Directorate 90-day plan	**Develop the People Directorate (PD) Team** All actions are now complete and integrated a BAU ways of working.	
		Reduce recruitment time to hire: Actions completed: • Time to Hire Action plan in place co-ordinated with Strategy Lead support. • Values Based Assessment Centre Delivery Plan for 2024 • Recruitment Engagement Activity Plan (draft) and submitted to OMG (Operational Management Group) for approval 28/02 • Communications in place via Trust Bank for clinical support to planned Values Based assessment centre. • Roll out of in-progress tracker across the recruitment team. Allowing for greater visibility on in-progress pipeline, outstanding tasks and actions, improved reporting cycles. • Time to hire (T2H) metric – first phase of T2H in place. Action on track: • Recruitment Knowledge & Understanding - Survey to drive improved ways of working and online recruitment training for recruiting Managers re-started and delivered by Recruitment Leads. 88 responses to date. • Diverse Interview Panels – Scoping setting up a diversity register for panel members, building capacity of available panel members. • EOI for an ATS/LMS/Work Pal replacement with procurement. • Development of Recruitment/Resourcing Dashboard – Task and finish group in place with PB&I support to implement suite of recruitment metrics reportable monthly.	
		80% of Trust staff have received an appraisal in the last 12 months: On track: Having achieved the 80% threshold, the focus is to aim to 95%	

Great place to work	People Directorate 90-day plan	**Improve International Nurse experience and support:** Actions taken: (IEN) Monthly meetings re-established with co-ordinated leadership oversight from Daryl Thompson (Chief Nursing Officer) and Nikki Macfarlane (Interim Deputy CPO) under steering group framework. Structured project programme management is now in place with revised task and finish groups identified. New leads identified with representation from all care groups where IEN has presence. Deliverables for each group being scoped out to inform the end-to-end colleague experience for IEN. On track: Support to IENs regarding transition into private accommodation. 8 IEN nurses transitioning from SWYPFT accommodation into private – All complete by May.	
		Improve Quality of Workforce Data: Action Completed: •First stage of end-to-end recruitment time to hire metrics complete Action completed: Quarterly trust wide visa status report in place. •Visa Compliance Reporting in place quarterly and management of Visa data in ESR in place. Trust is 100% complaint re Visa status of all staff. Actions off track/requiring further focus: •DBS (Disclosure and Barring Service) update service compliance reporting under review for inclusion into metrics and reporting •Implementation of project team between PBI/People Directorate to oversee transfer of people data (starting with ESR). Project brief including structure/timeline developed by P&BI to be finalised and agreed with LJ and AS, this will include required BI and People resources to be part of the project delivery team. New action: commenced Discussion/development/capacity plan regarding management of datasets/control and delivery of online information to managers and HRBPs under consultation with PB&I and People Directorate.	
		Improve People Experience Actions completed: •New data monitoring introduced in recruitment for posts 8a and above, VRF line adding to system as check for recruiting managers of diverse panel requirements, monthly reporting on data from recruitment to people experience team so that support can be monitored, and expectations set. •Your voice counts (appreciative enquiry) staff session findings evaluated, and mapping has begun to weave into improving diversity, belonging and inclusion workstreams. Action on track: Inclusive leadership: steering group, established Inclusive leadership workshop and Task and Finish group set up to improve diversity in recruitment selection process targeting 8a and above posts. New Action - Active Bystander principles review. Task and finish subgroup established from All of You Race Forward Group to co-design, co-create and co-deliver How to be an "active" bystander, now to report and support.	
		Improve employee relations support: Action Completed: People Partner offering in line with the entire employee lifecycle defined and now delivered out to stakeholder groups across the trust to excellent feedback. Action Completed: HR Operations Team name change to People Relations Team to align with the rest of the People Directorate. Roles defined to enable a clear tiered service level approach for advice and enquiries for colleagues and managers. Action Requires further focus: PD Policy audit and redesign to support Employee relations. Engagement commenced with staff side w/c 15/01 and tabled at JPF 23/01 on proposals to revamp the existing policies and procedures to more user-friendly formats compliant with current employment legislation and best practice and address access and visibility	
		Develop the workforce plan Action complete: •3rd submission to NHSE required 19th April •Workforce narrative to support workforce plan agreed and sign-off from Acting CPO 14th April – Submitted to EMT for final sign off •Review of final plan and workforce growth rate to EMT timeout 14/05/24. 0% substantive growth agreed with forecasted reduction in temporary workforce (bank & Additional hours) Action ongoing: •Trust wide Strategic workforce plan due as a replacement to existing by Jul 24. Significant skills gap to produce on time, but work ongoing to develop skills within the post holder/support from Head of Resourcing. •Review and redesign of workforce planning/annual planning cycle to develop Care Group Workforce plans •Set up of Workforce planning Steering Group. Implementation and stakeholders being arranged (April 2024)	

Overall Financial Performance 2023/24

Executive Summary / Key Performance Indicators

Performance Indicator		2023/24	Narrative
1	Surplus / (Deficit)	£0.5m	The Trust agreed to a revised surplus position in February 2024. This has been achieved with a surplus of £0.5m (being £0.5m better than the breakeven target).
2	Agency Spend	£8.3m	Agency spend has continued to reduce in March 2024 with total spend of £8.3m in year. This is a £1.7m (17%) reduction from the prior year. Work continues to maintain, and improve, this run-rate into 2024 / 25.
3	Financial sustainability and efficiencies	£12m	The Trust financial sustainability programme has achieved the target of £12.0m. The majority of this is recurrent schemes and those not delivered in 2023 / 24 will continue to form key lines of enquiry for 2024 / 25.
4	Cash	£69.2m	The Trust cash position remains strong although this has reduced to under £70m in March 2024. This was forecast in line with expected revenue and capital payments.
5	Capital	£8.2m	In total £8.2m has been spent against the capital allocation of £8.3m. This is less than 1% lower than plan. Headline achievements in year have focused on safety and sustainability.
6	Better Payment Practice Code	98%	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.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 12 (2023 / 24)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

1.0 Executive Summary / Key Performance Indicators

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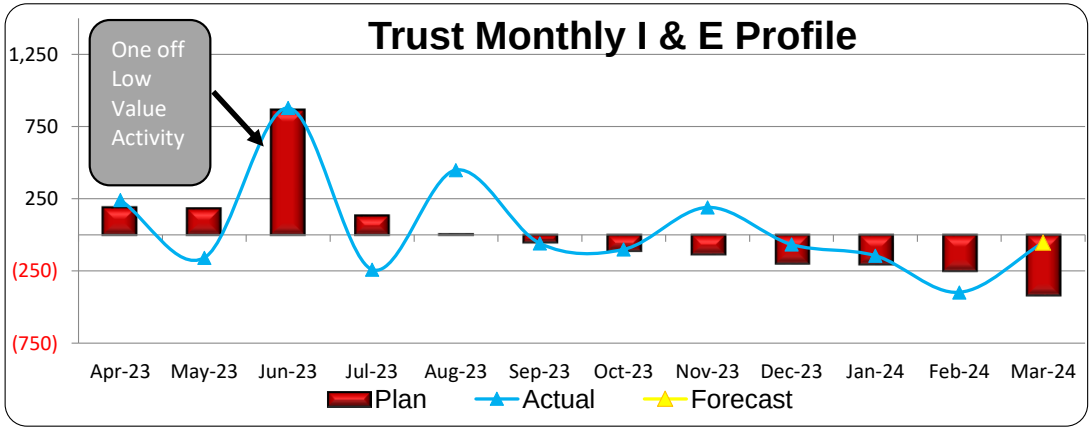
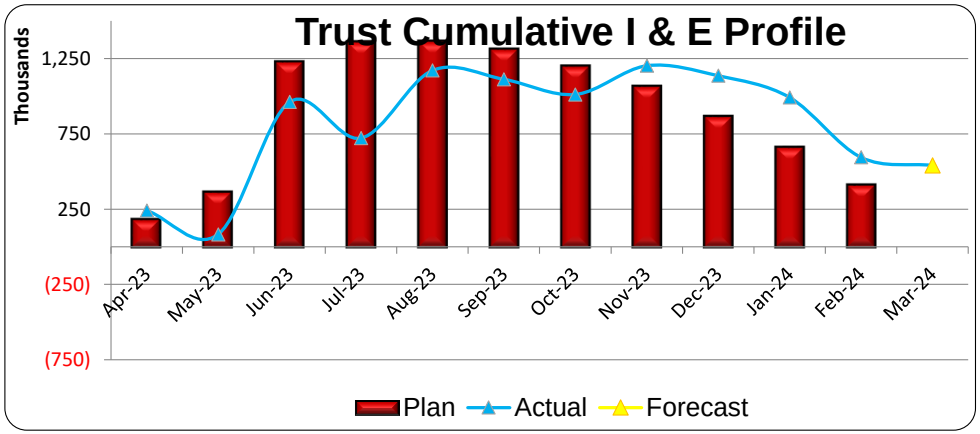
2.0 Income & Expenditure Position 2023 / 24

The table below presents the total consolidated financial position for South West Yorkshire Partnership NHS Foundation Trust. This incorporates it's role as co-ordinating provider for a number of Mental Health Provider Collaboratives but excludes it's linked charities which are consolidated into the Trust's group annual accounts. The impact of the Provider Collaboratives is highlighted separately within this report.

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					34,224	36,883	2,659	399,259	400,723	1,465	399,259	400,723	1,465
Other Operating Revenue					1,487	11,733	10,246	13,362	25,789	12,427	13,362	25,789	12,427
Total Revenue					**35,711**	**48,616**	**12,905**	**412,621**	**426,513**	**13,892**	**412,621**	**426,513**	**13,892**
Pay Costs	5,046	5,110	64	1.3%	(21,492)	(31,267)	(9,775)	(247,903)	(253,473)	(5,569)	(247,903)	(253,473)	(5,569)
Non Pay Costs					(14,232)	(16,994)	(2,762)	(159,691)	(168,571)	(8,880)	(159,691)	(168,571)	(8,880)
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	**5,046**	**5,110**	**64**	**1.3%**	**(35,724)**	**(48,261)**	**(12,537)**	**(407,594)**	**(422,039)**	**(14,445)**	**(407,594)**	**(422,039)**	**(14,445)**
EBITDA	**5,046**	**5,110**	**64**	**1.3%**	**(13)**	**355**	**368**	**5,027**	**4,474**	**(553)**	**5,027**	**4,474**	**(553)**
Depreciation					(481)	(613)	(132)	(5,949)	(6,130)	(181)	(5,949)	(6,130)	(181)
PDC Paid					(179)	(155)	24	(2,148)	(2,124)	24	(2,148)	(2,124)	24
Interest Received					257	360	103	3,070	4,320	1,250	3,070	4,320	1,250
Surplus / (Deficit) - ICB performance measure	**5,046**	**5,110**	**64**	**1.3%**	**(416)**	**(53)**	**363**	**0**	**540**	**540**	**0**	**540**	**540**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(232)	(232)	0	(232)	(232)
Losses Peppercorn Leases (IFRS16)					0	(380)	(380)	0	(380)	(380)	0	(380)	(380)
Revaluation of Assets					0	0	0	0	870	870	0	870	870
Surplus / (Deficit) - Total	**5,046**	**5,110**	**64**	**1.3%**	**(416)**	**(453)**	**(37)**	**0**	**798**	**798**	**0**	**798**	**798**





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	400,723	69,251	1,185	36,426	293,862
Other Operating Revenue	25,789				25,789
Total Revenue	**426,513**	**69,251**	**1,185**	**36,426**	**319,652**
Pay Costs	(253,473)	(1,540)	(113)	(746)	(251,073)
Non Pay Costs	(168,571)	(67,876)	(785)	(36,324)	(63,586)
Gain / (loss) on disposal	5				5
Impairment of Assets	0				0
Total Operating Expenses	**(422,039)**	**(69,417)**	**(898)**	**(37,070)**	**(314,655)**
EBITDA	**4,474**	**(166)**	**287**	**(644)**	**4,997**
Depreciation	(6,130)				(6,130)
PDC Paid	(2,124)				(2,124)
Interest Received	4,320				4,320
Surplus / (Deficit) - ICB	**540**	**(166)**	**287**	**(644)**	**1,063**
Depn Peppercorn Leases (IFRS16)	(232)				(232)
Losses Peppercorn Leases (IFRS16	(380)				(380)
Revaluation of Assets	870				870
Surplus / (Deficit) - Total	**798**	**(166)**	**287**	**(644)**	**1,321**
Surplus / (Deficit) - Forecast	**540**	**(166)**	**287**	**(644)**	1,063

The year to date financial performance of each provider collaborative, which SWYPFT is lead for, is shown on the left.

There is currently no risk / reward arrangement for the Forensic CAMHS and South Yorkshire Adult Secure services and, as such, their financial positions flow directly into the overall financial position.

The South Yorkshire Adult Secure collaborative has reported as a deficit for 2023 / 24. Although there are other financial pressues then main driver relates to financial and operational pressure with one independant sector provider.

West Yorkshire Adult Secure, previously reported as breakeven, has transacted the reward share arrangement. This was based on the month 11 forecast position; as costs were higher in March 2024 than forecast this has shown as a small deficit to the Trust.

2.0 Income & Expenditure Position 2023 / 24

The position of South West Yorkshire Partnership NHS Foundation Trust, excluding the financial impact of Provider Collaboratives, is shown below. The movement between the total financial position and the total excluding the collaboratives is reconciled below for ease.

Total Financial Position

Description	Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Budget	Forecast	Forecast Variance
	WTE	WTE	WTE	%	£k	£k	£k	£k	£k	£k	£k	£k	£k
Healthcare contracts					25,524	26,628	1,104	294,784	293,862	(921)	294,784	293,862	(921)
Other Operating Revenue					1,487	11,733	10,246	13,362	25,789	12,427	13,362	25,789	12,427
Total Revenue					**27,011**	**38,361**	**11,350**	**308,146**	**319,652**	**11,506**	**308,146**	**319,652**	**11,506**
Pay Costs	5,025	5,077	53	1.0%	(21,347)	(31,040)	(9,693)	(246,101)	(251,073)	(4,972)	(246,101)	(251,073)	(4,972)
Non Pay Costs					(5,677)	(6,177)	(500)	(57,018)	(63,586)	(6,568)	(57,018)	(63,586)	(6,568)
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	**5,025**	**5,077**	**53**	**1.0%**	**(27,025)**	**(37,218)**	**(10,193)**	**(303,119)**	**(314,655)**	**(11,535)**	**(303,119)**	**(314,655)**	**(11,535)**
EBITDA	**5,025**	**5,077**	**53**	**1.0%**	**(13)**	**1,143**	**1,157**	**5,027**	**4,997**	**(30)**	**5,027**	**4,997**	**(30)**
Depreciation					(481)	(613)	(132)	(5,949)	(6,130)	(181)	(5,949)	(6,130)	(181)
PDC Paid					(179)	(155)	24	(2,148)	(2,124)	24	(2,148)	(2,124)	24
Interest Received					257	360	103	3,070	4,320	1,250	3,070	4,320	1,250
Surplus / (Deficit) - ICB performance measure	**5,025**	**5,077**	**53**	**1.0%**	**(416)**	**735**	**1,151**	**0**	**1,063**	**1,063**	**0**	**1,063**	**1,063**
Depn Peppercorn Leases (IFRS16)					0	(19)	(19)	0	(232)	(232)	0	(232)	(232)
Losses Peppercorn Leases (IFRS16)					0	(380)	(380)	0	(380)	(380)	0	(380)	(380)
Revaluation of Assets					0	0	0	0	870	870	0	870	870
Surplus / (Deficit) - Total	**5,025**	**5,077**	**53**	**1.0%**	**(416)**	**335**	**752**	**0**	**1,321**	**1,321**	**0**	**1,321**	**1,321**

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	5,046	5,110	64	1.3%	(416)	(53)	363	0	540	540	0	540	540
Provider Collaboratives	21	33	12	55.6%	(0)	(789)	(789)	0	(523)	(523)	0	(523)	(523)
Total excluding Collaboratives (as shown above)	**5,025**	**5,077**	**53**	**1.0%**	**(416)**	**735**	**1,151**	**0**	**1,063**	**1,063**	**0**	**1,063**	**1,063**

Income & Expenditure Position 2022 / 23

The consolidated Trust position is a surplus of £0.5m. This is in line with forecast.

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.

This forecast outturn position was increased in February 2024 to a surplus of £0.5m. This was delivered through additional income received and was part of supporting the West Yorkshire ICB to deliver it's overall financial target.

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

As in previous years there is an increase in income reported in March 2024 when compared to the previous run rate. This includes notional income (and expenditure accounted elsewhere) in relation to NHS pension contributions paid directly. (included in other operating revenue line c. £10m).

The majority of the healthcare income is as agreed, and physically paid, by commissioners. This incorporates agreed positions on investments for 2023 / 24 and the part year effect / slippage impact of these.

Pay

Impacted by the pension contribution noted above there is an increase in pay expenditure in March 2024. The subsequent pay analysis normalises this to exclude this value although this still includes other adjustments only transacted at each year end (for example estimates of unpaid bank shifts).

March 2024 has followed the trend of continued workforce growth. This is primarily in substantive staff groups with a small reduction in bank (which by it's temporary nature would be expected to fluctuate depending on demand). This is a continued trend of growth which has been throughout the whole financial year. This growth has been experienced across a wide range of services and localities.

Non Pay

The additional non pay analysis continues to highlight the trend and variance on non pay expenditure. Spend in year has been impacted by a number of material one off costs which have been agreed.

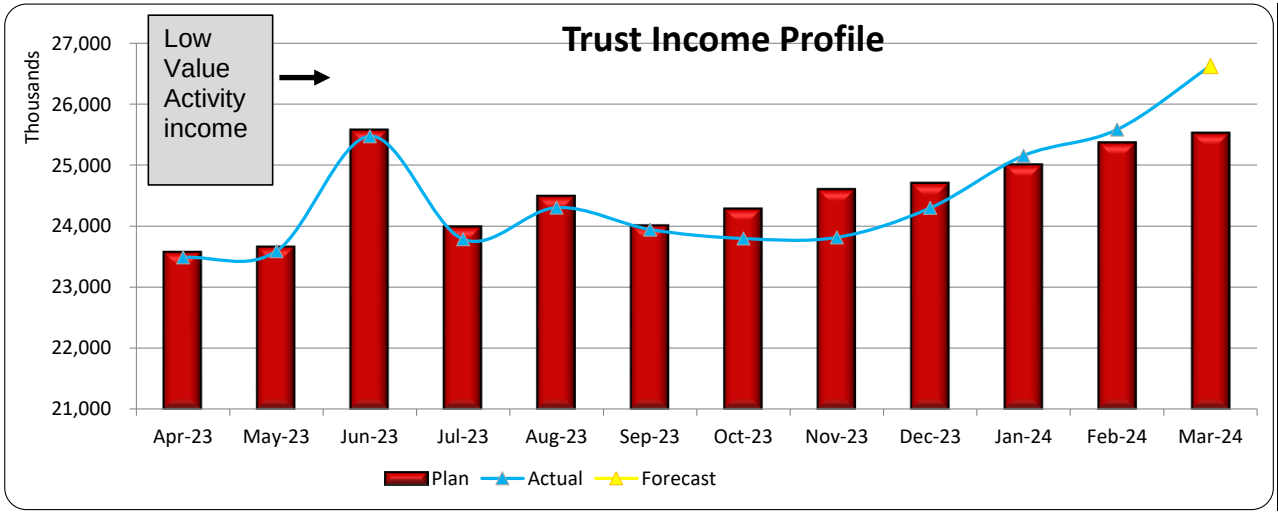
2.1 Income Information

The Trust Income and Expenditure position separately identifies clinical revenue, and other revenue received as part of these significant contracts, as a result of the post covid-19 financial architecture. These contracts are historically those to provide healthcare services as the purpose of this Trust. This does not include other income which the Trust receives such as contributions to training, staff recharges and catering income. This is reported as other operating income.

This excludes the income received for the commissioning role as co-ordinating provider for mental health collaboratives. This is reported separately.

The vast majority of income continues to be received from local commissioners (formerly CCGs, now Integrated Care Boards (ICBs)) and NHS England.

Income source	Apr-23 £k	May-23 £k	Jun-23 £k	Jul-23 £k	Aug-23 £k	Sep-23 £k	Oct-23 £k	Nov-23 £k	Dec-23 £k	Jan-24 £k	Feb-24 £k	Mar-24 £k	Total £k	Total 22/23 £k
NHS Commissioners	19,533	19,642	21,396	19,968	20,628	20,005	20,009	20,116	20,482	21,444	20,865	21,231	**245,319**	**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	2,737	2,746	2,740	3,172	3,897	**34,541**	**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	531	402	468	466	702	462	**5,799**	**5,311**
Partnerships	514	584	546	591	472	608	377	493	504	376	755	930	**6,748**	**5,052**
Other Contract Income	197	96	144	102	144	138	140	67	98	130	89	109	**1,454**	**2,256**
Total	**23,486**	**23,590**	**25,476**	**23,783**	**24,304**	**23,945**	**23,797**	**23,815**	**24,298**	**25,157**	**25,583**	**26,628**	**293,862**	**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**	



The increase in income in March 2024 is in line with forecast. This includes agreed positions with commissioners and the enactment of the West Yorkshire Adult Secure reward share agreement.

This also includes an addiitonal £500k received which has supported delivery of the £0.5m surplus.

Baseline contract values have been agreed with commissioners for 2024 / 25 and these will be updated to ensure that they match current planning guidance.

2.2 Pay Information

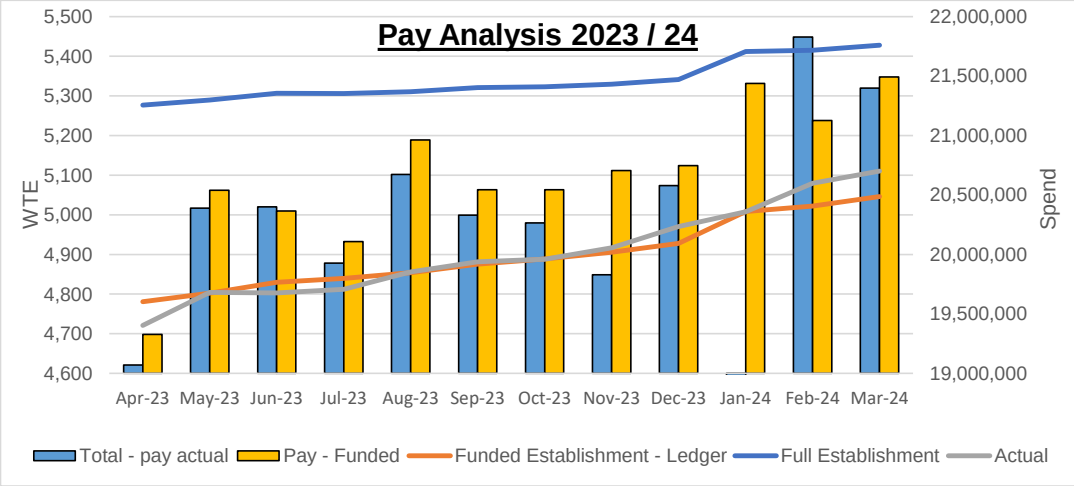
Our workforce is our greatest asset, and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for c.80% of our budgeted total expenditure (excluding the Adult Secure Collaboratives). Trust priorities include a focus on the health and wellbeing of this workforce.

Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

Staff type	Apr-23 £k	May-23 £k	Jun-23 £k	Jul-23 £k	Aug-23 £k	Sep-23 £k	Oct-23 £k	Nov-23 £k	Dec-23 £k	Jan-24 £k	Feb-24 £k	Mar-24 £k	Total £k
Substantive	17,149	18,033	17,940	17,603	18,250	17,827	18,124	18,001	18,324	16,462	19,522	19,030	**216,264**
Bank & Locum	849	1,355	1,337	1,360	1,481	1,454	1,442	1,511	1,587	795	1,729	1,794	**16,693**
Agency	939	908	1,002	855	810	915	635	209	564	581	483	438	**8,338**
Total	**18,936**	**20,296**	**20,278**	**19,819**	**20,540**	**20,195**	**20,200**	**19,722**	**20,475**	**17,837**	**21,734**	**21,262**	**241,295**
22/23	17,397	18,201	17,728	18,510	17,937	20,464	18,972	18,425	17,828	16,905	19,719	18,889	**220,976**

Bank as % (in month)	4.5%	6.7%	6.6%	6.9%	7.2%	7.2%	7.1%	7.7%	7.7%	4.5%	8.0%	8.4%	6.9%
Agency as % (in month)	5.0%	4.5%	4.9%	4.3%	3.9%	4.5%	3.1%	1.1%	2.8%	3.3%	2.2%	2.1%	3.5%

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	4,400	4,417	4,454	4,490	4,558	4,604	**4,413**
Bank & Locum	222	314	326	321	356	369	363	387	408	415	438	421	**362**
Agency	157	161	164	163	144	145	126	113	108	103	84	86	**129**
Total	**4,721**	**4,804**	**4,803**	**4,812**	**4,856**	**4,881**	**4,888**	**4,917**	**4,970**	**5,008**	**5,079**	**5,110**	**4,904**
22/23	4,461	4,455	4,396	4,447	4,494	4,494	4,489	4,450	4,482	4,559	4,532	4,591	**4,488**



The pay expenditure above excludes the notional pension contribution included within the main Trust financial position. This totals £9,778k and helps to ensure comparability to the previous months and the prior year.

In March there has been a continued growth of the Trust, and specifically substantive, workforce. Worked WTE increased by 46. Agency has remained broadly the same and there was a small reduction of bank, although this still remains higher than the majority of the financial year.

In total there has been an increase of 519 worked WTE from March 2023 to March 2024 which a workforce trajectory that suggests this will continue into 2024 / 25.

2.2 Agency Expenditure Focus

Agency spend is £438k in March.

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.

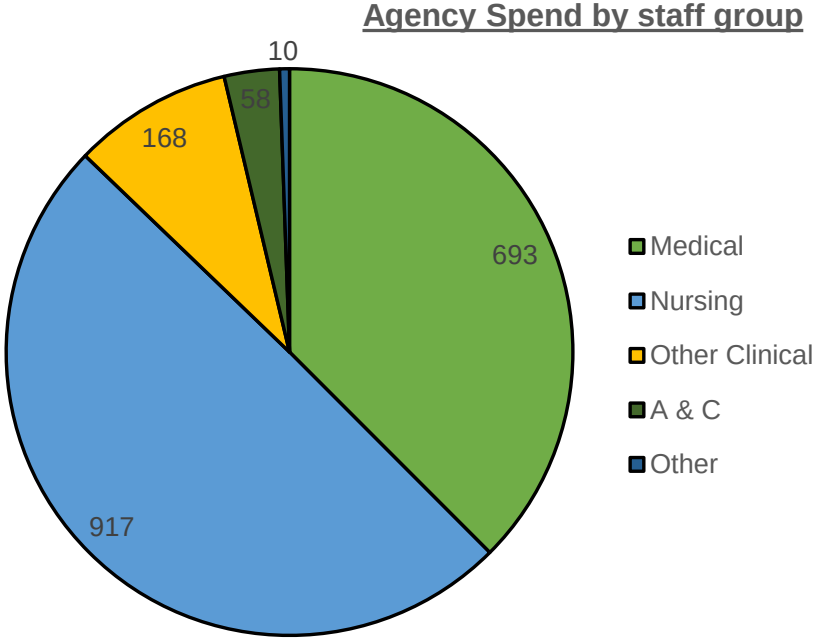
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible use of resources and providing a cost effective strategy.

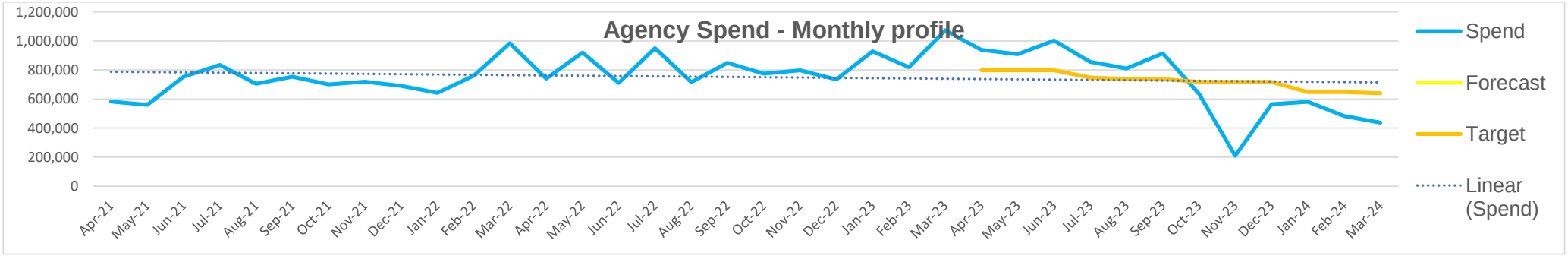
Under the NHS Oversight Framework expected maximum agency levels have been set for 2023 / 24. The Trust planned for delivery of this target at £8.7m. This represents a £1.3m reduction from expenditure incurred in 2022 / 23 and the target trajectory is outlined in the graph below.

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.

March 2024 spend is £438k which is the lowest spend in year (excluding November which included a one off adjustment). Overall there has been a £1.7m (17%) reduction from 2022 / 23 with reductions in most spend categories. The largest has been unregistered nursing and this has been triangulated with changes in substantive and bank staffing. As the largest users of this category of agency staff the biggest care group reductions have been seen in inpatient (adult acute) and Forensics.

Work continues as part of the Trust annual plan and financial sustainability programme to reduce agency spend focusing on where this is the least cost effective option.



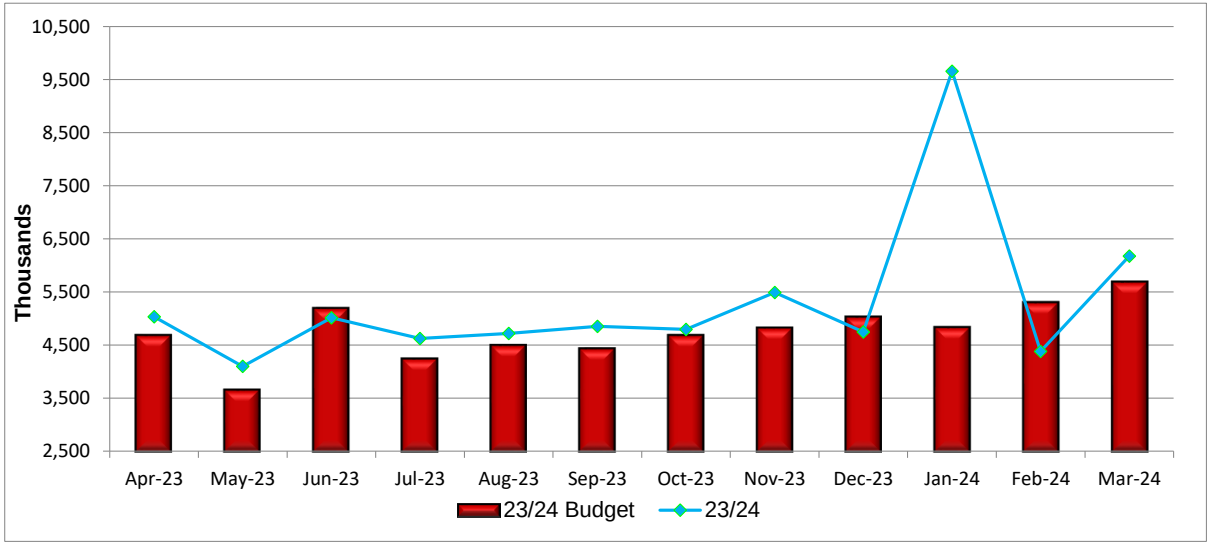


2.3 Non Pay Expenditure

Whilst pay expenditure is the majority of Trust expenditure, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the care groups and corporate services, and excludes capital charges (depreciation and PDC) which are shown separately in the Trust Income and Expenditure position. This also excludes expenditure relating to the provider collaboratives.

Non pay spend	Apr-23 £k	May-23 £k	Jun-23 £k	Jul-23 £k	Aug-23 £k	Sep-23 £k	Oct-23 £k	Nov-23 £k	Dec-23 £k	Jan-24 £k	Feb-24 £k	Mar-24 £k	Total £k
2023/24	5,035	4,097	5,015	4,621	4,719	4,851	4,793	5,489	4,749	9,659	4,382	6,177	**63,586**
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	4,134	3,975	(159)
Establishment	10,098	10,300	202
Lease & Property Rental	8,714	8,546	(168)
Premises (inc. rates)	5,663	6,620	957
Utilities	2,345	2,503	158
Purchase of Healthcare	9,279	13,480	4,201
Travel & vehicles	5,122	4,864	(258)
Supplies & Services	6,725	8,166	1,441
Training & Education	2,131	1,915	(216)
Clinical Negligence & Insurance	1,060	1,061	1
Other non pay	1,748	2,156	408
Total	**57,018**	**63,586**	**6,568**
Total Excl OOA and Drugs	**43,605**	**46,131**	**2,526**



Key Messages

Overall expenditure has been higher in 2023 / 24 than in the prior year. The largest factor is within the purchase of healthcare which includes payments to local NHS providers relating to mental health activity within an acute setting. Part of this was transacted in January 2024 with further adjustments in February and March. These were one off adjustments.

Other areas of overspend, against budget, include premise costs and the purchase of supplies and services. Both have been impacted by high inflationary pressures and this will continue to be monitored in 2024 / 25.

The purchase of healthcare, highlighted as a cost pressure above, is reported in detail on page 12. This is shown as £5m overspent which relates to the mental health activity in acute hospitals as previously reported.

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.

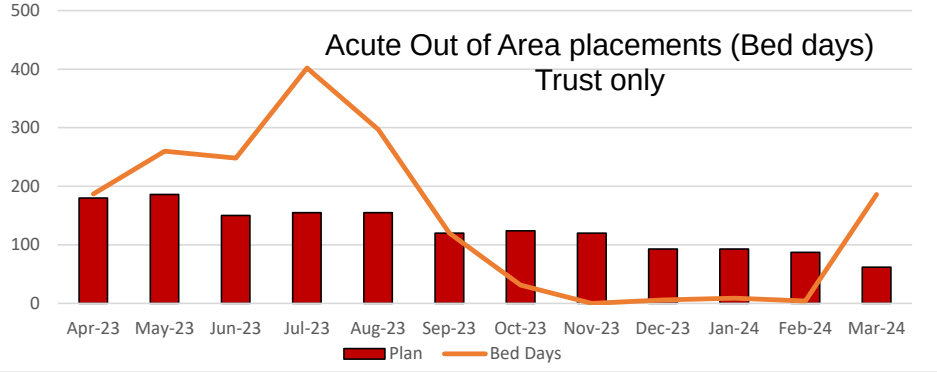
The largest value relates to out of area bed placements (split acute and PICU and the focus of this analysis) which can be volatile and expensive. The reasons for taking this action can be varied but can include:

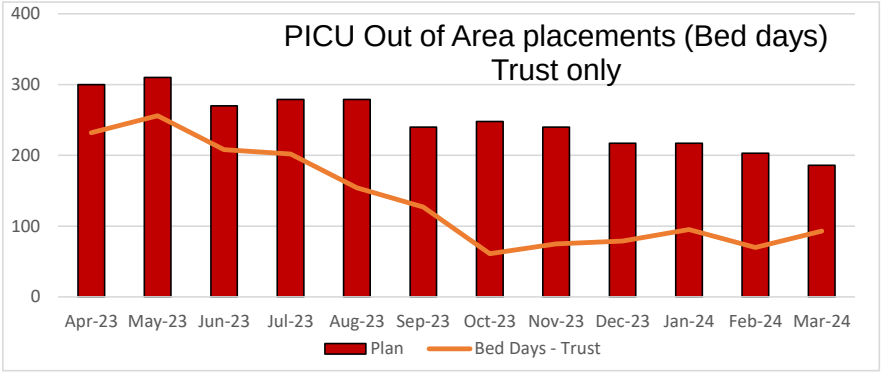
* Specialist health care requirements of the service user not directly available / commissioned within the Trust
* No current bed capacity to provide appropriate care

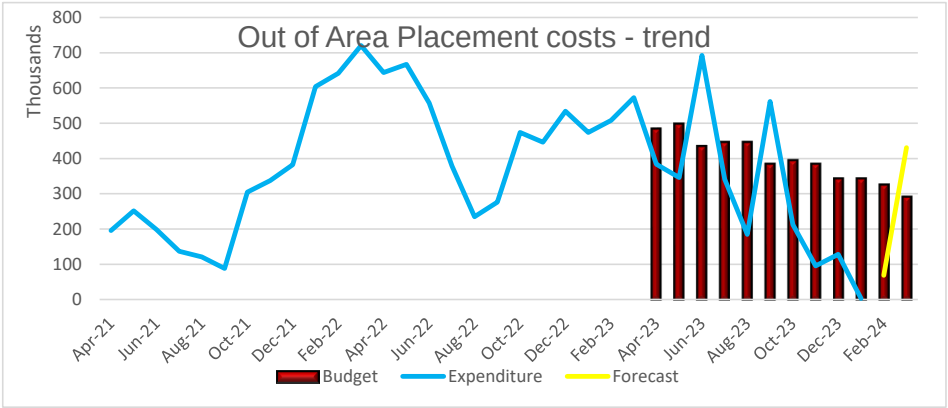
On such occasions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where possible service users are placed within the Trust geographical footprint.

Breakdown - Purchase of Healthcare

Heading	Budget Year to date £k	Actual Year to date £k	Variance £k
Out of Area			
Acute	1,169	1,225	56
PICU	3,488	2,126	(1,362)
Locked Rehab	2,283	2,509	226
Services - NHS	394	5,946	5,552
IAPT	176	422	246
Yorkshire Smokefree	77	37	(40)
Other	1,693	1,215	(478)
Total	**9,279**	**13,480**	**4,201**







There has been an increase of activity in both acute and PICU placements during March 2024 as shown in the graphs above. This follows the sustained improvements in the previous 6 months.

As at the end of March there were 3 acute and 3 PICU. As well as the gender specific reasons (which had been the previous driver) activity in March was also impacted by bed availaiblity within the Trust.

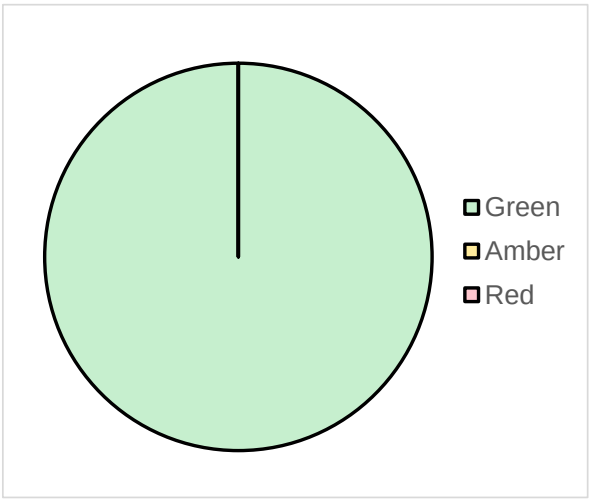
This remains volatile and increases in both areas have been included in the baseline forecast scenario for 2024 / 25. Other West Yorkshire mental health providers have seen rapidly escalating usage of placements over this period.

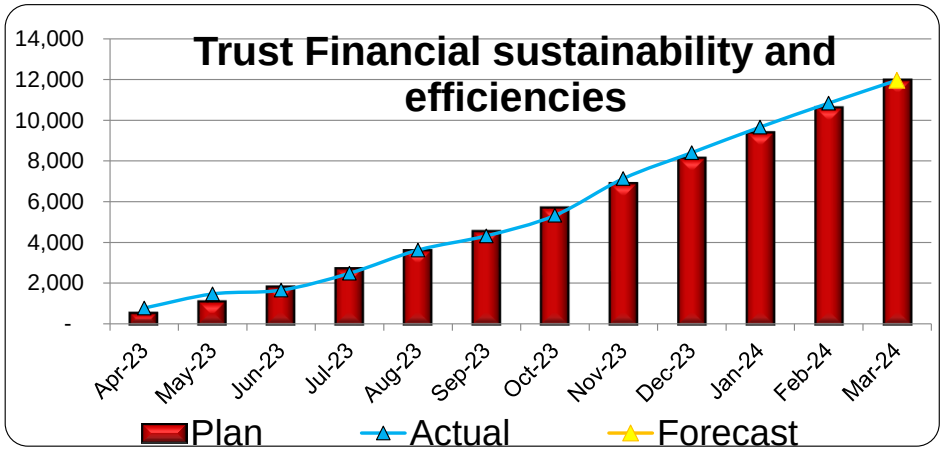
2.4 Value for Money, Financial sustainability and efficiency

The Trust financial plan includes a requirement to demonstrate financial sustainability and efficiency in order to achieve the financial target. This is both the current financial year and as part of the longer term financial plan where continual savings are required to safeguard long term financial sustainability. For 2023 / 24 a target of £11.96m has been identified and included within the plan.

This links closely with the Trust priority to improve the use of resources with a continual strive to ensure that services provide value for money and the best possible use of resources.

		Year to Date			Forecast			
Workstream Categorisation	**Breakdown**	**Target**	**Achieved Recurrent**	**Achieved Non Recurrent**	**Target**	**Green**	**Amber**	**Red**
Out of Area Placements	Pg. 12	3,197	4,526		3,197	4,526		
Agency & Workforce	Pg. 10	4,380	785	1,892	4,380	2,677		
Medicines optimisation		400	188		400	188		
Non Pay Review		1,048	0		1,048	0		
Income contributions		500	885		500	885		
Interest Receivable	Pg. 4	1,400	2,650		1,400	2,650		
Provider Collaborative	Pg. 5	1,044	1,044		1,044	1,044		
Total		**11,969**	**10,077**	**1,892**	**11,969**	**11,969**	**0**	**0**
Recurrent		10,943	10,077		10,943	10,077		
Non Recurrent		1,026		1,892	1,026	1,892		





The Trust value for money programme of £11,969k has been delivered in full for 2023 / 24. The majority of this has been achieved recurrently with the exception of non-recurrent savings in workforce.

Successful programme in year have included:

* Out of area placements - maintained reduction in volume of placements required
* Interest receivable - maximised Trust cash position
* Cessation of shift incentive payments (without detrimental impact)

Schemes which have not achevied in year remain key lines of enquiries for 2024 / 25. This includes agency and workforce and realisation of non pay schemes.

3.0 Statement of Financial Position (SOFP) 2023 / 24

Balance Sheet / Statement of Financial Position (SOFP)	2022 / 2023 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	165,175	167,330	1
Current Assets			
Inventories & Work in Progress	231	179	
NHS Trade Receivables (Debtors)	1,574	1,072	
Non NHS Trade Receivables (Debtors)	2,853	1,058	
Prepayments	3,482	3,491	
Accrued Income	9,372	1,062	2
Cash and Cash Equivalents	74,585	69,199	Pg 15
Total Current Assets	**92,097**	**76,061**	
Current Liabilities			
Trade Payables (Creditors)	(6,524)	(11,975)	3
Capital Payables (Creditors)	(739)	(1,392)	
Tax, NI, Pension Payables, PDC	(7,696)	(8,469)	4
Accruals	(32,952)	(15,842)	4
Deferred Income	(4,172)	(408)	
Other Liabilities (IFRS 16 / leases)	(51,979)	(50,632)	1
Total Current Liabilities	**(104,062)**	**(88,718)**	
Net Current Assets/Liabilities	**(11,965)**	**(12,657)**	
Total Assets less Current Liabilities	**153,210**	**154,673**	
Provisions for Liabilities	(4,319)	(3,510)	
Total Net Assets/(Liabilities)	**148,891**	**151,162**	
Taxpayers' Equity			
Public Dividend Capital	45,657	45,696	
Revaluation Reserve	14,026	14,983	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	83,988	85,263	
Total Taxpayers' Equity	**148,891**	**151,162**	

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. The liability has reduced in year as the remaining life of the lease reduces and also with the 2 leases ended during 2023 / 24.

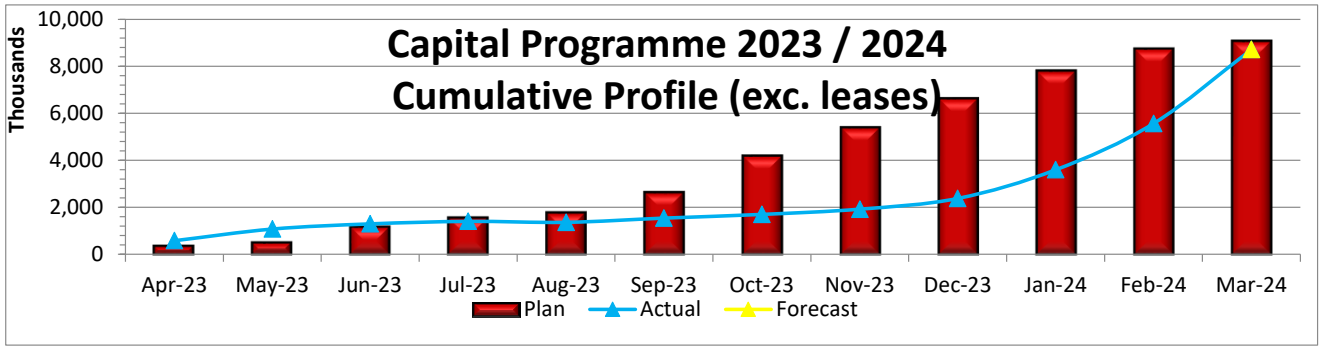
2. Through continued discussions with commissioners contractual values for 2023 / 24 have been received as cash payments. This has meant a reduction in accrued income. The 2022 / 23 included c. £9m relating to national pay award assumptions.

3. Work continues to minimise the value of payables / creditors and ensure that all invoices are resolved in a timely manner. This is exceptionally high at the financial year end due to the timing of invoices received. No specific issue / problem has been identified.

4. Accruals for 2022 / 23 included c. £9m of the national pay awards (opposite entry in accrued income). Excluding this accruals have gone down as work has been undertaken to ensure that invocies are received and paid.

3.1 Capital Programme 2023 / 2024

Capital schemes	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k
Major Capital Schemes						
Site Infrastructure	1,475	1,475	71	(1,404)	71	(1,404)
Seclusion rooms	750	750	652	(98)	652	(98)
Maintenance (Minor) Capital						
Clinical Improvement	285	285	687	402	687	402
Safety inc. ligature & IPC	990	990	2,522	1,532	2,522	1,532
Compliance	430	430	101	(329)	101	(329)
Backlog maintenance	510	510	118	(392)	118	(392)
Sustainability	300	300	170	(130)	170	(130)
Plant & Equipment	40	40	199	159	199	159
Other	1,223	1,223	1,190	(33)	1,190	(33)
IM & T						
Digital Infrastructure	1,100	1,100	1,445	345	1,445	345
Digital Care Records	180	180	58	(122)	58	(122)
Digitally Enabled Workforce	815	815	664	(151)	664	(151)
Digitally Enabling Service Users & Carers	400	400	209	(191)	209	(191)
IM&T Other	270	270	156	(114)	156	(114)
TOTALS	**8,768**	**8,768**	**8,241**	**(526)**	**8,241**	**(526)**
Lease Impact (IFRS 16)	5,203	5,203	6,099	896	6,099	896
New lease	303	303	478	175	478	175
TOTALS	**14,274**	**14,274**	**14,819**	**545**	**14,819**	**545**



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 was originally set at £8,768k which represented the capital allocation plus 5%.

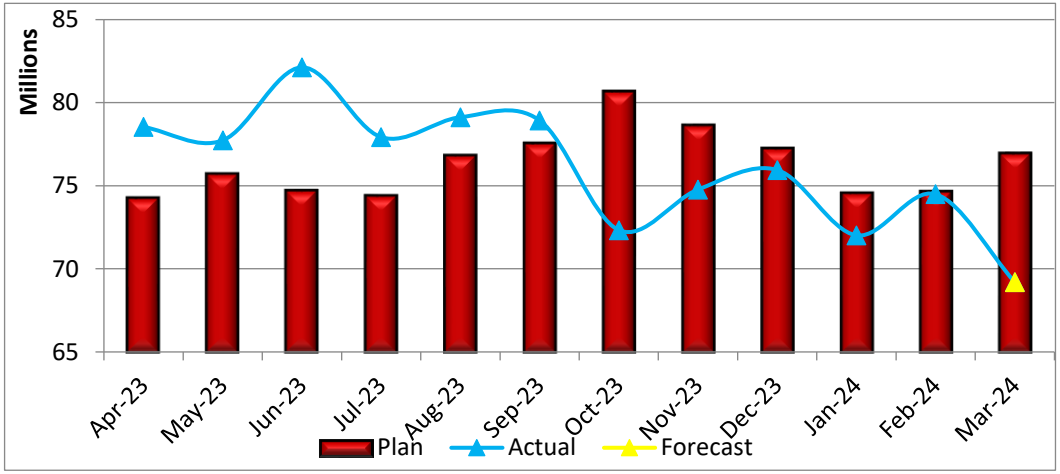
In November 2023 the ICB agreed for all Trusts to revert to baseline allocations. For the Trust the revised target is £8,300k.

Total expenditure, excluding leases, is £8,241k which is £59k less than plan (less than 1% variance).

Key projects delivered in year includes:

* Start of the seclusion room programme
* Continuation of door replacement
* Sustainability including energy efficient light replacement
* Completion of the watermist system in Forensics to increase fire safety in inpatient areas
*Introduction of technologies to enable proactive cyber security enhancement capabilities
* Commencement of the Trustwide Digital Dictation solution

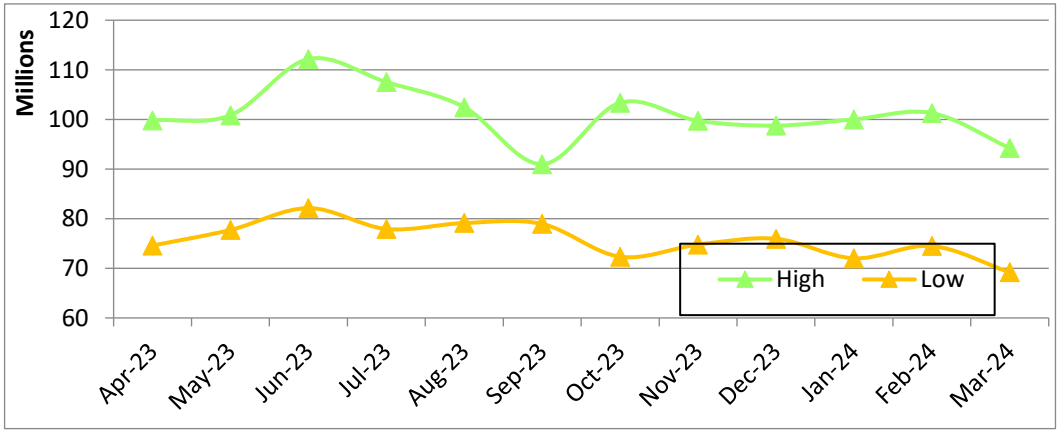
3.2 Cash Flow & Cash Flow Forecast 2023 / 2024



Although cash has reduced in month the balance remains positive at nearly £70m.

As previously communicated cash reduced in month as expected. This related to payment of a number of large invoices and PDC (which is paid at month 6 and month 12 each year).

	Plan £k	Actual £k	Variance £k
Opening Balance	74,585	74,585	
Closing Balance	76,947	69,199	(7,748)



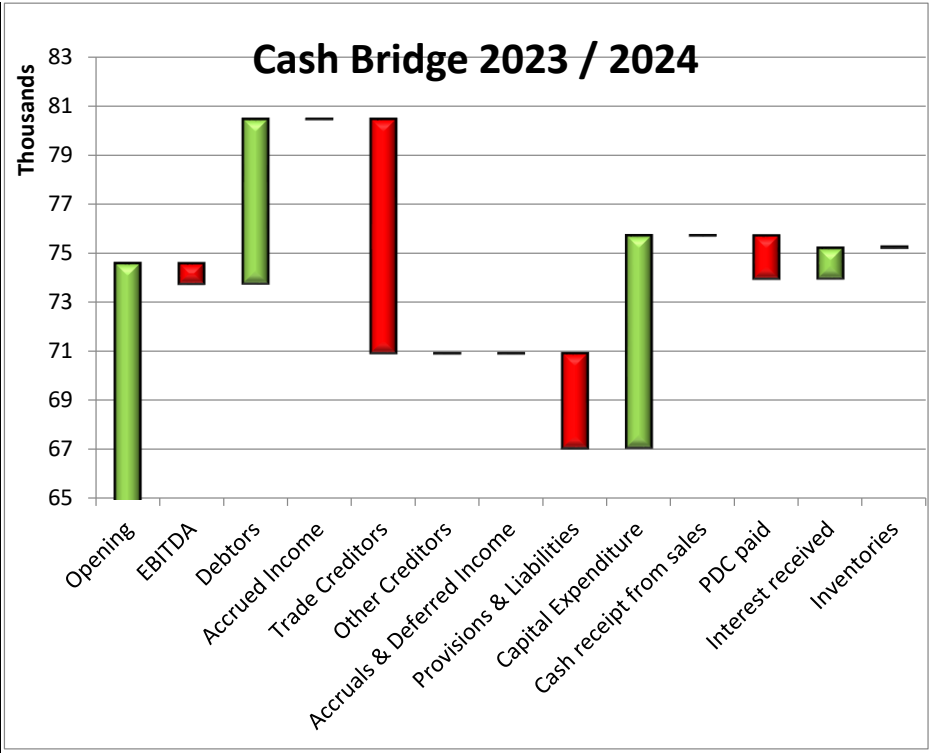
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £94.2m
The lowest balance is: £69.2m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**74,585**	**74,585**	0	
Surplus / Deficit (Exc. non-cash items & revaluation)	13,975	13,139	(836)	
Movement in working capital:				
Inventories & Work in Progress	0	52	52	
Receivables (Debtors)	3,506	10,211	6,705	
Trade Payables (Creditors)	(589)	(10,120)	(9,531)	
Other Payables (Creditors)	0		0	
Accruals & Deferred income	0		0	
Provisions & Liabilities	(706)	(4,572)	(3,866)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(16,894)	(8,241)	8,653	
Cash receipts from asset sales	0	5	5	
Leases	0	(8,453)	(8,453)	
PDC Dividends paid	0	(1,765)	(1,765)	
PDC Dividends received	0	39	39	
Interest (paid)/ received	3,070	4,320	1,250	
Closing Balances	**76,947**	**69,199**	**(7,748)**	



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.

There is significant movements when compared to plan and this will help to inform the 2024 / 25 planning submission. Overall the main driver for the reduction is that one off agreements have been physical cash payments but these have been offset by one off non cash adjustments such as release of provisions or reduction in accruals.

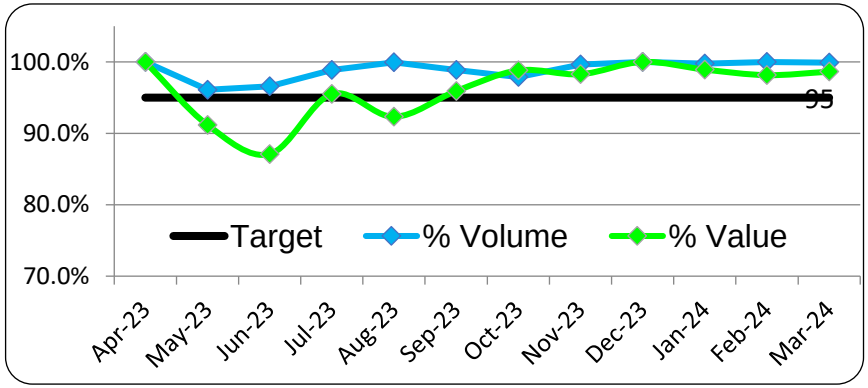
4.0 Better Payment Practice Code

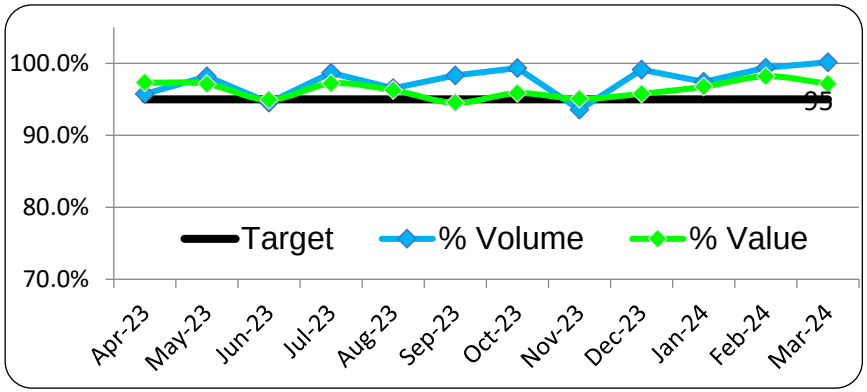
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance continues to be positive although work continues to ensure that no issues remain outstanding and that systems work efficiently.

NHS	Number %	Value %
In Month	100%	99%
Cumulative Year to Date	99%	97%

Non NHS	Number %	Value %
In Month	100%	97%
Cumulative Year to Date	98%	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 (£)
02-Mar-24	Purchase of Healthcare	Trustwide	Mid Yorkshire Hospitals Nhs Trust	1600025954	2,000,000
02-Mar-24	Purchase of Healthcare	Trustwide	Mid Yorkshire Hospitals Nhs Trust	1600025998	1,000,000
14-Mar-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5424	850,000
14-Mar-24	Purchase of Healthcare	AS Collaborative	Nottinghamshire Healthcare Nhs Trust	1000057903	740,183
22-Mar-24	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1001388	680,394
17-Mar-24	Purchase of Healthcare	AS Collaborative	Bradford District Care Nhs Foundation Trust	204198	620,647
17-Mar-24	Purchase of Healthcare	AS Collaborative	Bradford District Care Nhs Foundation Trust	204197	597,000
25-Mar-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS44CINV	450,000
01-Mar-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510007276	421,444
28-Mar-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS44	375,054
24-Mar-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS44	375,054
20-Mar-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGSYS21	270,000
22-Mar-24	Purchase of Healthcare	Trustwide	Leeds & York Partnership Nhs Foundation Trust	1001463	269,000
26-Mar-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5446	263,000
06-Mar-24	Purchase of Healthcare	AS Collaborative	Waterloo Manor Ltd	HO NHS LS 282	251,416
12-Mar-24	Purchase of Healthcare	AS Collaborative	Rotherham Doncaster & South Humber Nhs Found	4400001156	232,254
22-Mar-24	Rates	Barnsley	Barnsley Metropolitan Borough Council	CY5602653010002024	217,035
18-Mar-24	Staff Recharge	Trustwide	Mid Yorkshire Hospitals Nhs Trust	1600026076	202,992
24-Mar-24	Staff Recharge	Trustwide	Mid Yorkshire Hospitals Nhs Trust	1600025623	202,992
05-Mar-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5422	138,458
05-Mar-24	Audit Fees	Trustwide	Deloitte Llp	8004499399	120,000
01-Mar-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D510007275	100,305
22-Mar-24	Rates	Kirklees	Kirklees Council	9691650732024	98,826
07-Mar-24	IT Services	Trustwide	Daisy Corporate Services	3I523386	90,250
06-Mar-24	IT Services	Trustwide	Daisy Corporate Services	3I523494	88,761
15-Mar-24	NHS Recharge	Calderdale	Calderdale & Huddersfield Nhs Foundation Trust	4710179146	87,514
20-Mar-24	NHS Recharge	Calderdale	Calderdale & Huddersfield Nhs Foundation Trust	4710179273	87,514
11-Mar-24	Purchase of Healthcare	AS Collaborative	Oxford Health Nhs Foundation Trust	A0129454	75,010
24-Mar-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	CYGWYS44	74,946
01-Mar-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	NCO2000007640	71,613
05-Mar-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	128 REC09 10	68,652
13-Mar-24	Purchase of Healthcare	AS Collaborative	Leeds & York Partnership Nhs Foundation Trust	1001329	66,273

20-Mar-24	Drugs	Trustwide	Bradford Teaching Hospitals Nhs Foundation Trus	326253	65,679
13-Mar-24	Rates	Calderdale	Calderdale Metropolitan Borough Council	25202490998904	60,606
21-Mar-24	Drugs	Trustwide	Nhs Business Services Authority	1000080045	56,052
21-Mar-24	Purchase of Healthcare	AS Collaborative	Elysium Healthcare Ltd	NCO2000007779	56,000
13-Mar-24	Service Recharge	Barnsley	Barnsley Hospital Nhs Foundation Trust	6027600	55,674
25-Mar-24	Training	Trustwide	Leeds Beckett University	6096816	50,000
27-Mar-24	Furniture & Fittings	Trustwide	Pineapple Contracts	SI91694	49,459
05-Mar-24	Purchase of Healthcare	AS Collaborative	Mersey Care Nhs Foundation Trust	72486926	47,313
05-Mar-24	IT Services	Trustwide	Mri Software Emea Ltd	MRIUK1024544	47,067
12-Mar-24	Legal Fees	Trustwide	Fischer Associates Ltd	FISCH202316	46,754
14-Mar-24	IT Services	Trustwide	Dell Corporation Ltd	7402992783	46,200
14-Mar-24	IT Services	Trustwide	Dell Corporation Ltd	7402992784	46,200
16-Mar-24	IT Services	Trustwide	Dell Corporation Ltd	7402993785	46,200
21-Mar-24	Utilities	Trustwide	Edf Energy Customers Ltd	000018414715	46,017
28-Mar-24	Staff Recharge	Trustwide	Leeds & York Partnership Nhs Foundation Trust	1001462	45,134
27-Mar-24	Purchase of Healthcare	Kirklees	Invictus Wellbeing Services Cic	164	45,000
21-Mar-24	Service Recharge	Barnsley	Sheffield Childrens Nhs Foundation Trust	2400003982	42,605
22-Mar-24	Rates	Kirklees	Kirklees Council	96921639X2024	40,131
13-Mar-24	Purchase of Healthcare	AS Collaborative	Cygnet Health Care Ltd	WYS042INV	39,742
20-Mar-24	Legal Fees	Trustwide	Old Square Chambers	INVDP134	36,000
27-Mar-24	Mobile Phones	Trustwide	Vodafone Ltd	105438438	35,923
27-Mar-24	Mobile Phones	Trustwide	Vodafone Ltd	105610221	35,906
06-Mar-24	Purchase of Healthcare	AS Collaborative	Partnerships In Care Ltd	D190001154EPC	35,162
22-Mar-24	Service Recharge	Barnsley	Bhf Corporate Services Ltd	0825	34,917
22-Mar-24	Service Recharge	Barnsley	Bhf Corporate Services Ltd	0835	34,917
09-Mar-24	Rates	Barnsley	Chapelfield Medical Centre	342	32,819
27-Mar-24	Purchase of Healthcare	AS Collaborative	Nhs Shared Business Services Ltd	100135888	31,340
07-Mar-24	Service Recharge	Kirklees	Socrates Clinical Psychology Ltd	SPS09656RMD9656	31,200
21-Mar-24	Purchase of Healthcare	AS Collaborative	Cheswold Park Hospital	5445	31,149
13-Mar-24	Staff Recharge	Trustwide	Leeds & York Partnership Nhs Foundation Trust	1001328	30,853
27-Mar-24	Purchase of Healthcare	Kirklees	Nouvita Ltd	11452	30,575
11-Mar-24	Service Recharge	Trustwide	Humber Teaching Nhs Foundation Trust	59894504	30,255
20-Mar-24	Rates	Barnsley	Barnsley Metropolitan Borough Council	CY5602654240062024	29,757
11-Mar-24	Alarm System	Trustwide	Pinpoint Ltd	70965	29,612
22-Mar-24	Rates	Kirklees	Kirklees Council	9689426262024	29,484
28-Mar-24	Purchase of Healthcare	Trustwide	Cheadle Royal Hospital	2900023870	29,078
22-Mar-24	Rates	Kirklees	Kirklees Council	9689128942024	28,938
28-Mar-24	Purchase of Healthcare	Trustwide	Cheadle Royal Hospital	2900023871	28,930
26-Mar-24	Purchase of Healthcare	Trustwide	Elysium Healthcare Ltd	FDN01316	28,648
22-Mar-24	Furniture & Fittings	Kirklees	Uk Pods Ltd	SP2957	28,187
28-Mar-24	Staff Recharge	Trustwide	Leeds & York Partnership Nhs Foundation Trust	1001462	28,134
22-Mar-24	Rates	Kirklees	Kirklees Council	9692164152024	28,119
16-Mar-24	IT Services	Trustwide	Dell Corporation Ltd	7402992926	27,900
19-Mar-24	Staff Recharge	Barnsley	Barnsley Hospital Nhs Foundation Trust	6027615	26,293
28-Mar-24	Utilities	Trustwide	Totalenergies Gas & Power Ltd	33421337924	26,101
16-Mar-24	IT Services	Trustwide	Dell Corporation Ltd	7402992927	25,668
04-Mar-24	Rent / Lease	Kirklees	Bradbury Investments Ltd	1850	25,530
22-Mar-24	Staff Recharge	Trustwide	Leeds & York Partnership Nhs Foundation Trust	1001465	25,000

4.2 Glossary

* Recurrent - an action or decision that has a continuing financial effect.

* Non-Recurrent - an action or decision that has a one off or time limited effect.

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year.

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a post / new investment were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year.

* Surplus - Trust income is greater than costs.

* Deficit - Trust costs are greater than income.

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

* Forecast Surplus / Deficit - This is the surplus or deficit we expect to make for the financial year.

* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions). This is set in advance of the year and before all variables are known.

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. As such they are part of the forecast surplus, but not part of the recurrent underlying surplus.

* Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency, reduce expenditure or increase income.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.

* CDEL - Capital Departmental Expenditure Limit. This refers to the amount of capital set by Her Majesty's Treasury each year which the whole of the NHS must remain within for capital expenditure.

* ICS - Integrated Care System. ICB - Integrated Care Board.

* EBITDA - earnings before interest, tax, depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.

Appendix 2 - Statistical Process Control (SPC) Charts Explained

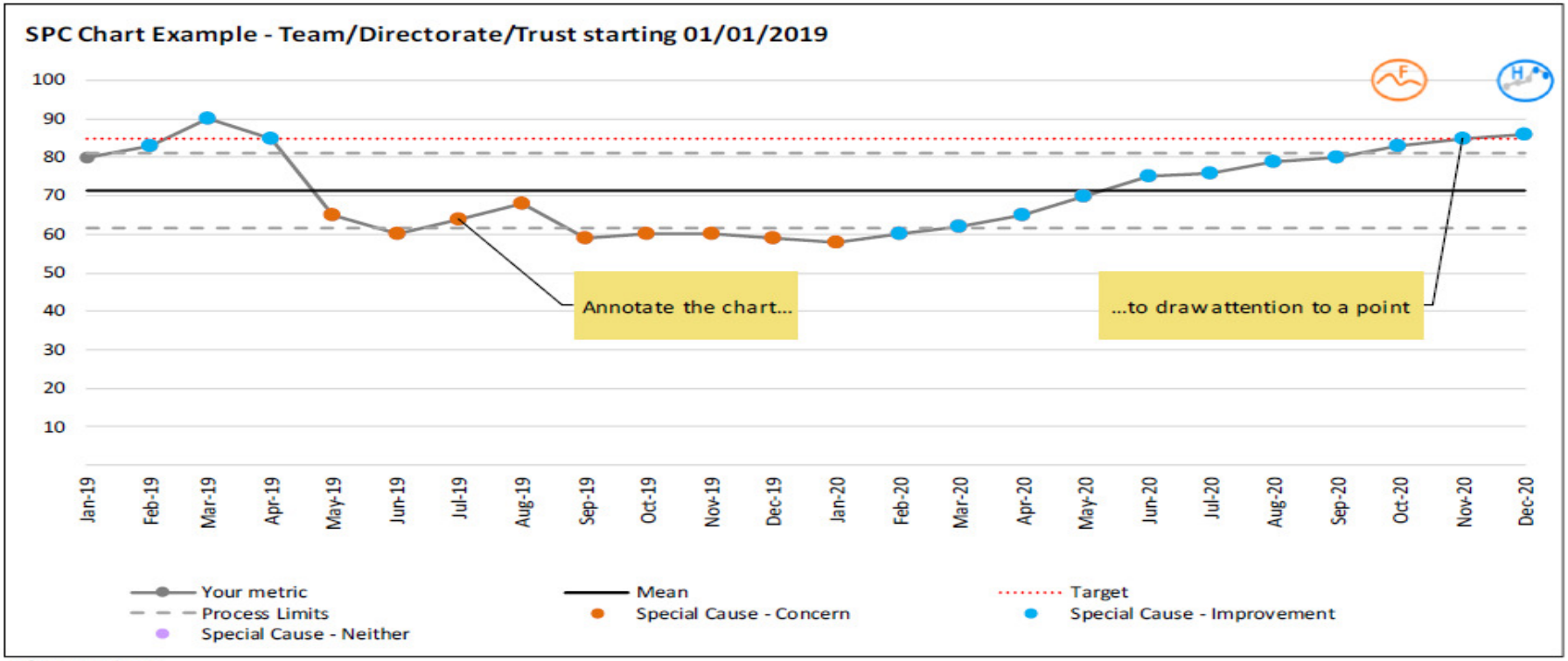
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data which are unlikely to have occurred due to chance and require investigation. They can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting the target without a change.

Special Cause Variation is statistically significant patterns in data which may require investigation, including:

- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	Variation Icons **The icon which represents the last data point on an SPC chart is displayed.**						**Assurance Icons** **If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.**		
ICON									
SIMPLE ICON	● ● ●	● ? H L ●	● H ●	● L ●	● H ●	● L ●	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2 - Statistical Process Control (SPC) Charts Explained



Observations

Based on the data from latest calculation date (data point 1 - 01/01/19).

Single Point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There are 6 points above the UCL and 7 points below the LCL.
Trend	When there is a run of 6 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 10.2

Private/Public paper:	**Public**
Title:	**Care Group Dashboards**
Paper presented by:	**Carol Harris - Chief Operating Officer**
Paper prepared by:	Gill Stansfield - Director of Services
Mission/values:	The report focuses on service delivery and as such aligns with the mission and values for the organisation. Improving performance in Barnsley physical health and wellbeing care group contributes towards the Trust's vision to provide outstanding physical, mental and social care in a modern health and care system. The key performance indicators link to all the Trust's values which are: • 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 members with a summary of the performance in Barnsley physical health and wellbeing services and the action being taken to deliver high quality care. The report provides assurance to Trust Board members on compliance with key performance indicators. It identifies emerging issues and actions being taken to address risks to operational delivery and therefore achievement of strategic intent.
Strategic objectives:	Improve Health ✓ Improve Care ✓ Improve Resources ✓ Make this a great place to work ✓
BAF Risk(s):	Monitoring and managing performance in Barnsley physical health and wellbeing services contributes to managing all the risks on the Board Framework and makes a specific contribution to actions to address the following risks: Risk 2.2 - Failure to create a learning environment leading to lack of innovation and to repeat incidents. Risk 2.3 - Increased demand of services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care. 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.

	Risk 4.1 - Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce, leading to poor service user and staff experience and the inability to sustain safer staffing levels. Risk 4.2 - Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience, meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Barnsley physical health and wellbeing services work with primary care as part of the Barnsley Community Health and Care Alliance to deliver community services for Barnsley Place. The care group is a key partner in the wider place system in supporting patient flow, preventing hospital admission, supporting early discharge and providing care across a wide range of community and hospital settings. Wellbeing services are provided across West and South Yorkshire.
Any background papers / previously considered by:	Care group performance is provided in an aggregated format within the integrated performance report provided to the public Board meetings. To provide more opportunity for understanding of specific groups a format has been developed which will result in each care group providing greater depth on a rolling basis. This report has been reviewed by the Executive Management Team. Reporting is one month retrospective to allow sufficient time for the report preparation. Specific performance detail for inpatient services (stroke and neuro rehabilitation wards) is set out in the inpatient section of the integrated performance report and performance is reviewed in the operational management group.
Executive summary:	Barnsley Physical Health and Wellbeing Care Group was established in 2023 and relates to all physical health services provided by the previously titled Barnsley Integrated Services Care Group / Barnsley General Operations. After this report was completed, the care group reflected that future reports should be developed to incorporate more specific measures including, for example, data on intermediate care, virtual beds and wellbeing outcomes. Trust Board members are asked to note specifically from this report: Appraisal performance in February was 85.8%, and above the overall Trust performance of 83.4%. The focus towards achieving the 95% target has been maintained, with 90% expected by the beginning of May (mid-April is 88.2%). Sickness is well managed across the care group, with hotspots understood and managed. Seasonal illnesses cause spikes, but these are consistent with expectations. The increase to 4.2% in February from January's 3.8% is not a cause for concern. Where individual service lines are dependent upon a small number of very specific professionals, absence of one person can cause a

	significant disruption to service delivery and redistribution of resources is not an available option. Performance in cardiopulmonary resuscitation training is 79.1% and above the overall Trust wide performance of 76.1%. Staff rostering ensures consistent availability of appropriately trained staff for the two inpatient wards and performance hotspots are managed to ensure that staff are booked on to future training. The cancellation of courses has presented some challenges. The new training report helps managers to accurately monitor and manage training performance and exploration of how trainers can provide training to better fit with shift patterns is underway. Performance for information governance training stands at 94.0% and is expected to achieve the 95% Trust and national target. The care group have worked hard to understand and address the factors that influence staff turnover as a stable workforce provides continuity of care and retains skills and experience. A focus on recruitment, retention and improved engagement contributes to overall turnover being stable with February at 11.6% overall. Turnover for registered staff is higher at 13.9% compared to the Trust average at 9.5%. This however includes the planned seasonal staffing increase for school vaccinations and immunisations and a particular spike in October 2023, where a number of retirements coincided with resignations. Despite turnover, both patient and staff survey results are positive and there has been significant improvement in staffing district nursing which had been previously challenging. Local information provides reassurance that staff receive support and take the opportunity to discuss care both individually and in groups, but the reporting and recording of clinical supervision does not yet provide sufficient assurance. Focused attention and an improvement plan, including a drive to improve recording of supervision are demonstrating improvements and this will need to be maintained. The financial information includes the mental health teams until 1 April 2024, so detailed information is not provided in this report and will be available in the future. Specific pressures in BICES (Barnsley Integrated Community Equipment Service) and the musculoskeletal service (MSK) radiology costs are noted. Additional capacity to address post-covid demand and rising referrals helps the Musculoskeletal Service to consistently achieve and exceed the national 18 weeks target. The 6 weeks wait for a paediatric audiology diagnostic appointment remains challenging and below target at 68.94%. The longest wait is 11 weeks. Services within the integrated care system and nationally are experiencing similar challenges and audiologists are scarce. Referrals have increased and referral patterns have changed as hearing assessments are now incorporated into other clinical assessment pathways. Additional clinics have been delivered to maintain capacity during periods of staff absence and options for additional support have been explored. Work is also taking place to reduce the number of appointments that have a ‘child was not brought’ outcome.

	The care group consistently over-achieves the national standard that at least 70% of urgent referrals should be seen within 2 hours, with February's performance at 87.8%. Other services across the South Yorkshire integrated care system only provide the service 8am to 8pm, but the Barnsley urgent community response is provided 24 hours a day, 7 days a week. On average this team support 68 people every 24 hours to avoid a hospital admission. This contribution to proactive care and supporting people at home is well recognised by partners and contributes to good patient flow and improved outcomes for the population. Although demand is high, the neuro rehabilitation unit (NRU) has not made the spot purchase beds available for admission as appropriate increased staffing levels are not possible in the current establishment. Work is taking place on the business model and temporary staffing solutions are in place to ensure safe staffing levels of the commissioned beds. Excellent system-wide working to ensure that patients have access to the right care packages in a timely way is the main reason that there have been no incidences of patients being clinically ready for discharge but remaining in a bed since April 2022. Significant efforts are made to gather feedback from patients and their families. 97% of people said they would recommend community services and 94% rated Barnsley general community services as good or very good. There is a high number of low-level incidents which reflects a positive culture in managing patient safety and risk. The highest number of incidents relates to pressure areas, which is consistent with the services offered, and these are subject to close scrutiny and monitoring. People receiving care on the stroke rehabilitation unit (SRU) and the neuro rehabilitation unit (NRU) are at a higher risk of falls due to the combination of their physical and cognitive functioning. Ensuring appropriate staffing levels is critical, and particularly the ability to respond to demand flexibly as patients become more able to mobilise. The teams work closely with the falls coordinator to support the delivery of safe effective care. The inequalities data is reviewed at care group level and referrals are noted to be typical of demographic of the local population with approximately 40% of referrals related to people living in the 20% most deprived areas of the country. Over 32 different service lines in the care group adds a complexity as inequalities could present in individual service lines but not be visible in aggregated data. The care group has improved the completion of equality impact assessments and is using these to better understand how to recognise and take action to address inequality.
Recommendation:	**Trust Board is asked to:** • **RECEIVE** and **NOTE** the report.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Care Group Summary

February 2024

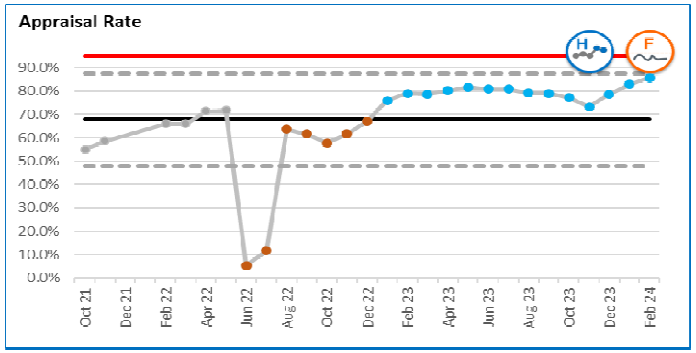
With **all of us** in mind.

Barnsley Physical Health & Wellbeing

Barnsley Physical Health and Welllbeing Care Group relates to all physical health services provided by the previously titled Barnsley Integrated Services Care Group / Barnsley General Operations. This includes the Stroke (SRU) and Neuro Rehabilitation (NRU) units at Kendray Hospital, Live Well Wakefield, Health Integration Teams in both Barnsley and Wakefield , Yorkshire Smokefree Services (both across the South West Yorkshire Partnership Foundation Trust (SWYPFT) footprint and beyond) as well as specialist services such as, audiology, children's therapy services, epilepsy - children's and adult's, tissue viability, long covid, palliative care, district nursing and continence. Some services are provided under the umbrella of the Integrated Neighbourhood Teams specification with reporting of associated key performance indicators. The Care Group was established in 2023 when the former Barnsley General Operations portfolio was separated off from Barnsley Community Mental Health / CAMHS. The new Care Group continues to reflect the extent of partnership working within Barnsley Place and supports the aspiration of integration of health services with Barnsley. The Care Group challenges reflect those of others i.e. safer staffing levels, staff recruitment and retention, succession planning, extending waiting times into services, and staff wellbeing. The Care Group is currently undertaking an number of service reviews including intermediate care, and has produced a a series of papers relating to safer staffing levels in the NRU, most recently developing a proposal paper exploring three key themes. Work continues on Virtual Ward development and Connecting Care at Home which has a multi-disciplinary team focus in neighbourhoods.

Workforce

Appraisals



Insights

The Care Group performance at the end of February stands at 85.8%, compared to a total Trust position of 83.4%. Work continues with all services and teams, ensuring this is prioritised in workplans to continue driving improvements and achievement of the ultimate target of 95%.

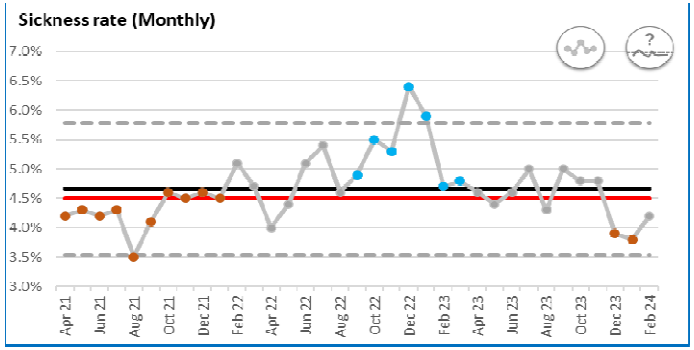
Work continues to cleanse data linked to ESR and the read across to WORKPAL. Additional complications have presented with the transfer of mental health staff from Barnsley into the Mental Heatlh care group.

Senior managers regularly access the appraisal dashboard resulting in better tracking, progress and identifying appraisal completion rates and overdue appraisals

The care group expect to achieve 90% by May and continue to push towards 95% performance (on 16/04/24 performance is at 88.2% with 116 outstanding appraisals).

Barnsley Physical Health & Wellbeing

Sickness



Insights

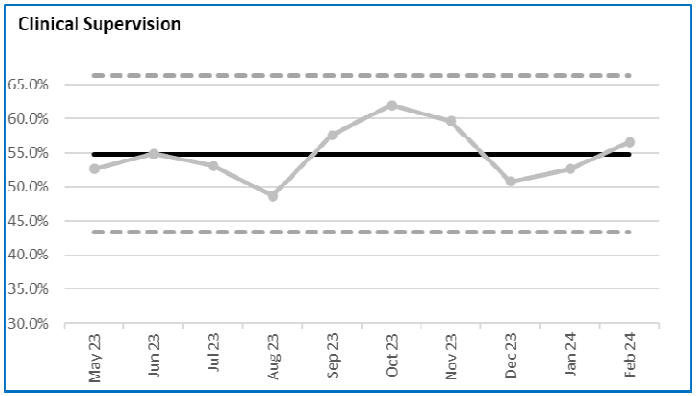
February 2024 sickness rate for the care group was 4.2% which is an increase from 3.8% in January 2024, but remains under the 4.5% Trust target.

The focus on managing sickness continues, supported by effective use of policies and the People Directorate.

There has been a seasonal spike in respiratory illness which is consistent with the general population.

Sickness hotspots are the inpatient areas and reasons are understood and managed. Although not yet on this data, in March 2024 the neuro rehabilitation unit has reduced from 10.3% to 6.8% and the stroke rehabilitation unit has reduced from 5.9% to 3.2%.

Supervision



Insights

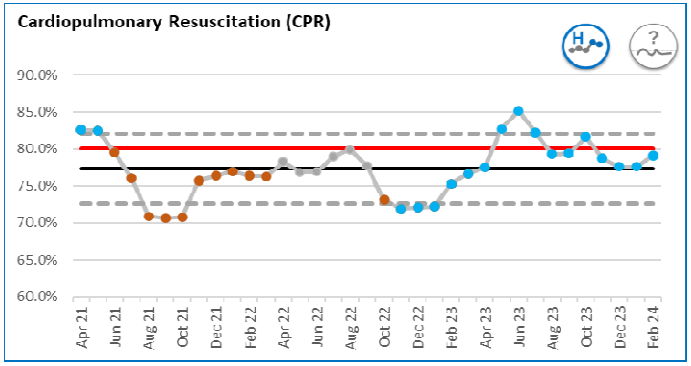
Clinical supervision is receiving focused attention with the development of an improvement plan giving support to specific areas with lowest rates of clinical supervision.

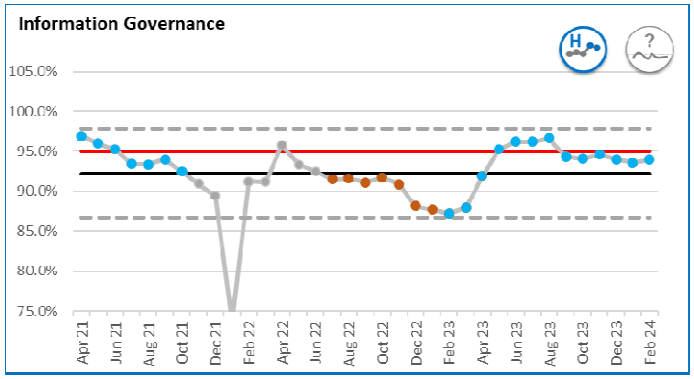
Supervision compliance has recently showed some improvement with a drive on recording data, although it remains below target. Trajectories for improvement are being worked through with each of the service lines.

The Associate Director of Nursing and Professions recently met with the clinical leads in the care group to discuss barriers to clinical supervision and the majority is regarding the ease and reliability of recording. This is being further explored.

Barnsley Physical Health & Wellbeing

Mandatory Training





Insights

The February 2024 performance for cardiopulmonary resuscitation training stands at 79.1% with the Trustwide performance at 76.1%.

The care group expects to achieve and maintain the target shortly, noting there has been a potential seasonal dip due to increased sickness. A recovery plan is in place for the inpatient units, where staff are being booked on the training by managers in order to achieve compliance. Trajectories for improvement are being agreed locally.

Staff rostering ensures the availability of appropriately trained staff on inpatient wards at all times

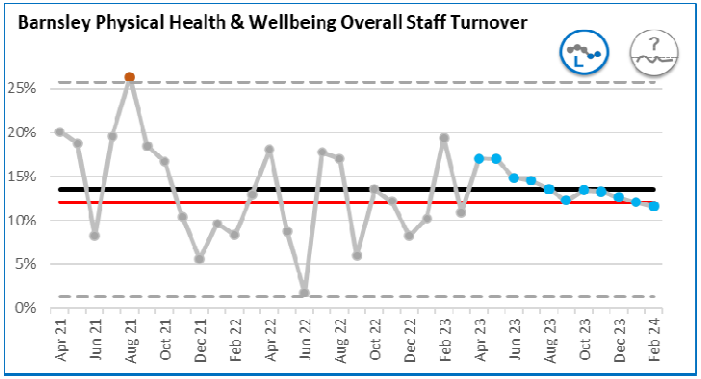
The newly developed training report will help managers to accurately monitor and manage training performance. Cancellation of courses has presented challenges. Exploration of how Learning and Development can accommodate training to fit with shift patterns is underway.

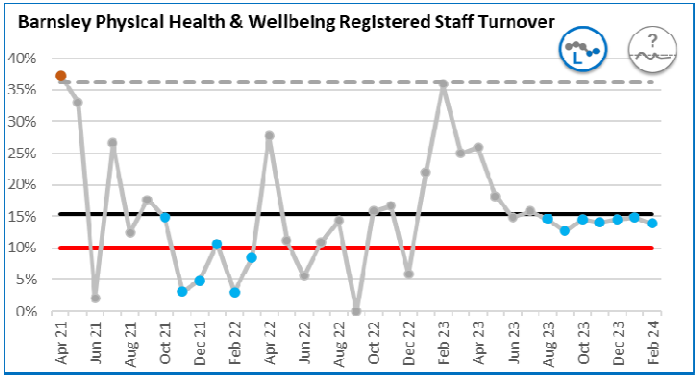
The February 2024 performance for information governance training stands at 94.0% with the Trustwide performance at 91.8%.

The care group continues to strive to meet the 95% target and have plans in place at at individual team and staff level.

Barnsley Physical Health & Wellbeing

Turnover





Insights

Staff turnover as at February 2024 is 11.6% and shows a stable, settled trend.

Turnover has reduced over last 12 months. In addition to improving continuity of care, the benefits of having a more settled workforce are that knowledge and skills are retained which builds confidence in teams, making it a great place to work.

A focus on recruitment, retention, and workforce engagement, including regular analysis of leavers and exit data are contributing factors to drop in turnover.

For the recent Trust strategy refresh, a series of face-to-face sessions were added across Barnsley to increase senior leadership visibility and give a deeper insight into how people are feeling. Quick wins such as the request to celebrate national administrative professionals day on 24th April have been escalated and implemented.

The Care Group continues to implement an approach to encourage staff to stay e.g. flexible working, shift pattens and the transfer scheme.

Registered nurse turnover as at February 2024 is 13.9%, which is above the overall trust registered nurse turnover of 9.5%. Despite this our staff survey results are very favourable and shows improvement in one of our previoulsy challenged areas of district nursing .

We have had a concentrated focus within neighbourhood nursing. We previously experienced a high number of vacancies in hard to fill posts, but our recruitment and retention efforts have resulted a more settled workforce , with minimal bank and overtime spend. An improved career pathway, an increase in workforce engagement and senior leadership visibility are contributing factors to the improvement.

Turnover spiked in October 2023 in our inpatient rehabilitation units . Information from leavers data and exit surveys revealed the majority were attributed to retirements. Although, there was a high number of leavers, there was an equally high number of peopel recruited. Retire and return staff will impact turnover, although in fact means that skill and experience has been retained.

We also have some planned seasonal turnover spikes relating to our childhood vaccination team, where we bring in temporary staff each year to cover the childhood flu campaign from october upto the end of Janaury.

Barnsley Physical Health & Wellbeing

Finance

Finance

Agency Spend YTD
£101k

Variance to Budget YTD
£85k Overspent

Insights

Work is underway to disagregate mental heatlh team finances from the overall financial information. More detailed finance information for this care group will be provided in future reports.

Specific pressures for this care group include:

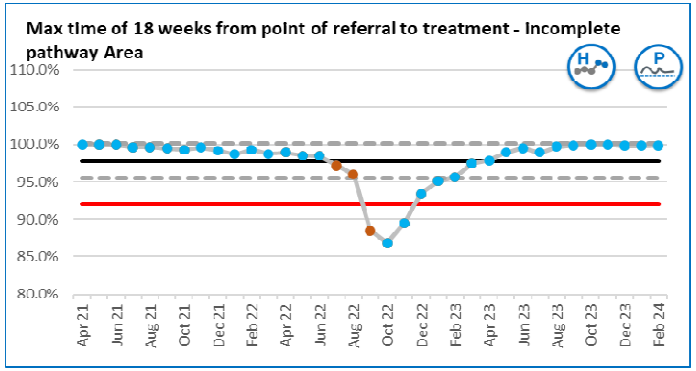
BICES (Barnsley Integrated Community Equipment Service), where there is high spend on equipment purchases due to inflation and demand, along with agency spend, agency spend will cease from 1st April 2024

Musculoskeletal service (MSK) due to increased costs of radiology tests , further exploration of cost and numbers being profiled .

Lymphoedema service where funding from ICB (Integrated Care Board) had not flowed to us but it is now confirmed as being in budgets from 2024/25.

Access

Maximum time of 18 weeks from point of referral to treatment - incomplete pathway (MSK)

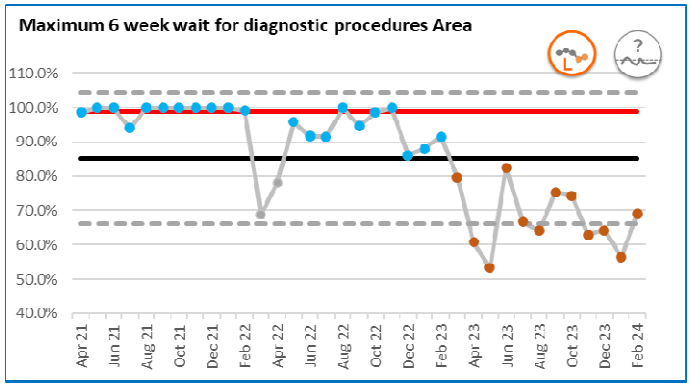


Insights

Musculoskeletal Service consistently achieves the national target of 92%; as at February 2024 the figure is 99.9%. This is excellent given the continued increase in referral rate. This has been achived through additional resources as part of post coivd recovery plans.

Barnsley Physical Health & Wellbeing

Maximum 6-week wait for diagnostic procedures (Paediatric Audiology only)



Insights

The service has seen a growth in the number of referrals from October 2022, with a significant increase from October 2023. This ultimately has impacted on waiting times within the service.

Children should not wait more than 6 weeks for a diagnostic assessment but the current performance indicates that this is only achieved for 68.94% of all children referred. The underperformance relates to increased referrals and changes to referral pathways where, for example, children are being referred to audiology as part of a neurodevelopment assessment pathway.

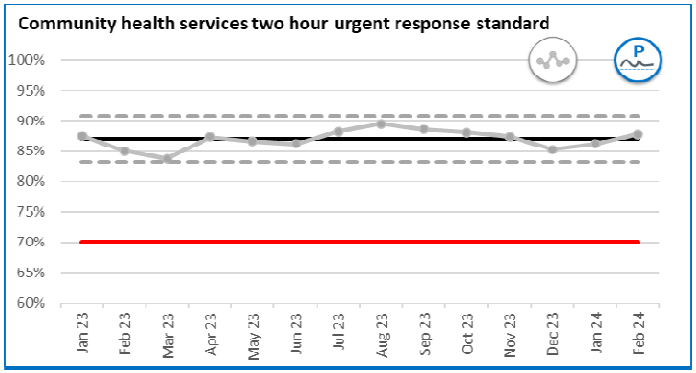
Additional clinic appointments have taken place throughout January/February 2024 to maintain capacity levels during periods of staff absence due to leave and sickness,but the availability of further audiologist resources has been identified as a challenge across South Yorkshire integrated care system.

Work is underway to reduce the high number of instances where the child was not brought to clinic by their parent/carer, and work has been undertaken to mitigate this through revision of the patient text messaging system and referral form.

While demand continues to be much higher than previously experienced, the service is taking all possible action to increase capacity which should begin to improve waits over the coming months.

The longest a child will wait for an appointment is 11 weeks. If a parent is concerned, a general audiology appointment can be offered before 5 weeks.

Community health services two hour urgent response standard



Insights

This is a national standard that applies to the urgent community response (UCR) team and requires at least 70% of urgent referrals to be seen within 2 hours.

The Trust has consistently over-achieved against this standard since its introduction in January 2023, with February 2024 performance being 87.8%.

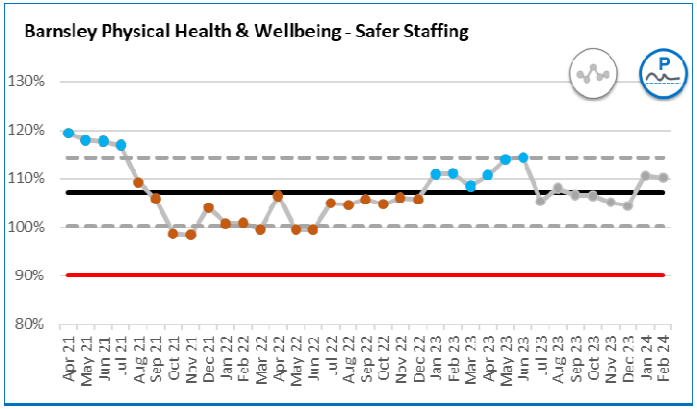
The UCR offers a 24 hours 7 day service compared with other South Yorkshire services that operate 8am - 8pm, therefore Barnsley are providing a more comprehensive service offer. Because the rest of the South Yorkshire services only provision is 8am to 8pm and the numbers seen are much lower than our own , it is difficult to benchmark our good practice locally, many services are not flowing the data into the national set at this point.

UCR are seeing on average 68 people in a 24 hour period. 99.9% of these people have avoided a hospital admission, our contribution to proactive care and supporting people to be cared for at home is well recognsied by partners and contrbutes alongside many other services we provide to ensure good patient flow and improved outcomes for our population.

Barnsley Physical Health & Wellbeing

Quality and Safety

Safer Staffing



Insights

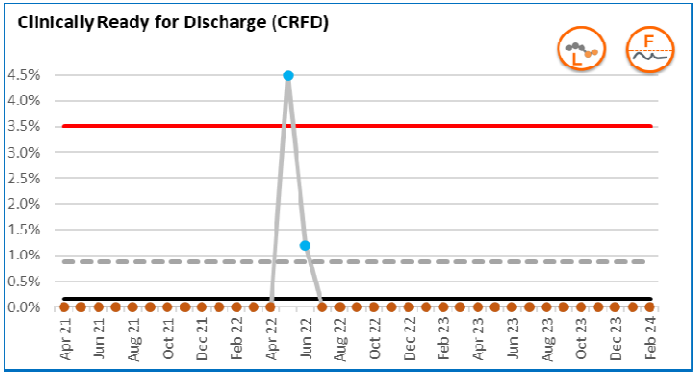
Specific concerns relate to the Neuro Rehabilitation Unit (NRU):
Of the 12 beds, 8 are on a block contract. As of February 2024, Barnsley commissioners are currently utilising 9 beds (i.e. above their commissioned allocation). The remaining beds previously available for for spot purchase are not in use as staffing levels do not support additional patients. NRU safer staffing data continues to present as being achieved, however there is an ongoing challenge to fill trained staff shifts; staffing continues to be supplemented by additional untrained staff. Safer Staffing Level guidelines for specialst Nuero rehab units advise 2 trained nurses per shift for this bed base (applies to 8 or 12 beds); currently we are only achieving 1 trained nurse per shift.

A safer staffing audit identified a need to increase the base establishment and work continues with contracting and finance colleagues to explore staffing and pricing structure linked to the cost per bed day.

The complexity, unpredictability and co-dependencies of the patient cohort often require additional staffing (both trained and untrained) to be requested at short notice. This currently relies upon temporary staffing.

Where temporary staffing solutions are not available patients requiring additional observations cannot be admitted in a timely way. This may impact in the wider healthcare system i.e. acute trust or Trauma networks.

Clinically Ready for Discharge

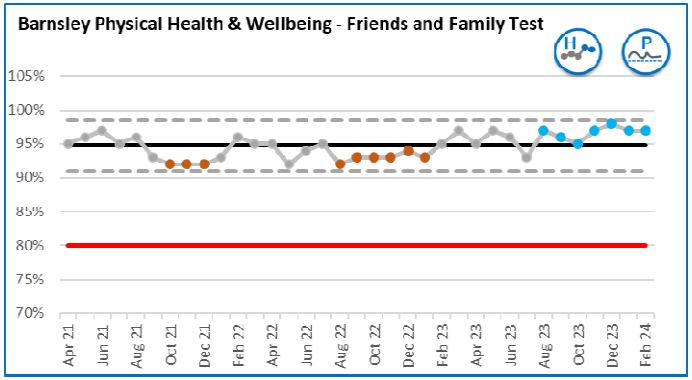


Insights

- There have been no incidences of patients being clinically ready for discharge but remaining in a bed since April 22. This is due to support from system partners such as social care in accessing care at home or a move to specialist residential beds locally.

Barnsley Physical Health & Wellbeing

Friends and Family Test



Insights

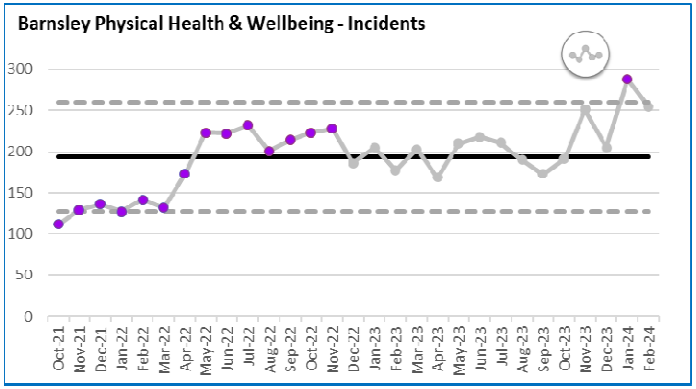
Performance is very good.

97% of people said they would recommend community services as at Febuary 2024.

94% of respondents rated Barnsley general community services as good or very good.

The care group have 5 standard patient experience surveys and each include the Friends and Family Test and form the requirement for reporting to commissioners. Hand held devices are scheduled with each community team over a 4/6-week period twice per year. Community teams also use electronic links, QR codes, posters displayed in clinical areas and text messages to gather patient experience feedback.

Incidents



Insights

No serious incidents have been reported in the last 5 months. This care group would not expect serious incident reports to be comparable with mental health care group reporting of suicide and self harm. A grade 4 pressure ulcer would be the most likely type of serious incident.

The Barnsley care group records a high number of low level incidents which reflects a positive culture in managing patient safety and risk.

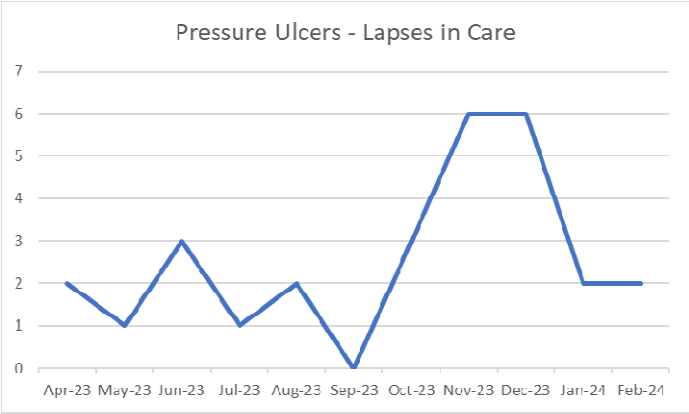
The care group has a robust learning feedback process for incidents and is implementing the principles of PSIRF.

The care group has undertaken 1 specialist learning review (SLR) and 1 after action review (AAR) in the last month with a further 2 AARs planned for April/May. 4 debriefs have been undertaken with teams.

The top number of incidents reported are consistently related to pressure areas and the monitoring of these is described below.

Barnsley Physical Health & Wellbeing

Number of pressure ulcers which developed under SWYPFT care where there was a lapse in care



Insights

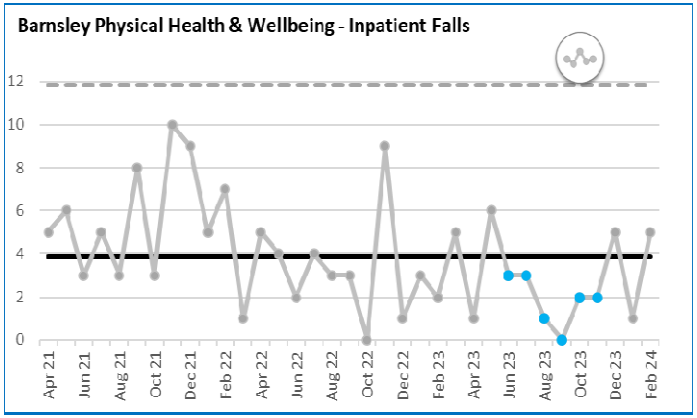
In line with the implementation of the patient safety incident review framework (PSIRF) there is an active move away from using the terminology 'lapse in care' to 'area of improvement' identified. Lapses in care that have occurred, primarily relate to the pressure ulcer risk assessment document 'Waterlow Score' not being completed. Current improvement work will review clinical documentation around pressure ulcers and a proposal to move from Waterlow to the nationally recommended Purpose-T is in development.

The care group set up a local patient safety oversight group (PSOG) that meets weekly. The group reviews all red and amber incidents including pressure ulcers; only pressure ulcer incidents where there are areas of improvement identified go to the Trust PSOG.

Learning obtained will also be used as part of the quality improvement work associated with the new PSIRF pressure ulcer workstream.

A series of workstreams are in progress relating to wound care, including pressure damage, across the Trust and in partnership with the South Yorkshire ICS (Integrated Care System). This includes a deep dive report on the increase in prevalence of pressure sores prepared for our internal review and the establishment of a communities of interest group in relation to wound care.

Number of Falls (inpatients)



Insights

Stroke Rehabilitation Unit (SRU) - It is widely accepted within rehabilitation that patients with a neurological impairment are often at a higher risk of falls as their rehabilitation progresses (National Clinical Guidelines for Stroke: 2023). These patients present with mobility, balance and cognitive impairment. All patients receive a multifactorial falls assessment, a bone health assessment for patients is undertaken for those that met the criteria and a falls risk assessment tool (FRAT) which is reviewed regularly. The senior nursing team work closely with the falls co-ordinator ensuring that all relevant mitigations are in place.

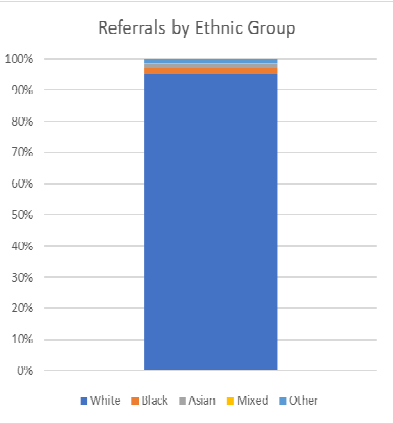
Neuro Rehabilitation Unit (NRU) - Falls are a recognised problem for people with long-term neurological conditions. The first two weeks of admission is a high risk time for patients prone to falls, in particular those who are becoming increasingly mobile but may still be cognitively impaired. Prevention policies are in place based on fall characteristics. When patients become more aware and gain independence the falls risk again increases.

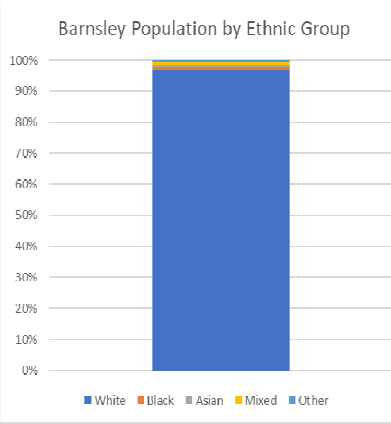
Safer Staffing levels if not achieved, can have a direct impact on the number of falls experienced on the ward. Cognition is assessed on admission. Most patients on admission have considerable deficits in capacity and falls assessments, mobility assessments, physio assessments , FRAT, safety huddles are all completed in accordance with Trust guidance for each patient . Datix are completed and investigated, bed and chair alarms are in place and patient levels used for monitoring as required.

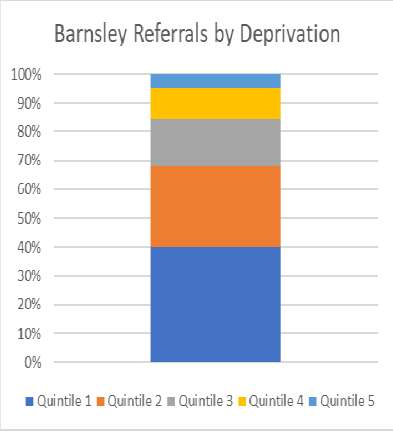
Barnsley Physical Health & Wellbeing

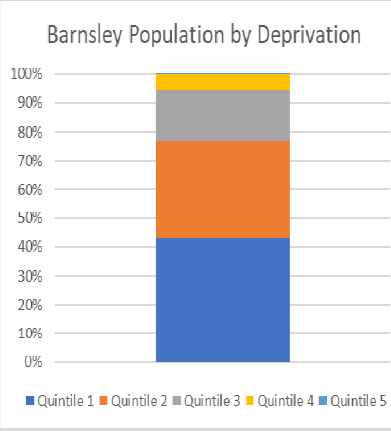
Inequalities

Referrals









Insights

Based on year to date (YTD) Referrals (Apr23 - Feb24)

Referrals are typical to the demographic of the local population, however the care group are drawing on expertise from Performance and Business Intelligence, in SWYPFT and at Place to explore the data further.

The complexity of over 32 different service lines is challenging as inequalities could present in individual service areas.

Ethnicity not recorded rate is currently 8.6%; this is an improvement from 13% last time.

A significant piece of work has taken place to review the core assessment documentation on SystmOne with the aim of facilitating the necessary completion of data including ethnicity.

The care group has improved in the completion of equality impact assessments and review accessibility of services to people with protected characteristics including ethnicity.

Based on YTD Referrals (Apr23 - Feb24)

Understanding the impact that deprivation has on the service offer is again very complex and multi facetted.
Approximately 40% of referrals are from service users living in the 20% most deprived parts of the country.

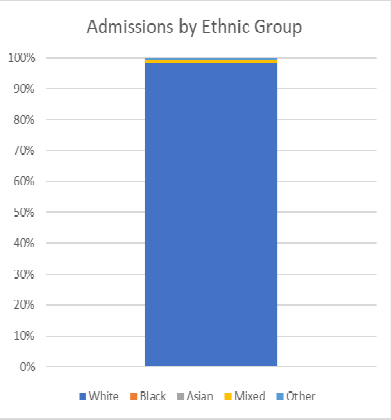
This is similar to the population profile for Barnsley where 43% of population live in Quintile 1 (the 20% most deprived areas of the country). This is unlikely to change significantly.

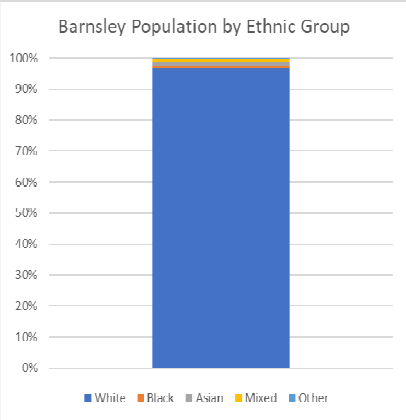
Work is taking place with the support of our Intelligence Change Partner to unpack this data at a more detailed service level, starting with the neighbourhood nursing service.

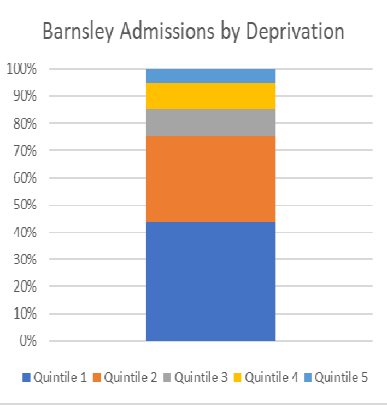
Early work is underway to review the data held on dashboards such as the Population & Person Insight (PaPI) report, initially focusing on how this data may influence our proactive approach to care for a small number of pathways. As this work progresses it will help to provide a greater level of understanding of the Barnsley population, with the aim of improving our ability to maximise opportunities for improved public health outcomes when considering both clinical risk factors (co-morbidities), alongside socio economic

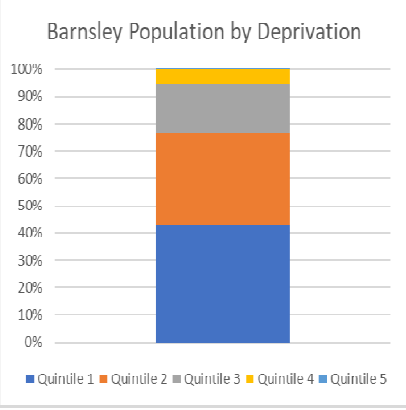
Barnsley Physical Health & Wellbeing

Admissions









Insights

Based on YTD Admissions (Apr23 - Feb24)

Ethnicity not recorded rate is currently 2.4%.

This data is consistent with population demographics, given that admissions onto both Neuro and Stroke pathways are not part of any planned service activity; they are all as a result of a crisis incident.

The most recent Sentinel Stroke National Audit Programme (SSNAP) numbers with regarding the case mix for stroke patients from April – June 2023 for the South Yorkshire ICB are shown below. This is the most up to date validated data. During this time there were 631 patients admitted across the ICB. Specific numbers of patients seen by SWYPFT cannot be extrapolated as this is recorded during admission to the HASU or ASU. However, previous drill down into local data indicates that the number of BAME admissions onto the Barnsley Integrated Community Stroke Team reflects the population statistics for Barnsley. Local data (via the Office for Health Improvement & Disparities) has shown that one of the most significant factors in stroke in Barnsley is health inequalities across the borough.

Ethnicity	National (%)	SYB ICB (%)
White	81.5	78.0
Black	2.0	0.2
Asian	3.9	2.8
Mixed	0.6	0.3
Other	1.8	0.9
Not known	10.2	17.8

The UK Rehabilitation Outcomes Collaborative UKROC (Est 2008) is a recognised national dataset allowing comparison to other UK neuro rehab units but unfortunately it does not collate ethnicity data and therefore it is difficult to determine if there are any national trends in each ethnicity accessing neurological rehabilitation. This is one example of we use our HI data to improve service offers.

Based on YTD Admissions (Apr23 - Feb24)

This is consistent with population demographics and given the numbers are quite low, this can fluctuate from month to month.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Statistical Process Control (SPC) Charts Explained

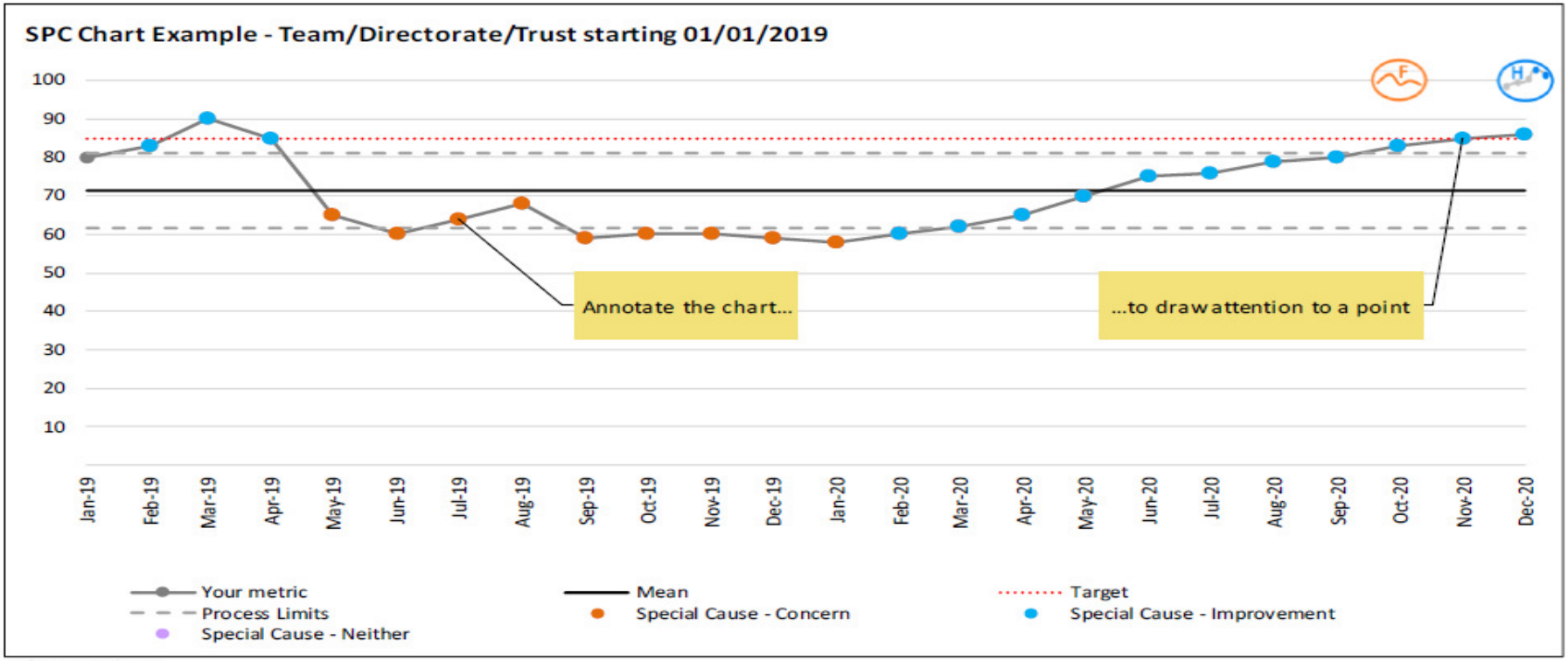
An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (**common cause**) in performance and unusual patterns (**special cause**) in data which are unlikely to have occurred due to chance and require investigation. They can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting the target without a change.

Special Cause Variation is statistically significant patterns in data which may require investigation, including:

- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	Variation Icons **The icon which represents the last data point on an SPC chart is displayed.**						**Assurance Icons** **If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.**		
ICON									
SIMPLE ICON	● ● ●	● ? H L ●	● H ●	● L ●	● H ●	● L ●	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Statistical Process Control (SPC) Charts Explained



Observations

Based on the data from latest calculation date (data point 1 - 01/01/19).

Single Point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There are 6 points above the UCL and 7 points below the LCL.
Trend	When there is a run of 6 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
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 – Executive Director of Strategy & Change		
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	The development of joined-up care through Place and system working is central to the Trust's strategy, and is supportive of our mission- to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is: • To update the Trust Board on key developments in SY ICS and the SY MHLDA provider collaborative and linked programmes. • To update on partnership developments in Barnsley.		
Strategic objectives:	Improve Care	✓	
	Improve Health	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):	Risk 1.1- Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place. Risk 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. Risk 3.1- Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. Risk 3.2- Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		
Contribution to the objectives of the Integrated Care System/Integrated	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through Place- based partnership arrangements and provider collaboratives, and also developments and discussions in progress where relevant.		

Care Board/Place based partnerships	
Any background papers / previously considered by:	The Trust Board receive regular updates on the progress and developments in the SY ICS, including the development of the provider collaborative.
Executive summary:	From 1 July 2022, NHS South Yorkshire Integrated Care Board (ICB) took on the commissioning responsibilities of clinical commissioning groups and leads the integration of health and care services across South Yorkshire. This report provides an update of key points discussed at from the most recent Integrated Care Board meeting including the patient story, highlights by place, performance, and planning. The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative continues to develop. Work continues with our partners in Barnsley to evolve and develop place-based partnership governance arrangements. We have continued to develop the partnership with primary care as part of the Health and Care Alliance. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register and will need to be kept in view as the SY ICS and MHLDA Provider Collaborative develops. New risks may emerge.
Recommendation:	**Trust Board is asked to:** • **NOTE** the SY ICS and Barnsley Place updates.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024

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 3rd April 2024 Key updates are as follows: • Staff survey results have been received. For the ICB staff, these were broadly average when compared with other ICBs, but represent a notable decline since 2022. • Operational delivery is improving. • The ICB is on target to achieve a c£48 deficit for 2023/24. • There was a well-received presentation on the ICB's Data and Insight Strategy. Key points included culture, prioritisation, analytical capacity, how to use data to improve health and how to use data to help reduce waste/improve efficiency. • Proposals regarding the Organisational Development Plan for the ICB were received and discussed. • An update on operational and financial planning was provided. Finances continue to be challenging.
Date of next meeting	Next meeting in public is scheduled for 1st May 2024.
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	There have not been any further meetings of the Provider Collaborative since the report to March Trust Board.
Date of next meeting	The next meeting is scheduled for 15th May 2024.

4. Barnsley Place

Barnsley Place Committee & Barnsley Place Partnership Board

Member	Chief Executive and Chair

Items discussed	<u>Update from meeting on 28th March 2024</u>
	
	Key items discussed included:
	• Story from our communities- consortium model development for SEND parents and carers in Barnsley.
	• Questions from the public.
	• Place Director update and Place achievements. Updates included:
	  o The latest data shows continued pressures in urgent and emergency care but positive progress in many areas of planned care, mental health and learning disabilities.
	  o The intermediate care redesign has been completed with a new service model established, workforce modelling and medical oversight plans finalised.
	  o At the end of February, the Family Hubs in North East and North Barnsley were launched.
	  o Barnsley Children's Social Work Academy, a new initiative aimed at providing a high-quality and consistent programme of learning and development for children's social workers has been launched.
	  o Partners in Barnsley have come together to agree a shared ambition for a whole-system approach to increase physical activity across the Borough.
	• Feedback from South Yorkshire Integrated Care Partnership Board.
	• Health on the High Street.
	• Refreshing the South Yorkshire NHS Joint Forward Plan for 2024/25- updated NHS Joint Forward Plan (JFP) guidance for 2024/25 was published on 22nd December 2023. A light touch refresh approach was agreed in January 2024 and no major changes are recommended. The refreshed JFP reaffirms the continuation of the priorities identified in the initial plan.
	• Place priorities progress update- updates were given on the urgent and emergency care front door and respiratory.

	• Quality and safety report. • Barnsley partnership risk register. • Performance dashboard (including SY ICB Performance Report). • Committee minutes and assurance reports. • Board assurance framework, risk register and issues log.
Date of next meeting	Next meeting scheduled for 30th May 2024.
Minutes	Papers and draft minutes when available Barnsley place public board meetings :: South Yorkshire ICB

Barnsley Place Partnership Delivery Group

Member	Deputy Director of Strategy and Change

Items discussed	Update from meeting on 9th April 2024
	
	Key items discussed included:
	
	• Strategic Workforce Group
	  ○ The group met for the second time on 19th March where terms of reference were finalised.
	  ○ Three priority themes have been established (proud to care, we care into the future and better careers, better care) and updates on each of these were given.
	• Forward planner.
	• Escalations from other subgroups.
	• Escalations for Partnership Board.

Date of next meeting	Next meeting scheduled for 14th May 2024.

Barnsley Community Health and Care Alliance

Member	Chief Executive, Chair, and Director of Strategy and Change
Items discussed	There have been no further meetings since the report to the March Trust Board. Planned agenda items for the upcoming meeting on 24th April 2024 are as follows: • SMI (severe mental illness) Health Checks. • Connecting Care approach. • Urgent response integrated service offer out of hours. • Health Service Journal awards. • Development session- May 2024. • The Alliance and Barnsley Hospital.
Date of next meeting	Next meeting scheduled for 26th June 2024.

Barnsley Health and Wellbeing Board

Invited observer	Director of Strategy and Change
Items discussed	There have been no further meetings since the report to the March Trust Board.
Date of next meeting	The next meeting is scheduled for 6th June 2024
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=143

Recommendation

To **RECEIVE** papers and **NOTE** updates from SY ICB and Barnsley Place.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 11.2

Private/Public paper:	**Public**		
Title:	**West Yorkshire Health & Care Partnership (WYHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update.**		
Paper presented by:	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):	Risk 1.1- Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place. Risk 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. Risk 3.1- Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. Risk 3.2- Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		

Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The paper highlights the opportunities available to the Trust to work with other partners 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 1 July 2022. The ICB has responsibility to commission the majority of NHS services for the West Yorkshire (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:
	  ○ West Yorkshire Health and Care Partnership.
	  ○ Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees.
	• **RECEIVE** the minutes of relevant partnership boards/committees.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024

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 (WY) 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 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 to develop effective system working and improve population health.

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	There has been no been further meeting of the West Yorkshire Integrated Care Board since the update to Trust Board in March 2024.
Date of next meeting	Next meeting scheduled for 25th June 2024.
Further information:	https://www.westyorkshire.icb.nhs.uk/meetings/integrated-care-board/nhs-west-yorkshire-icb-board-meeting-19-march-2024

West Yorkshire Health & Care Partnership Board

Member	Chief Executive
Items discussed	There has been no further meeting of the West Yorkshire Health and Care Partnership Board since the update to Trust Board in March 2024.
Date of next meeting	Next meeting scheduled for 16th July 2024.
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-march-2024

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 18th April 2024
	
	Agenda items included:
	• Chair's update.
	• LeDeR (Learning from lives and deaths- people with a learning disability and autistic people).
	• Workforce.
	• Children and young people's (CYP) mental health:
	  o CYP crisis event report.
	  o Gender dysphoria.
	• Housing.
	• Eating Disorders.

	• Mental Health, Learning Disability and Autism Plan. • Planning and performance. • Escalation from AAA reports.
Date of next meeting	Next meeting scheduled for 10th May 2024.

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	There has been no further meeting of the Wakefield District Health and Care Partnership Committee since the update to Trust Board in March 2024.
Date of next meeting	Next meeting scheduled for 6th June 2024.
Further information	Meeting papers are available here: Committee meetings - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk) https://www.wakefielddistricthcp.co.uk/wp-content/uploads/2024/03/WDHCP-Meeting-Pack-7-March-2024-Publication-1.pdf

Transformation and Delivery Collaborative (formerly Wakefield Provider Collaborative)

Member	Associate Director of Operations, Adults and Older People Mental Health Care Group
Items discussed	There has been no further meeting of the Transformation and Delivery Collaborative since the update to Trust Board in March 2024.
Date of next meeting	Next meeting scheduled for 30th April 2024.

Wakefield Mental Health Alliance

Member	Director of Provider Development (Chair), with Trust representative as a member.
Items discussed	There has been no further meeting of the Wakefield Mental Health Alliance since the update to Trust Board in March 2024. Key agenda items for the upcoming meeting on 24th April 2024 include: • Mental Health Alliance performance dashboard.

	• Standing item updates:
	  o Mental Health Emergency Dept Strategy Group.
	  o Community Mental Health Transformation.
	  o NHS 111 roll out.
	• Introducing the Wakefield VCSE Collaborative.
	• Mental Health Alliance stakeholder meeting.
	• Children and young people deep dive.
	• 2024/25 planning update.
	• Assurance meeting updates.
	• Community Mental Health Transformation: Disordered Eating Service scoping and proposed model.
	• Development session feedback.
	• 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 22nd May 2024.

Wakefield Health and Wellbeing Board

Member	Chief Executive (deputy - Director of Provider Development)
Items discussed	There has been no further meeting of the Wakefield Health and Wellbeing Board since the update to Trust Board in March 2024.
Date of next meeting	Next meeting scheduled for 23rd May 2024.
Further information	Papers and draft minutes are available at: Health and Wellbeing Board - Wakefield Council

Calderdale

SWYPFT is a partner in delivering the Calderdale Vision 2024 and Calderdale Cares. We have continued to work with partners to develop a place-based approach.

Calderdale Cares Partnership Board

Member	Chief Executive
Items discussed	Update from meeting on 28th March 2024 Agenda items included: • Public questions. • Deep dive- health inequalities. • Place Lead Report- updates included: o Spring 2024 Covid-19 vaccination campaign - a letter has been published setting out further information on preparing for a successful Spring 2024 Covid-19 vaccination campaign. All five of Calderdale Primary Care Networks have signed up

	to be part of the Spring campaign, and 17 community pharmacies. o Older Peoples mental health Inpatient Services Public Consultation- it was reported that the public consultation by South West Yorkshire Partnership NHS Foundation Trust in partnership with the West Yorkshire ICB on these services was ongoing. o Operational planning- the annual financial and operational planning round continues for 2024/25- final submissions by the ICB will be made in April. o Performance. o Risk management. • SWYPFT engagement- there was a presentation on SWYPFT's Strategy refresh, and discussion. • Clear Improvement Plan Emergency Department. • Quality and safety report. • Place Committee Work Plan. • Papers received for information: o Quality Group minutes. o Clinical Professional Forum minutes. o Cancer Alliance Board minutes.
Date of next meeting	Next meeting scheduled for 30th May 2024.
Further information	Further information and meeting minutes can be found here: https://www.calderdalecares.co.uk/about-us/meeting-papers/

Calderdale Cares Community Programme Board

Member	Deputy Director Strategy and Change & Associate Director of Operations, Adults and Older People Mental Health Care Group
Items discussed	Update from meeting on 11th April 2024 Items discussed included: • Age Friendly Community. • 'Bid ready'- exploring with partners how to be bid ready/aware. • Calderdale Cares Community Programme Board workshop delivery next steps.
Date of next meeting	Next meeting is scheduled for 9th May 2024.
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 of Provider Development.
Items discussed	There has been no further meeting of the Calderdale Health and Wellbeing Board since the update to Trust Board in March 2024.
Date of next meeting	Next meeting is scheduled for 18th July 2024.
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.

Kirklees ICB Committee

Member	Chief Executive (deputy – Director of Provider Development)
Items discussed	There has been no further meeting of the Kirklees ICB Committee since the update to Trust Board in March 2024.
Date of next meeting	Next meeting scheduled for 8th May 2024.
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	There has been no further meeting of the Kirklees Integrated Health and Care Partnership Forum since the update to Trust Board in March 2024.
Date of next meeting	Next meeting scheduled for 6th June 2024.

Kirklees Health and Wellbeing Board

Invited Observer	Director of Provider Development
Items discussed	There has been no further meeting of the Kirklees Health and Wellbeing Board since the update to Trust Board in March 2024.
Date of next meeting	The planned meeting of 4th April 2024 was cancelled. Next meeting to be confirmed.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Kirklees Delivery Collaborative

Member	Director of Provider Development

Items discussed	Update from meeting on 22nd April 2024
	
	This meeting was an in person development meeting.
	
	Programme updates were shared as follows:
	
	• Starting Well Programme.
	• Living Well Programme.
	• Ageing Well Programme.
	• Dying Well Programme.
	• Kirklees Health and Care Plan.
	  ○ Crisis response priority.
	  ○ Latest draft of the Kirklees Health and Care Plan (24/25 refresh).

Date of next meeting	Next meeting scheduled for 13th May 2024.

Kirklees Mental Health Alliance

Member	Director of Provider Development (Co-Chair), with Trust representative as a member.
Items discussed	There has been no further meeting of the Kirklees Mental Health Alliance since the update to Trust Board in March 2024.
Date of next meeting	Next meeting scheduled for 7th May 2024.

Recommendations:

Trust Board is asked to:

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 11.3

Private/Public paper:	**Public**		
Title:	**Specialised NHS-Led Provider Collaboratives and Alliances - Update**		
Paper presented by:	Adrian Snarr - Director of Finance, Estates and Resources		
Paper prepared by:	Izzy Worswick – Associate Director, Provider Collaboratives & Planning		
Mission/values:	The development of joined- up care through partnership working is central to the Trust's strategy, and is supportive of our mission- to help people reach their potential and live well in their community. The Trust values are central to our approach to partnership working.		
Purpose:	The purpose of this paper is to provide the Trust Board with: 1. An update on key developments within the West Yorkshire and South Yorkshire and Bassetlaw Specialised NHS-Led Provider Collaboratives and key priorities that are of relevance to the Trust. 2. An update on the Phase 2 Provider Collaboratives.		
Strategic objectives:	Improve Care	✓	
	Improve Health	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):	Risk 1.1- Changes to integrated care system operating models and required cost reductions could result in less focus on mental health, learning disability and autism, community services and/or place. Risk 1.2- Internally developed service models and influence across the wider system could lead to unwarranted variation in service provision. Risk 3.1-Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively. Risk 3.2- Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.		
Contribution to the objectives of the Integrated Care System/Integrated	The paper highlights the opportunities available to the Trust to work with other providers to tackle shared challenges through provider collaboratives, and also developments and discussions in progress where relevant.		

Care Board/Place based partnerships	
Any background papers / previously considered by:	Strategic discussions and updates on Provider Collaboratives and developments have taken place regularly at Trust Board.
Executive summary:	**West Yorkshire Specialised NHS-Led Provider Collaboratives** The Adult Secure Provider Collaborative Board has continued to meet monthly, and the collaborative has progressed a range of items including: • Response to the national review of WEMSS (women's enhanced medium secure services). Work is being undertaken to support the safe transition/discharge of 2 West Yorkshire women currently cared for in WEMSS to alternative services, with both women expected to step down to conditions of low security. • The collaborative has led the way in establishing a national women's pathway network with other provider collaboratives. A national transformation programme is being established by NHSE following a review of women's secure services. Much of the work initiated in West Yorkshire is aligned to the proposed programme. The Adult Secure Provider Collaborative Women's Pathway Lead now co-chairs the National Women's Service Pathway Transformation Implementation Support Group and is a member of the National Strategic Transformation Group. • Review of the 2024/25 Commissioning Intentions for the collaborative. • Development of a West Yorkshire- wide community model. The final 'Gateway 3' report was received by the Provider Collaborative Board in December, and associated investment proposal. Implementation of the new model cannot be progressed until further savings have been made by the collaborative. • Community redesign work is focussing on developing regional consistencies of approach aligned to the proposed community model within existing resource. • A proposal was developed to undertake a bed modelling exercise with all providers to identify reconfiguration/improved bed utilisation, and a reduction in out of area placements. Events are scheduled to take place in May and June involving all partners. • Work with the Yorkshire and Humber Involvement Network to develop a clear specification and operating procedure for the network. • A project is underway to improve patient experience. This includes standardising the approach across West Yorkshire adult secure services to patient reported experience measures, development of expert by experience roles, peer reviews, and a West Yorkshire- wide patient AGM, and greater focus on quality and oversight of 'You said we did', strengthening our validation of patient experience and action. A review of how the collaborative embed patient experience into our governance structures is underway with proposed recommendations being developed. • Development of a procedure setting out standards and key performance indicators for access assessments, with an annual audit programme. The first audit is completed and being reported in April to the West Yorkshire Clinical Lead Forum. • Repatriation plans continue for patients placed out of area and outside of natural clinical flow.

	• Focus on the culture of collaboration within the collaboration when supporting complex cases, with a view to reduce the need for out of area and improving timeliness of admissions to secure care. • The clinical and operational workstream groups are focussing discussions on how services manage and support high levels of acuity and seclusion use, due to recent challenging cases that have impacted on service resilience/ability to admit into unoccupied beds. • 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 improve the interface with prisons, improving assessment and transition processes. • Involvement in national work to revise the secure service specifications. The year end position for 2023/24 for West Yorkshire Adult Secure Provider Collaborative is an overspend of £166k (including the investment fund). The risk/reward share was agreed and transacted based upon the month 11 forecast. Month 12 spend was higher than forecast due to increased out of area usage and exceptional packages of care. Excluding this from the number quoted, the true reported trading position is a surplus of £539k. The Adult Eating Disorders Provider Collaborative reported a deficit at year end. The Children and Young People Mental Health Provider Collaborative reported a deficit position at year end. **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 collaborative has submitted a response to the request from NHS England to evidence Lead Provider roles and responsibilities, and progress against the Quality Maturity Framework. Feedback from NHSE is awaited. The South Yorkshire Adult Secure collaborative reported a deficit for 2023 / 24. Although there are other financial pressures, the main driver relates to financial and operational pressure with one independent sector provider. **Phase 2 Provider Collaboratives** Commissioning oversight of Yorkshire and Humber FCAMHS has transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub from 1st January 2024. To ensure all Yorkshire and Humber Specialised Provider Collaborative commissioners remain updated on the service, despite oversight being via the West Yorkshire hub, a Yorkshire and Humber Provider

	Collaborative Oversight Meeting will meet for the first time in January, between the three Yorkshire and Humber Commissioning Hubs. If successful, this arrangement could be considered for other Yorkshire and Humber wide collaboratives going forward. Reporting arrangements for FCAMHS continue to be developed under the new provider collaborative arrangements. The Perinatal Mental Health Provider Collaborative is expected the to go live on 1st October 2024. A mobilisation group has been established. A Clinical Director for the PMH Provider Collaborative is in post, and Provider Collaborative Programme Lead, started in post in February 2024. **Risk Appetite** The development and delivery of Provider Collaboratives is in line with the Trust's risk appetite.
Recommendation:	**Trust Board is asked to:** • **RECEIVE** and **NOTE** the Specialised NHS-Led Provider Collaboratives update.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024

Agenda item 11.3

Specialised NHS-Led Provider Collaboratives and Alliances - Update

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the Specialised NHS-Led Provider Collaboratives, focusing on developments that are of importance or relevance to the Trust. The paper includes updates on the West Yorkshire and South Yorkshire & Bassetlaw Provider Collaboratives where the Trust is a Co-ordinating Provider or partner, and an update on the national Phase 2 Provider Collaboratives.

2. Phase 1 Provider Collaboratives

In **West Yorkshire**, Provider Collaboratives have been established for national Phase 1 services:

- Adult Low and Medium Secure Services - co-ordinated by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).
- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - co-ordinated by Leeds and York Partnership NHS Foundation Trust (LYPFT).
- Adult Eating Disorder Services - co-ordinated by LYPFT.

In addition to being Co-ordinating Provider for Adult Secure, the Trust is a partner in both the Adult Eating Disorder and CYPMH Provider Collaboratives.

The Adult Eating Disorder Collaborative went live on 1st October 2020, and the CAMHS and Adult Secure Collaboratives 1st October 2021 (with transitional support from NHSE/I until 31st March 2022).

In **South Yorkshire and Bassetlaw**, Provider Collaboratives have also been established for all national Phase 1 Services:

- Children and Young People Mental Health (CYPMH) inpatient services (Tier 4) - co-ordinated by Sheffield Children's Hospital.
- Adult Eating Disorder Services - co-ordinated by Rotherham Doncaster and South Humber NHS Foundation Trust.
- Adult Secure Services - co-ordinated by SWYPFT.

The Adult Eating Disorder and CYPMH Provider Collaboratives went live on 1st October 2022, and the Adult Secure Provider Collaborative on 1st May 2022.

Although the South Yorkshire Integrated Care System does not now include the Bassetlaw population, for the purpose of the Phase 1 services the Provider Collaboratives continue to include the Bassetlaw population. Hence Bassetlaw is still included in the title.

3. Phase 1 Provider Collaboratives - West Yorkshire

3.1 West Yorkshire Adult Secure Provider Collaborative

The Adult Secure Provider Collaborative Board has continued to meet monthly, and the collaborative has progressed among a range of items:

- Response to the national review of WEMSS (women's enhanced medium secure services). Work is being undertaken to support the safe transition/discharge of 2 West Yorkshire women currently cared for in WEMSS to alternative services, with both women expected to step down to conditions of low security.
- The collaborative has led the way in establishing a national women's pathway network with other provider collaboratives. A national transformation programme is being established by NHSE following a review of women's secure services. Much of the work initiated in West Yorkshire is aligned to the proposed programme. The Adult Secure Provider Collaborative Women's Pathway Lead now co-chairs the National Women's Service Pathway Transformation Implementation Support Group and is a member of the National Strategic Transformation Group.
- Review of the 2024/25 Commissioning Intentions for the collaborative.
- Development of a West Yorkshire- wide community model. The final 'Gateway 3' report was received by the Provider Collaborative Board in December, and associated investment proposal. Implementation of the new model cannot be progressed until further savings have been made by the collaborative.
- Community redesign work is focussing on developing regional consistencies of approach aligned to the proposed community model within existing resource.
- A proposal was developed to undertake a bed modelling exercise with all providers to identify reconfiguration/improved bed utilisation, and a reduction in out of area placements. Events are scheduled to take place in May and June involving all partners.
- Work with the Yorkshire and Humber Involvement Network to develop a clear specification and operating procedure for the network.
- A project is underway to improve patient experience. This includes standardising the approach across West Yorkshire adult secure services to patient reported experience measures, development of expert by experience roles, peer reviews, and a West Yorkshire- wide patient AGM, and greater focus on quality and oversight of 'You said we did', strengthening our validation of patient experience and action. A review of how the collaborative embed patient experience into our governance structures is underway with proposed recommendations being developed.
- Development of a procedure setting out standards and key performance indicators for access assessments, with an annual audit programme. The first audit is completed and being reported in April to the West Yorkshire Clinical Lead Forum.
- Repatriation plans continue for patients placed out of area and outside of natural clinical flow.
- Focus on the culture of collaboration within the collaboration when supporting complex cases, with a view to reduce the need for out of area and improving timeliness of admissions to secure care.
- The clinical and operational workstream groups are focussing discussions on how services manage and support high levels of acuity and seclusion use, due to recent challenging cases that have impacted on service resilience/ability to admit into unoccupied beds.
- 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 improve the interface with prisons, improving assessment and transition processes.
- Involvement in national work to revise the secure service specifications.

The year end position for 2023/24 for West Yorkshire Adult Secure Provider Collaborative is an overspend of £166k (including the investment fund). The risk/reward share was agreed and transacted based upon the month 11 forecast. Month 12 spend was higher than forecast due to increased out of area usage and exceptional packages of care. Excluding this from the number quoted, the true reported trading position is a surplus of £539k.

Following review of the 2023/24 Lead Provider Contract Variation, this was signed by the Trust and NHSE. All 2023/24 contract variations for in area providers have now been signed by all partners and by the Trust. A discussion took 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 have been prepared and issued to providers. These are being progressed as a priority.

All Phase 1 Provider Collaboratives in West Yorkshire had Lead Provider contracts in place up until end of March 2024. Draft contract documentation has been issued from 1st April 2024, which is in the process of being reviewed by the Trust.

The most recent meeting of the Collaborative Committee of the Trust Board took place on 2nd April 2024, with a further meeting planned for 4th June 2024.

3.2 West Yorkshire Adult Eating Disorders Provider Collaborative

The original Adult Eating Disorder Provider Collaborative business case assumed a level of income generation from other provider collaboratives placing patients in West Yorkshire. The national ambition for provider collaboratives to place patients close to home has resulted in a reduction of referrals and admissions from out of area, which negatively impacts on income.

At month 12, a deficit position of £534k is reported. This is a deterioration against a break-even plan and can be attributed to deficits against the out of area budget (£332k) and the cross flows income target (£315k).

The risk and gain share has been enacted. The collaborative is investigating potential strategies to improve the financial position.

3.3 West Yorkshire Children and Young People's Mental Health (Inpatient) Provider Collaborative

A deficit of £325k is reported for the 2023/24 financial year against a balanced plan. High levels of exceptional packages of care (EPCs) across the year have driven the collaborative's deficit position. Funding earmarked for investment on clinical schemes is currently mitigating the deficit position of the collaborative.

The provider collaborative financial envelope to end of March 2024 included £1.1m non-recurrent funding from NHSE that was allocated to support the development of Red Kite View. This funding ended on 31st March 2024, which poses a further risk to the collaborative financial position going forward.

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:

- The Provider Collaborative Oversight Group for the collaborative continued to provide oversight of the Trust's commissioning responsibilities. This reports into the Trust's Collaborative Committee.
- The collaborative has submitted a response to the request from NHS England to evidence Lead Provider roles and responsibilities, and progress against the Quality Maturity Framework.
- There are ongoing discussions between the Trust, Commissioning Hub and NHSE/I regarding the Lead Provider contract.
- The specialist community services business case was approved by the Provider Collaborative Oversight Group in November, and by the Collaborative Committee at its December meeting.
- The CQC report for Cheswold Park Hospital, one of the providers within the provider collaborative, was published in December 2023- the Commissioning Hub have been supporting the provider to implement improvement plans, and to consider future options, working closely with CQC and NHSE.

The South Yorkshire Adult Secure collaborative reported a deficit for 2023 / 24. Although there are other financial pressures, the main driver relates to financial and operational pressure with one independent sector provider.

The main risk, as with other collaboratives, relates to unknown activity and exceptional packages of care pressures. For South Yorkshire this is increased due to ongoing contractual discussions.

5. Phase 2 Provider Collaboratives

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.

Commissioning oversight of Yorkshire and Humber FCAMHS transferred to the West Yorkshire Specialised Provider Collaboratives Commissioning Hub from 1st January 2024. To ensure all Yorkshire and Humber Specialised Provider Collaborative commissioners remain updated on the service, despite oversight being via the West Yorkshire hub, a Yorkshire and Humber Provider Collaborative Oversight Meeting met for the first time in January, between the three Yorkshire and Humber Commissioning Hubs. If successful, this arrangement could be considered for other Yorkshire and Humber wide collaboratives going forward.

Reporting arrangements for FCAMHS continue to be developed under the new provider collaborative arrangements.

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 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 agreed for the PMH Provider Collaborative of 1st October 2024. A mobilisation group continues to meet, with SWYPFT representation. A Clinical Director for the PMH Provider Collaborative is in post, and Provider Collaborative Programme Lead, started in post in February 2024.

Recommendation:

Trust Board is asked to:

RECEIVE and **NOTE** the Specialised NHS-Led Provider Collaboratives update.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 12.1

Private/Public paper:	**Public**		
Title:	**Audit Committee Annual Report 2023/24 including updated Terms of Reference and 2024/25 workplans for Trust Board committees**		
Paper presented by:	**Mike Ford – Audit Committee Chair**		
Paper prepared by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Mission/values:	A strong and effective Board and committee structure enables the Trust to achieve its vision and goals and maintain a sustainable and viable organisation.		
Purpose:	The purpose of this paper is: • To provide assurance to Trust Board that its committees operate effectively and meet the requirements of their terms of reference. • Make suggested improvement to Board and sub-committee arrangements. • Support the Annual Governance Statement		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Audit Committee annual reported provides assurance to Trust Board that Committees are adhering to their terms of reference to demonstrate their effectiveness and integration. This allows Trust Board to ensure the organisations effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnership and Integrated Care Board.		
Any background papers / previously considered by:	Committee annual reports were considered at the following meetings: • Audit Committee 9 April 2024. • Quality and Safety Committee 12 March 2024. • Equality, Inclusion and Involvement Committee 13 March 2024. • Finance, Investment & Performance Committee 18 March 2024. • Mental Health Act Committee 5 March 2024. • People & Remuneration Committee 12 March 2024. • Collaborative Committee 2 April 2024 Annual reports from each committee were considered by the Audit Committee on 9 April 2024.		

Executive summary:	The Audit Committee is required under its terms of reference to review other risk Committees' effectiveness and integration to provide assurance to Trust Board that: • risk is effectively managed and mitigated within the organisation; • Committees are fulfilling their terms of reference; and • integration between Committees avoids duplication. The Committee agreed to combine this process with the production of the Annual Governance Statement (AGS). Trust Board committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their terms of reference. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met, and to address and mitigate risk. As part of this process, Trust Board committees are required to produce an annual report, an annual work programme, undertake an annual self-assessment, and review their terms of reference. The Audit Committee received an annual report, work programme, and updated Terms of Reference from each committee at its meeting on 9 April 2024. The reports were presented by each committee Chair and/or lead Director to provide assurance against their terms of reference, A summary is contained within the Audit Committee annual report to Trust Board. Updated committee Terms of Reference and workplans are provided for the final approval of Trust Board.

Recommendation:	**Trust Board is asked to:**
	• **RECEIVE** the annual report from the Audit Committee as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through:
	  ○ committees meeting the requirements of their Terms of Reference;
	  ○ committee work programmes are aligned to the risks and objectives of the organisation within the scope of their remit; and
	  ○ committees can demonstrate added value to the organisation.
	• **APPROVE** the update to the Terms of Reference and workplans for the:
	  ○ Audit Committee;
	  ○ Quality and Safety Committee;
	  ○ Equality, Inclusion and Involvement Committee;
	  ○ Finance, Investment & Performance Committee
	  ○ Mental Health Act Committee;
	  ○ People and Remuneration Committee;
	  ○ Collaborative Committee

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024

Audit Committee Annual Report 2023/24

1. Purpose of report

The purpose of the report is to provide a summary of the Audit Committee's activities during the financial year 2023/24, and to provide assurance and evidence to Trust Board of its effectiveness and impact through compliance with its Terms of Reference.

2. Terms of Reference and Audit Committee duties

The Audit Committee is a formal Committee of Trust Board, which provides the Board with assurance that the Trust is discharging its responsibilities in relation to the following.

- The establishment and maintenance of effective systems and processes that provide internal control within the organisation, particularly, review of all risk and control related disclosure statements, such as the Annual Governance Statement and value for money audit opinion.
- The effectiveness of the governance arrangements that cover evidence of achievement of corporate objectives and the adequacy of the assurance framework.
- The effectiveness of policies and processes to ensure compliance with regulatory frameworks, including Monitor's (referred to as NHS Improvement's) risk assessment framework.
- The effectiveness of systems of internal control for the management of risk including the risk strategy, risk management systems and the risk register.
- The effectiveness of policies and procedures to prevent and manage fraud and compliance with regulatory requirements monitored through the Counter Fraud and Security Management Service.
- Overview of the work of other Committees to provide Trust Board with assurance in relation to the overall effectiveness of governance arrangements through the committee structure.

Changes to Committee Terms of Reference

At its meeting on 9 April 2024, the Committee reviewed its Terms of Reference amended to reflect the code of governance for NHS provider trusts (October 2022). They were recommended for final formal approval by the Trust Board on 30 April 2024.

Reporting to Trust Board

Under its terms of reference, the Audit Committee is required to produce a brief annual report on its activities, which is presented formally to Trust Board. The Committee's minutes are presented to the Trust Board once ratified.

Membership

The Committee is made up of Non-Executive Directors and members from 1 April 2023 to 31 March 2024 were as follows.

Name/role	Attendance 2023/24
Mike Ford, Non-Executive Director - Committee chair	5/5
Mandy Rayner Non-Executive Director	4/5
David Webster, Non-Executive Director	5/5

The Director of Finance and Resources attends as lead Director.

3. Review of Audit Committee activities

The Audit Committee's activities during the year have been cross referenced to its Terms of Reference.

3.1 Governance, risk management and internal control

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation.

	Progress
Review all risk and control related disclosures, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances.	As part of its consideration of the annual report, and accounts, the Committee received and recommended for approval the Chief Executive's Annual Governance Statement for 2022/23. The Committee also received the statement from external audit for those with responsibility for governance in relation to 2022/23 and the Head of Internal Audit opinion.
Review underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principle risks and the appropriateness of the disclosure statements (above), including the fitness for purpose of the assurance framework.	The Committee was presented with the external audit plan for 2023/24. Significant audit risks were outlined as follows. - Management override of controls - Validity of accruals These were noted by the Committee and the Trust's annual report will specifically outline the management action to address these risks, explaining the mitigating action in place to address the risks or, where appropriate, an explanation as to why the Trust does not consider these to be risks, and explaining its tolerance of any residual risk. The Trust Board has agreed to conduct the full process to develop the Board Assurance Framework (BAF), which is presented quarterly to Trust Board. As such the fitness for purpose of the BAF is currently covered at Trust Board
Review policies and processes for ensuring compliance with relevant regulatory, legal or code of conduct requirements, including the NHSE risk assessment framework.	The Committee last reviewed and approved the Trust Standing Financial Instructions and Scheme of Delegation in January 2023. Any issues or breaches are updated at each Committee meeting. This was supported for approval by Trust Board. The Risk Management Governance Framework came to the Committee in April 2022 and was supported for approval to Trust Board. In July 2022 the Committee received the updated Risk Management Procedure.

	Progress
Review the systems for internal control, including the risk management strategy, risk management systems and the risk register.	Approval of the Trust's Risk Management Governance Framework is a matter reserved for Trust Board. As stated above this was approved in April 2022. The Committee receives a report at each meeting on the triangulation of risk, performance and governance, which provides assurance that all key strategic risks are captured by the risk management process, that risks are appropriately highlighted and managed through governance committees and operational meetings, and there is a clear link between risk management and identifying areas of poor performance by the cross-reference of performance reporting to the risk register. The Committee finds this report particularly helpful in supporting scrutiny of performance and risk through Trust Board. The corporate / organisational risk register is reviewed quarterly by Trust Board and risks aligned to the Committee are reviewed at each meeting.
Review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service.	See section 3.3.
Review the work of other Committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.	See section 4.2.
Review the arrangements that allow Trust staff to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.	Updates in relation to arrangements and Freedom to Speak Up (including whistleblowing) Guardians are provided to the People & Remuneration Committee.

3.2 Internal Audit

The Committee shall consider the appointment of the internal auditor (for approval by Trust Board) and ensure that there is an effective internal audit function, established by management, that meets Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chair, Chief Executive and Trust Board.

	Progress
Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.	Through a procurement framework and tender process, 360 Assurance were re-appointed as the Trust's internal auditor from 1 April 2022 for a period of 3 years with an option to extend to 5 years. Under the Public Sector Internal Audit Standards, all internal audit service providers are required to develop an internal audit charter, which is a formal document that defines the activities, purpose, authority and responsibilities of internal audit at the Trust. It also ensures the internal audit service provided to the Trust meets the requirements of both Professional Internal Auditing Standards and 360 Assurance's own

	Progress
	Internal Audit Manual.
Review and approval of the Internal Audit strategy and programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	The Internal Audit Annual Plan for 2023/24 was presented to and approved by the Committee in April 2023. This followed a period of engagement with the Chair of the Audit Committee and Director of Finance, Estates & Resources. The plan provides a risk-based analysis of the Trust's operations, utilising the Trust Board assurance framework, reflecting the Trust's corporate objectives, priorities and areas identified for improvement. Progress against the plan is reviewed at every meeting and this includes reports on the Trust's progress against actions identified to address recommendations made by internal audit. Regular meetings are held between the Head of Internal Audit and Director of Finance & Resources to monitor progress against the work plan.
Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2022/23. This provided significant assurance. The Audit Committee has reviewed and received interim reports regarding the development of the Head of Internal Audit Opinion for 2023/24. A further update is being provided at the Audit Committee meeting in April 2024. The Committee receives audit reports and audit findings in line with the audit plan. The recommendations are followed up to ensure actions are taken in line with the action plans agreed. At the time of writing this initial draft report for the 2023/24 programme, 9 internal audit reports to date have been completed and presented to the Committee. Of these, there were: - 6 'significant assurance' reports; - 1 'substantial' assurance report - 2 'limited assurance' report Completion of further reports is expected during the year-end process and this report will be updated to include those conclusions prior to presenting this report to the Trust Board. Management action has been agreed for all recommendations. These are reported to the Committee and, where appropriate, progressed by 360 Assurance. In the main, there are no significant outstanding actions.
Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation.	The ongoing adequacy of resources is assessed as part of the review of the internal audit plan and monitoring progress. No significant issues have been raised in-year.
An annual review of the effectiveness of internal audit.	Performance is reported to the Committee through the internal audit progress report at each meeting

	Progress
	and a summary included in the internal audit annual report. In previous years the Committee and other relevant staff have also completed an established internal audit questionnaire to obtain feedback on the performance of internal audit.

3.3 Counter Fraud

The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service. The Committee shall also review the work and findings of the Local Counter Fraud Specialist as set out in the NHS Counter Fraud Authority Standards for Providers and as required by the NHS Counter Fraud Authority.

	Progress
Consideration of the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal.	Through a procurement framework and tender process, 360 Assurance was appointed as the Trust's Local Counter Fraud Specialist from 1 April 2022. This has now been amalgamated into one provider and contract.
Review the proposed work plan of the Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures.	360 Assurance presented a programme of work to the Committee in April 2023, which was approved. The Committee receives a Counter Fraud update report at each meeting to identify progress and any significant issues for action.
Receive and review the annual report prepared by the Local Counter Fraud Specialist.	The Committee received a progress report from the Local Counter Fraud Specialist at each meeting during 2023/24.
Receive update reports on any investigations that are being undertaken.	These are included in the progress reports to the Committee.
Have a responsibility to refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority	These would be included in the progress reports to the Committee as applicable.

3.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to their work.

	Progress
Consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit.	Our external audit contract, with Deloitte, has been extended in line with the reprocurement exercise undertaken in 2020. This is expected to run until 2025.
Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.	The Audit Committee is expected to receive and approve the Annual Audit Plan in April 2024. Progress against the plan is monitored, where appropriate, at each meeting. Regular updates are provided at each Committee.
Discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.	The fee for Deloitte was approved as part of the re-appointment process in 2020. A formal audit plan was presented to and approved by the Committee in April 2024. This included an evaluation of risk, which is

	Progress
	summarised under section 3.1 above.
Review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses.	The Audit Committee received and approved: - the statement for those with responsibility for governance in relation to 2022/23 accounts; - final reports and recommendations as scheduled in the annual plan.
Review of each individual provision of non-audit services by the External Auditor in respect of its effect on the appropriate balance between audit and non-audit services.	Deloitte has not been engaged to provide any non-audit services during 2023/24.

3.5 Financial reporting

	Progress
The Committee has responsibility for approving accounting policies.	The Committee considered and approved changes to accounting policies at its meetings in January 2024 and April 2024. These changes were supported by the Trust's external auditor. For 2023/24, changes again are very minimal. Further guidance may be provided before the year-end, which will be communicated to the Audit Committee when available.
The Committee has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and charitable Funds, and the Quality Accounts/Report and to make a recommendation to the Chair, Chief Executive and Director of Finance on the signing of the accounts and associated documents prior to submission.	The Committee recommended to the Trust Board for approval the annual report and accounts for 2023/24 at its meeting in June 2024 prior to submission to NHS England. As part of the consideration of the auditor's report, the Committee received and reviewed the Use of Resources Assessment for 2023/24. Revised arrangements were put in place for the Quality Account in 2022/23 and these were reviewed and recommended for approval by the Quality and Safety Committee. The Audit Committee also recommended for approval the stand-alone annual report and accounts for charitable funds in July 2023 in draft form. The final accounts went to the Charitable Trustee Committee.
The Committee also ensures that the systems for, and content of, financial reporting to Trust Board are subject to review so as to be assured of the completeness and accuracy of the information provided.	The internal audit programme includes routine testing of the Trust's financial reporting systems; however, financial reporting and scrutiny remains with Trust Board and Finance, Investment and Performance Committee, including any review of the adequacy of reporting. The Committee also receives a detailed report on procurement activity at each meeting, which monitors non-pay spend and progress on tenders, the use of single tender waivers, and progress against the Procurement Strategy and associated cost improvement programme. The Committee is also required, on behalf of Trust Board, to approve the methodology for determining the Trust's reference cost submission. This was considered in the October 2023 meeting.
The Committee also: - reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation;	The Committee last reviewed the Standing Financial Instructions in January 2023 and supported their approval by Trust Board. Changes to the Trust's Scheme of Delegation

	Progress
- examines circumstances associated with each occasion Standing Orders are waived; - reviews the schedules of losses and compensations on behalf of Trust Board.	were also considered by the Committee in January 2023 and it supported their approval by the Trust Board. There were no occasions when Standing Orders were waived in 2023/24. The losses and special payments report is received by the Committee at each meeting.

4. Review of Audit Committee administrative arrangements

The Committee met the requirement for the number of meetings in the year and has been quorate at each meeting. Agendas were reviewed regularly by the Chair of the Committee and Director of Finance, Estates and Resources as part of the agenda setting process.

The requirement to send papers out five working days prior to the meeting has been met throughout the year.

5. Audit Committee self-assessment

In line with the Terms of Reference, the Audit Committee has an agreed self-assessment process. The proforma used is that recommended by the Audit Committee Handbook. The self-assessment has eight sections:

- Composition, establishment and duties;
- Compliance with the law and regulations governing the NHS;
- Internal control and risk management;
- Internal audit;
- External audit;
- Annual accounts;
- Administrative arrangements
- Other issues

The self-assessment survey was completed by all members of the Audit Committee. Potential areas for future consideration raised in the survey were discussed at the meeting.

The Terms of Reference have been approved by the Chair of the Committee and lead director in Audit Committee on 9 April 2024.

The work programme for 2024/25 has been updated and agreed by the Chair of the Committee and lead director.

6. Governance assurance

6.1 Review of committee effectiveness

Each Committee has Terms of Reference and is required to produce an annual report outlining achievements against objectives and compliance with Terms of Reference. The annual reports, work programmes and updated terms of reference were provided to the Audit Committee to provide assurance to Trust Board.

6.2 Audit Committee review of the effectiveness of Trust Board committees

In April 2010, the Audit Committee agreed an approach and process to fulfilling its role to provide oversight and assurance to Trust Board on the effectiveness of the other sub-committees of the Board.

The committees assumed within scope of the Audit Committee review are:

- Clinical Governance and Clinical Safety Committee;
- Equality, Inclusion and Involvement Committee
- Mental Health Act Committee;
- Workforce and Remuneration Committee
- Finance, Investment and Performance Committee
- Collaborative Committee

The draft annual report, annual work programme and terms of reference for these committees will be provided to the Audit Committee on 9 April 2024. The purpose of the review is for the Audit Committee to provide assurance to Trust Board that:

- each meets the requirements of its Terms of Reference;
- each work programme is aligned to the risks and objectives of the organisation, which are in the scope of its remit;
- each can demonstrate added value to the organisation.

The review was undertaken as part of formal Audit Committee business with committee chairs and lead directors invited to present to provide assurance to the Audit Committee on the assurance each committee has provided to Trust Board in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other committees.

Audit Committee
Chair – Mike Ford; Lead Director – Adrian Snarr

Key areas highlighted for 2023/24 are:

- Review of all year-end reporting documents enabling approval to be recommended to the Board and within required timescales.
- Review and comment on the Annual Governance Statement.
- In-depth review of issues where it has been felt there are specific areas of risk or concern.
- Regular update and review of internal audit and counter fraud programmes of work.
- Engagement with external audit to agree audit plan, review areas of risk and receive external audit reports.
- The Audit Committee has covered key and appropriate areas. It has highlighted risks that are important to the trust and its objectives as well as giving good assurance.
- Regular review of organisational risks allocated to the Committee by the Trust Board.
- Oversight risk allocation to all Board committees to ensure each risk has a lead committee and to avoid duplication of oversight.
- Annual review of the Board Assurance Framework including updates on the implementation of the code of governance for NHS provider trusts.
- It continues to maintain a high standard of independent assurance at time of continued pressure for the organisation.
- There has been lots of change in guidance centrally this year, despite challenges, the committee has effectively steered its way through this, and comes with a better view on the Trust's performance versus new and more stringent regulations and guidance.
- The Committee provides oversight of its activities to the Council of Governors through Triple A reports going to all Public Boards to which all Governors are invited.

Quality and Safety Committee
Chair – Nat McMillan; Lead Director – Darryl Thompson

Key areas highlighted for 2023/24 are:

- Updates about the implementation of the Quality Strategy have been received by the committee throughout the year, following the strategy being approved by Trust Board in March 2023
- The Committee received updates throughout the year in relation to the changes to the Smoking Policy and the re-introduction of smoke free.
- Updates around the progress of the Patient Safety Strategy have been received throughout the year.
- Committee noted in March 2024 that the Review of Learning from Healthcare Deaths Policy has been further extended to June 2024 by the Executive Management Team.
- The Trust's new Quality Priorities were approved by the committee in April 2023.
- The Committee received the Quality Account for 2022/23 in May 2023, prior to its formal submission to the Audit Committee for approval with the annual report and accounts.
- The Committee received reports on waiting lists improvement plans for attention deficit hyperactivity disorder, adult autistic spectrum disorder, child and adolescent mental health services, learning disability services, improving access to psychological therapies and Musculo skeletal services in April 2023.
- There is a standing item on the Committee agenda for each meeting for updates on topical, legal and regulatory risks, as part of the Chief Nurse Report.
- During the year, the Committee continued its review of implementation of key Trust priority programmes from a clinical and quality perspective and receives exception reports as well as more detailed presentations as appropriate.
- The Committee also considers items from the Integrated Performance report, ensuring that progress is monitored in addressing our key strategic objectives.
- During the year, the Committee continued to receive 'alert, advise, assure' updates from its formal sub-groups covering Drugs and Therapeutics, Safety & Resilience, Safeguarding children and vulnerable adults, infection prevention and control, reducing restrictive physical interventions, improving clinical information group, clinical governance group, clinical ethics advisory group, physical health and QUIT, to ensure the Trust is discharging its statutory responsibilities and duties.
- During the year, the Patient Safety Strategy Group continued to provide assurance, through the Chief Nurse / Director of Quality & Professions and the Chief Medical Officer, to the Committee in relation to patient safety and learning lessons from incidents.
- The Medical Education Report was received by committee in November 2023.
- The Annual Ligature Report was received by committee in November 2023
- As a standing item, the Committee receives a report on progress to address issues raised by the CQC during any visits. This is now considered through the regular review within the Quality and Regulatory Oversight Report.
- The Committee received the NICE guidance annual report in June 2023 to provide assurance that the Trust is meeting these obligations.
- Updates from the Patient Safety Strategy Implementation Group Annual were received in July and November 2023.
- The Quality Monitoring Visits annual report was received in September 2023.
- Each committee receives a Care Group Quality and Safety Report, informed by the current integrated performance report but reviewed through a governance, quality and

safety lens. This is co-authored by the Chief Operations Officer, Chief Nurse / Director of Quality and Professions and Chief Medical Officer.

- The Committee received quarterly incident management / serious incident reports for detailed scrutiny on behalf of Trust Board, and the reviewed the annual Incident Management and Learning from Healthcare Deaths Report in June 2023 prior to submission to Trust Board. The 'Our Learning Journey' report is now part of the quarterly and annual incident management reports.
- During the year, the Committee received annual reports covering medicines management, reducing restrictive physical interventions, clinical audit and service effectiveness (CASE), emergency preparedness, mandatory training, and speaking up.
- The Safeguarding Annual Report was received and approved by the committee in September 2023.
- The infection prevention and control annual report was received by the committee in September 2023.
- The Committee provided detailed scrutiny on behalf of Trust Board of quarterly incident reports.
- The committee received regular updates throughout the year with regards to patient experience and complaints. It also received the first draft of the Patient Experience (including complaints) annual report in June 2023, and the final version in September 2023.
- The Committee received the clinical audit and practice effectiveness (CASE) annual plan in June 2023.
- The Committee received a report on apparent suicides in July 2023.
- The Committee receives the quarterly Patient Experience (previously Customer Services) report includes reporting on the Friends and Family Test (FFT) which is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience and this feedback should be used to improve services for service users. This information is also included in the Integrated Performance Report to Trust Board
- The Committee received updates on CQC patient surveys.

Equality, Inclusion and Involvement Committee

Chair – Marie Burnham; Lead Director – Dawn Lawson

Key areas highlighted for 2023/24 are:

- Equality and diversity annual report prior to Trust Board.
- Implementation of plan and Progress on peer support workers
- Delivery on carers agenda and accreditation
- Introduced a new Care Group report on equality and involvement received from the different care groups.
- Equality and Involvement exception and highlight report delivered majority of annual action plan with significant outcomes as set out in the report.
- Development of Equality Dashboard aligned to CORE20 PLUS 5 and captures data by deprivation index.
- Development of approach to addressing inequalities including deep dives and use of data to support service change.
- Embedding the Insight report and approach to capturing Service users public and partner voice
- The Committee monitored the Trust's progress against the equality standards including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES); and the Trusts progress against the Equality Delivery System 2 (EDS2).

- Received feedback from staff equality networks.
- Reviewed inclusive leadership and development programme updates.
- The Committee met all requirements set out in its terms of reference, including completing the annual self-assessment and report.
- In addition to the Committee members, meetings are regularly attended by representatives from the Trust's staff equality networks, staff side, Trust care groups equality forums, an elected governor, and staff from our equality and engagement team.
- Received first update on implementation of social responsibility and sustainability strategy and development of key priority areas.

Committee effectiveness

- **Lessons learned:**
  The EIIC strategy will be refreshed following the Trust Strategy Refresh in 24/25. This is an opportunity to take stock of progress over the last 3 years and determine the level of ambition for the future. The current strategy has developed the infrastructure and capability, the future strategy is an opportunity to really drive impact across the breadth of the equality and diversity agenda. This is a pivotal point for SWYT to better define and deliver impacts and outcomes over the next 3 years.

Finance, Investment & Performance

Chair – David Webster; Lead Director – Adrian Snarr

Key areas highlighted for 2023/24 are:

- With a new workplan in place, the committee had a more structured review of all areas, and ensured robust financial performance was delivered throughout the Trust.
- There was an increasing focus on Investment and Performance, but on reflection the balance is still more heavily weighted to Finance, this is being addressed with an updated workplan for 2024/25
- That said, the committee did play a key role in management of agency spend and reduction in out of area bed usage, which while have financial benefits, are primarily focussed on better service user experience (i.e. performance linked)
- Reviewed at each meeting, financial performance and forecast, including the financials linked to the provider collaborative
- Received and reviewed investments and opportunities ahead of wider Board updates, enabling the committee to discuss and challenge prior to gaining formal approval.
- Reviewed capital expenditure, this is an area that the committee have requested more in the way of risk based forecasting for 2023/24 to provide further assurance on expected position.
- Reviewed the risks delegated by the Board.
- Received updates to new/key finance/performance projects.
- Received benchmarking reports and investment updates including progress of delivering against these.

Mental Health Act Committee

Chair – Kate Quail*;* Lead Director – Dr Subha Thiyagesh

Key areas highlighted for 2023/24 are:

- The Committee received and scrutinised quarterly monitoring information; receiving exception reports, including mandatory MHA and Mental Capacity Act (MCA) training compliance; complaints compliments and concerns.
- MHA/ MCA Code of Practice Oversight Group and Multi agency partnership group provided feedback challenge and assurance.

- Independent Associate Hospital Managers (HMs) – provided ongoing scrutiny. MHAC formally receives minutes from the HMs' Forum and the Forum Chair attends Committee to raise any issues arising from appeals and/or by the Forum. All HMs attended the required number of Hearings in the year and received an annual personal review with the MHAC Chair or other Non-Executive Director. Committee received an Annual Report on this process. 6 new appointments this year. Recruitment ongoing in 2024/25, with a view to further increase diversity.
- Legal updates case law and 'horizon scanning' alert Committee to issues, publications or forthcoming legislation and implications for the Trust. Potential risks to the Trust are identified with mitigation plans developed and monitored.
- 'The Act in Practice' – staff experience – challenges, blocks, barriers good practice in application of the MHA. Provides assurance of compliance with the MHA and Code of Practice and increases committee members' knowledge and understanding, to ensure Committee is equipped to fulfil its scrutiny and assurance role.
- Consideration of organisational risk register and reviewing organisational risks which are relevant and may have an impact on compliance with the MHA. The MHAC Risk Register monitors any new risks relating to the implementation and compliance with mental health legislation. No current risks identified on this.
- Care Quality Commission (CQC) Mental Health Act visits – assurance gained that action plans are implemented with required outcomes achieved.
- Quality Improvement (QI) and Audit. MHAC remains strongly focused on improvement. The MHA Administrators and clinical staff continue their successful use of QI approaches to improve service delivery and compliance. For example, a QI programme started in April 2023 on the compliance rate of Responsible/Approved Clinician's recording assessments of capacity to consent to treatment (medication); compliance improved from 66% in Quarter 2 to 92.99% in Quarter 3.
- Service User Experience.
  MHAC initiated the 'Discovery Interviews' on the Forensic wards which provided an inclusive approach for patients to share their experiences of being detained under the MHA and staying on a Forensic ward. Following this patient feedback work, a range of improvement actions took place.
- Addressing Inequalities
  MHAC has this year developed a new health inequalities annual report 'BAME Inequalities in mental health in South West Yorkshire Partnership Trust'. The report presented data requiring further analysis to understand any impacts and address any service gaps for service users and carers. Work will look at service users accessing services, admitted and detained and the use of Community Treatment Orders.
- Committee Annual Review - Committee has met all the requirements under its term of reference and no issues were raised by Committee's Self-Assessment.

Committee effectiveness

- **What went well**
  MHAC takes a 'problem-sensing' approach – actively seeking out data and intelligence which offers challenge and identifies problems or potential weaknesses in systems. MHAC works to gain full assurance, rather than reassurance, by triangulating a range of internal and external data with 'soft intelligence', including from patients and staff and externally through partner agencies (Local Authorities, Acute Trusts and Advocacy services) and Hospital Managers, as well as CQC Mental Health Act (MHA) Visits.
  Committee followed a workplan aligned to the risks and objectives of the Trust, within the scope of its remit; and examined the following to provide assurance to Trust Board on the Trust's compliance with its regulations and Standing Orders.
- **What didn't go so well and learning**
  MHAC is improving the reports it receives, ensuring analysis of what data is telling us. It is also strengthening assurance on actions taken and outcomes following CQC MHA visits.

People & Remuneration Committee
Chair – Mandy Rayner; Lead Director – Lindsay Jensen

Key areas highlighted for 2023/24 are:

- The Committee received updates on the Clinical Excellence Awards Scheme and ratified payments in line with national guidance given at the time.
- The Committee agreed pay uplifts in line with the national uplift for Very Senior Managers from 1 April 2023.
- The Committee agreed the pay rate for the Director of Strategy and Change.
- The Committee agreed the pay rate for the Interim Chief People Officer from July 2023.
- The Committee oversaw the process for the appointments of the Director of Strategy and Change.
- A report was received by the Committee from the Guardian of Safe Working in May 2023, September 2023, November 2023 and March 2024.
- The Committee received an FTSU update report in July 2023 and the annual FTSU Report is scheduled to be received in July 2024.
- The Committee received regular updates on the delivery plan to support the Workforce Strategy Making SWYPFT a Great Place to Work. A comprehensive set of performance indicators are reported on at every meeting. From January 2024 a new People Directorate 90 Day+ Plan was received focussing on seven priority areas.
- There has been major focus on the wellbeing of our staff during the last 12 months recognising the pressures they have been under. This included a focus on the role of wellbeing champions and ongoing cost of living support.
- Workforce Integrated Performance report is received at every meeting and from January 2024 include a focus on hot spot areas and improvements plans to address.
- Mandatory training has been closely monitored with a focus on those areas below our targets.
- Agency Usage, through the Integrated Performance Report was reported on at every meeting.
- Risks from the corporate/organisational risk register aligned by the Trust Board to the Committee are reviewed as a standing item at each Committee meeting. There was a continued focus on the risk of industrial action since action started in November 2022 and ongoing during 2023/4 with this being reviewed in October 2023 and January 2024 and also the ability to recruit risk rating was reduced in October 2023.
- Appraisal rates and compliance have been a focus and closely monitored throughout the year.
- The Committee heard staff stories covering, Wellbeing Champions, e-Rostering and Safe Care roll-out, local recruitment and employability and the role and impact of Clinical Skills Facilitators.
- Recruitment Plan for nurse recruitment was monitored with an annual review in January 2023.
- From May 2023 the Organisational Development Tactical Plan was included on the Annual Work Programme and to be received quarterly.

Committee effectiveness

- **What went well**
  Strong focus on outcomes and key deliverables. Seen demonstrable improvements and progress on international recruitment, freedom to speak up and appraisal compliance.
- **What didn't go so well**

Challenges of not having a substantive Chief People Officer in post. Further improvement needed on quality of reports and more focussed executive summaries and front sheets.

- **Lessons learned**
  To provide more briefing/training for those attending PRC from the people directorate on the purpose and role of the committee to support confidence and contribution.

The Collaborative Committee
Chair – Mike Ford; Lead Director – Adrian Snarr

Key areas highlighted for 2023/24 are:

- Continued to carry out regular reviews of performance (finance, contracting, quality, commissioning) of the Specialised Provider Collaboratives for which the Trust is Coordinating Provider.
- Supported further improvements in reporting quality and consistency across these collaboratives.
- Requested and received assessments of the success of the collaboratives in achieving the objectives set out in the original business cases
- Successfully challenged management to improve timeliness of contract completion.
- Ensured oversight of the commissioning response to any significant quality concerns.
- Regularly reviewed the risks allocated to the Committee by Trust Board and kept under review any risks required to be escalated to Trust Risk Register.
- Began to receive reporting on the Yorkshire and Humber Forensic CAMHS Provider Collaborative for which the Trust is Co-ordinating Provider but requested further development to bring this reporting more in line with that received from the adult secure collaboratives.
- Received reports on the Specialised Provider Collaboratives where the Trust is a partner- the West Yorkshire Children and Young People's Mental Health Provider Collaborative and Adult Eating Disorder Provider Collaborative.
- Conducted regular reviews of the agenda and workplan to ensure the combined skills of both West Yorkshire and South Yorkshire attendees are used in the most effective way to provide assurance and insight to Committee members.
- Review of the Committee's Terms of Reference, particularly to ensure that the learning through the year on the balance of the agenda between executive assurance and detailed operational oversight is appropriately reflected in an updated Terms of Reference.
- Approved a paper setting out proposals covering the potential for the establishment of the Trust as the "co-ordinating provider" for Wakefield place based adult mental health services.

The Audit Committee will review the documents and presentation on the work of the committees and consider if it was sufficient to enable the Chair of the Audit Committee to support an assurance to Trust Board that the integrated governance arrangements in the Trust were operating effectively and that committees:

- had met the requirements of their Terms of Reference.
- had followed a workplan aligned to the risks and objectives of the organisation, within the scope of each committee's remit; and
- could demonstrate added value to the organisation.

6.3 Independent review of the Trust's governance arrangements

In 2014, Monitor (now NHS England) stated its expectation that all foundation trust boards would carry out an external review of their governance arrangements every three years.

Monitor issued guidance to support Trusts in ensuring they are 'well-led,' which supported the NHS response to the Francis Report and was aligned with the assessment the Care Quality Commission (CQC) makes on whether a foundation trust was well-led as part of its revised inspection regime.

In line with section 4.5 of the code of governance for NHS provider trusts (October 2022) there should be a formal and rigorous annual evaluation of the Trust Board committees.

7. Conclusion

In summary, the Annual Report of the Audit Committee will be used as evidence the Committee has discharged its responsibilities in relation to its statutory obligations and Terms of Reference. This includes providing the Trust Board with assurance on the effectiveness of other committees which is part of the Audit Committee role in supporting integrated governance.

Audit Committee Draft Work Programme for 2024/25			2024/25				
			11th	26th	11th	10th	9th
Standard Items	**Lead**	**Type**	April	June	July	October	January
Welcome & apologies for absence:	**Chair**	**Verbal**	X	X	X	X	X
Declaration of any conflict of interest.	**Chair**	**Verbal**	X	X	X	X	X
Minutes of the meeting held on xxxxx.	**Chair**	**Paper**	X		X	X	X
Matters arising & action log from the meeting held on the xxxx.	**Chair**	**Paper**	X		X	X	X
Actions delegated to FIP Committee from Trust Board.	**Chair**	**Paper**	X		X	X	X
Items to redact from public facing minutes due to being commercial in confidence	**Chair**	**Verbal**	X		X	X	X
Annual assurance update on progress against external audit actions	**RA**	**Verbal**	X				
(new IA request to be added to work programmes and agenda's)							
Corporate Governance							
Consideration of items from the Organisational Risk Register allocated to the Audit Committee	**JW**	**Paper**	X		X	X	X
BAF effectiveness review	**JW**	**Paper**	X				
Triangulation of risk, performance and governance	**JW**	**Paper**	X		X	X	X
Declaration of interest annual update	**JW**	**Paper**			X		
SFI and scheme of delegation update	**RA**	**Paper**	X		X		
Review other 'risk' committees' effectiveness and integration for annual report to Trust Board.							
· PRC (attached) - MR	**MR**	**Paper**	X				
· FIP (attached) - DW	**DW**	**Paper**	X				
· CGCS (attached) - NM	**NM**	**Paper**	X				
· MHA (attached) - KQ	**KQ**	**Paper**	X				
· EII (attached) - MB	**MB**	**Paper**	X				
Audit Committee annual report, effectiveness	**MF**	**Paper**	X				
Audit Committee ToR	**MF**	**Paper**	X				
Board Committee effectiveness surveys to be reviewed for 23-24		**Paper**					
Audit Committee work plan for 2023/24	**MF**	**Paper**	X		X	X	X
Year End Accounts and VFM							
Annual governance statement (AGS)	**AS**	**Paper**	X	X			
Annual account progress update	**RA**	**Paper**	X	X			X
FT ARM update	**RA**	**Paper**	X				X
Review of final draft accounting policies	**RA**	**Paper**	X				X
Review of accounts	**RA**	**Paper**		X			
External Audit							
External audit plan, risks and control measures - progress	**CJ**	**Paper**	X		X	X	X
Internal Control and Risk Management							
Procurement report ink waivers	**TC**	**Paper**	X		X	X	X
Losses and special payments	**RA**	**Paper**	X		X	X	X
Treasury management update	**RA**	**Paper**	X		X	X	X
Internal Audit and Counter Fraud							
Internal audit progress update including	**LR**	**Paper**			X	X	X
· draft head of internal audit opinion (HOIA) – stage 3 (attached)	**LR**	**Paper**	X	X			
· Internal audit plan for 23/24 – 360 Assurance	**LR**	**Paper**	X	X	X	X	X
· Shared full IA reports where limited opinions	**LR**	**Paper**	X		X	X	X
Internal Audit Annual report	**LR**	**Paper**		X			
Counter Fraud progress report – 360 Assurance	**CC**	**Paper**			X	X	X
Counter Fraud work plan	**CC**	**Paper**	X				
Counter Fraud - Annual return CFFR	**CC**	**Paper**		X			
Counter Fraud Risk Register	**JW**	**Paper**	X			X	
Digital & Cyber							
Systems Development Update report	**PF**	**Paper**	X			X	
Cyber progress report	**PF**	**Paper**			X		X
Costing							
Update on national cost collections, deadlines and process	**RA**	**Paper**			X		

EPPR & H & S (New)							
EPPR Update (new)	**NP**	**Paper**			X		X
Annual PLACE assessments	**NP**	**Paper**			X		
H & S Update (new)	**RW**	**Paper**			X		X
H & S (Annual Report) (new)	**RW**	**Paper**			X		
Other							
Policy updates (if any)	**Various**	**Paper**			X	X	X
Capacity of organisation to deliver change	**AS**	**Paper**			X		X
Oversight of Covid 19 public enquiry	**JW**	**Verbal**			X		
Approval of Charitable funds annual report and accounts	**TBC**	**Paper**			X		
Non Exec meeting with internal & external audit	**Chair**	**Verbal**					
Other Ad hoc updates as needed (if any)	**Various**	**Paper**	X		X	X	X
Agreement of committee meeting dates for 2023/24.	**Chair**	**Verbal**	X		X	X	X
Any other business	**Chair**	**Verbal**	X		X	X	X
Meeting evaluation & confirmation of:							
a. Meeting effectiveness	**Chair**	**Verbal**	X	X	X	X	X
b. Significant issues to report to the Board of Directors. · Alert, advise, assure	**Chair**	**Verbal**	X	X	X	X	X
c. Changes in level of assurance	**Chair**	**Verbal**	X	X	X	X	X
d. Agreed actions	**Chair**	**Verbal**	X	X	X	X	X
Review committee timetable/work programme (attached)	**Chair**	**Paper**	X	X	X	X	X

South West Yorkshire Partnership NHS Foundation Trust

AUDIT COMMITTEE
Terms of Reference
To be approved by Trust Board 30 April 2024

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Audit Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Audit Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Audit Committee's prime purpose is to keep an overview of the systems and processes that provide controls assurance and governance within the organisation as described in the Annual Governance Statement on behalf of Trust Board and that these systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring independent verification on systems for risk management and scrutiny of the management of finance. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
Taking guidance from the code of governance for NHS provider trusts (October 2022) and the Department of Health into consideration, neither the Chair of the Trust or the Chief Executive attends this Committee unless invited to do so. The Chair of the Committee is appointed by Trust Board and the Chair of the Committee cannot be the Chair of the Trust, the Deputy Chair or Senior Independent Director.

The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors. At least one Non-Executive member of the Committee should have recent and relevant financial experience.

Membership as at 1 April 2024
Chair – Non-Executive Director – Mike Ford
Non-Executive Director - David Webster
Non-Executive Director - Mandy Rayner.

Attendance

The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Company Secretary also attends meetings. Representatives of internal and external audit are also invited and expected to attend. The local counter fraud specialist is required to attend a minimum of two meetings a year.
The Chair of the Trust, the Chief Executive, other Directors, and relevant officers attend the Audit Committee by invitation. Administrative support is provided by the Personal Assistant to the Director of Finance and Resources.

Quorum

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

Frequency of meetings

The Committee will meet a minimum of four times per year to reflect best practice. The Audit Committee will meet with the External Auditor and Head of Internal Audit in private, on at least one occasion, per year. The Chair of the Committee, External Auditor or Head of Internal Audit may request a meeting if they consider one is necessary. The External Auditor and Head of Internal Audit have the right of direct access to the Audit Committee Chair.
There will also be an additional annual meeting to approve the annual report, accounts and Quality Accounts.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation, and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain external legal or other independent professional advice and to secure the attendance of external bodies or individuals with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Health and Safety - (moved across from Quality and Safety Committee 1st April 2022)

Duties

<u>Governance, risk management and internal control</u>
The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation. In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by Trust Board.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principal risks and the appropriateness of the above disclosure statements. This includes assessing the fitness for purpose of the assurance framework including risk appetite and providing assurance that action plans are in place to address significant control issues.
- The policies and processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements, including the NHS England risk assessment framework.
- The systems for internal control including the risk management strategy, risk management systems and the risk register.
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service.
- The work of other committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.

In carrying out its work, the Committee will primarily utilise the work of Internal and External Audit; however, it will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. The Committee will use the Trust's Assurance Framework to guide its work and that of the audit and assurance functions reporting to it.

The Committee will also review arrangements that allow Trust staff (and other individuals where relevant) to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Committee will ensure that:

- Arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
- Ensure safeguards for those who raise concerns are in place and that these safeguards operate effectively.
- Such processes enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure valid concerns are promptly addressed.
- These processes reassure individuals raising concerns that they will be protected from potential negative repercussions.

<u>Internal Audit</u>

The Committee shall consider the appointment of the Internal Auditor (for approval by Trust Board) and ensure there is an effective internal audit function established by management that meets Public Sector Internal Audit Standards, that provides appropriate independent assurance to the Audit Committee, Chief Executive, Chair and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation or dismissal.
- Review and approval of the Internal Audit approach, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.

- Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between internal and external auditors to optimise audit resources.
- Ensure the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit.

External audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to its work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as NHS England rules permit.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses.
- Review of each individual provision of non-audit services by the External Auditor in respect of its effect on the appropriate balance between audit and non-audit services.

The Committee will also advise the Members' Council with regard to the appointment and removal of the Trust's external auditors and, to inform this advice, carry out a market testing exercise for the appointment of the external auditor at least every five years.

Counter fraud

The Committee shall review the work and findings of the Local Counter Fraud Specialist as set out in the Government Functional Standard 013: Counter Fraud (Functional Standard)and as required by the NHS Counter Fraud Authority. In particular:

- Consider the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal;
- Review the proposed work plan of the Trust's Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures;
- Receive and review the annual report prepared by the Local Counter Fraud Specialist;
- Receive update reports on any investigations that are being undertaken.
- Have a responsibility to refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority

Financial reporting

The Committee has responsibility for approving accounting policies. It also has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and for charitable funds, and the Quality Accounts/Report on its behalf and to make a recommendation to the Chair and Chief Executive on the signing of the accounts and associated documents prior to submission to NHS England, Trust Board and the Members' Council.

In particular, the Committee shall focus on:

- Changes in, and compliance with, accounting policies and practices.
- Major judgemental areas.
- Significant adjustments arising from the annual audit.
- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee.
- Unadjusted misstatements in the financial statements.
- Letters of representations.
- Explanations of significance variances.

The Committee also ensures that the systems for, and content of, financial reporting to Trust Board, including those of and for budgetary control, are subject to review so as be assured of the completeness and accuracy of the information provided to Trust Board.

The Committee also:

- Reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation before these are laid before Trust Board;
- Examines the circumstances associated with each occasion Standing Orders are waived.
- Reviews schedules of losses and compensations on behalf of Trust Board.

Other Compliance:
To provide assurance that the Trust has effective arrangements for the management of safety and emergency response including through the receipt of assurance reports provided by the Health and Safety TAG.

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include any reviews by the Department of Health and Social Care, arms-length bodies, or regulators/inspectors (e.g. Care Quality Commission and NHS England, NHS Resolution, etc) professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Relationship with the Members' Council

To reflect best practice, Trust Board will consult with the Members' Council annually on the Audit Committee's terms of reference. At the discretion of the Chair of the Committee and/or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance

through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Approved by Trust Board:
Next review due: April 2025

South West Yorkshire Partnership NHS Foundation Trust

Quality & Safety Committee
Annual Work Programme
2024-2025

Agenda Item	Author	9 April	14 May QA	11 June	9 July	10 Sept	8 Oct	12 Nov	14 Jan 2025	11 Feb 2025	11 March 2025	Send to Board on
1. Standard Opening Items												
Welcome & Apologies		X	X	X	X	X	X	X	X	X	X	
Declarations of Interest		X	X	X	X	X	X	X	X	X	X	
Minutes of Previous meeting		X	X	X	X	X	X	X	X	X	X	
Action Log		X	X	X	X	X	X	X	X	X	X	
Committee Related Risks (alternate)		X		X		X		X		X		
Actions from Trust Board		X	X	X	X	X	X	X	X	X	X	
Staff/Team story		X	X	X	X	X	X	X	X	X	X	
2. Quality Improvement												
Chief Nurse Report		X	X	X	X	X	X	X	X	X	X	
Quality Accounts Production Update (standing item) **Inc in Chief Nurse update**												
Approval of Quality Accounts			X									**May TB And Private Board in June**

Agenda Item	Author	9 April	14 May QA	11 June	9 July	10 Sept	8 Oct	12 Nov	14 Jan 2025	11 Feb 2025	11 March 2025	Send to Board on
Clinical Audit and Service Effectiveness (CASE) Annual Plan				X								
Quality Monitoring Arrangements inc in Quality and Reg Oversight paper		X			X		X		X			
Quality Monitoring – Annual Report						X						
Consideration of external audit report on Trust Quality Accounts				X								
Quality and Regulatory Oversight Paper		X	X	X	X	X	X	X	X	X	x	
Care Quality Commission in-patient and community surveys (Inpatient survey every 2 years) inc in Chief Nurse Update												
Patient Safety Strategy update		X			X			X			X	
Patient Experience update					X		X		X		X	
Waiting List Management Report (now FIP)												
Quality Strategy						X				X		Update for Trust Board
Care Plans and Risk Assessment Improvement Update			X			X						
3. Key Clinical Risks												
Care Group Quality and Safety Report Slides	Trio	X	X	X	X	X	X	X	X	X	X	

Agenda Item	Author	9 April	14 May QA	11 June	9 July	10 Sept	8 Oct	12 Nov	14 Jan 2025	11 Feb 2025	11 March 2025	Send to Board on
4. Assurance												
Safer Staffing Report (6 monthly)				**X**					**X**			**June and January**
Trust wide Serious Incidents Quarterly Reports Annual Report 24/25 (inc LeDer) 2024/2025 Q4 2024/2025 Q1 2024/2025 Q2 2024/2025 Q3				**X AR and Q4**		**X Q1**		**X Q2**			**XQ3**	**annual for June** **Sept** **Nov** **March**
Committee Annual Report and Annual Governance Statement											**X**	**For Audit Committee and Board**
Internal Audit Reports (as appropriate)		**X**		**X**		**X**		**X**		**X**		
NICE Annual Report					**X**							
Patient Led Assessment of the Care Environment (PLACE) Report Now Audit Committee												
RRPI Annual Report					**X**							
Safeguarding Annual Report						**X**						
Patient Experience / Customer Services Report Annual Report				**X**								**June annual report only**
Customer Services Policy				**X**								**To Board**

Agenda Item	Author	9 April	14 May QA	11 June	9 July	10 Sept	8 Oct	12 Nov	14 Jan 2025	11 Feb 2025	11 March 2025	Send to Board on
Infection Prevention & Control Annual Report			**X**									
Drug & Therapeutics Annual Report					**X**							**To Board**
Review Healthcare Deaths Policy (***deferred 2024****)tbc*									**X**			**To Board**
Annual Nurse Revalidation Report											**X**	**To Board**
Annual Ligature Report								**X**				**Nov**
Medical Appraisal / Revalidation Report						**X**						**Sept**
Medical Education Report								**X**				**Nov**
Private Complex Case Incident Report		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	
Apparent Suicide Report			**X**								**X**	
Learning Journey Report (inc in quarterly report)												
EPRR Policy ***(next due at Trust Board Nov 2024)***												
Sexual Safety Report					**X**						**X**	
IPC BAF					**X**					**X**		**To Board**
Reports from Sub-Committees		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	
Clinical and Strategic Approach to LD Improvement		**X**					**X**					
5. Standard Closing Items												
Private Serious Incident verbal update		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	

Agenda Item	Author	9 April	14 May QA	11 June	9 July	10 Sept	8 Oct	12 Nov	14 Jan 2025	11 Feb 2025	11 March 2025	Send to Board on
Issues and items to bring to the attention of Trust Board & other Committees		X	X	X	X	X	X	X	X	X	X	
Review of Committee related Risks and any Exception Reports as required		X	X	X	X	X	X	X	X	X	X	
Work Programme		X	X	X	X	X	X	X	X	X	X	

Strategies and Policies due to QSC

Name	Date	Notes
Suicide Prevention Strategy	October 2025	
R&D Strategy	November 2025	
Customer Services Policy	March 2026	

South West Yorkshire Partnership NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE (FORMERLY CLINICAL GOVERNANCE AND CLINICAL SAFETY COMMITTEE)
Terms of Reference

To be approved by Trust Board 30 April 2024

All Trust Board Committees are responsible for scrutinising and providing assurance to Trust Board on key issues allocated to them by the Board. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose

The Quality and Safety Committee provides assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice. On behalf of the Trust Board, it will have an oversight of clinical risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership

The Quality and Safety Committee is chaired by a Non-Executive Director. Two other Non-Executive Directors (NED) also sit on the Committee as well as relevant Directors of the Trust.

Membership as at 1 April 2024:
Chair - Non-Executive Director - Natalie McMillan
Non-Executive Director – Marie Burnham (Chair of the Trust)
Non-Executive Director - Kate Quail
Lead Director – Chief Nurse / Director of Quality & Professions – Darryl Thompson
Chief Medical Officer - Dr Subha Thiyagesh
Chief Operating Officer, Carol Harris

Attendance

The Deputy Director of Nursing, Quality & Professions is in attendance at each meeting. Clinical representatives and relevant Trust officers are invited to meetings as appropriate to ensure the remit of the Committee is adequately covered. The Chief Executive, other Directors, and relevant officers attend the Quality and Safety Committee by invitation. A Patient Safety Specialist colleague will begin to attend committee in the coming year, as part of ensuring lived experience representation in line with patient safety incident response (PSIRF) expectations. Administrative support is provided by the Personal Assistant to the Chief Nurse / Director of Quality and Professions.

Quorum

The quorum will be two Non-Executive Director members and the Lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of ten times per year.

It is the responsibility of the lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-groups including but not limited to:

- Drugs and Therapeutics (Medicines Management);
- Safeguarding (vulnerable adults and children);
- Infection Prevention and Control;
- Reducing Restrictive Physical Interventions group;
- Clinical Governance Group;
- Improving Clinical Information Group;
- Clinical Ethics Advisory Group and
- Improving Clinical Information Group.
- Physical Health
- QUIT

Duties

The Committee provides assurance to Trust Board on service quality, practice effectiveness and the application of controls assurance in relation to clinical services and ensures the Trust is discharging its responsibilities with regard to clinical governance and clinical safety.

<u>Strategy and policy</u>

1. To approve relevant strategies and policies on behalf of the Trust Board
2. To monitor implementation of strategic objectives relevant to clinical governance, care delivery and practice effectiveness, such as implementation of care management processes and clinical information management, providing assurance to Trust Board that these are appropriately managed and resourced.

Clinical quality

3. To provide assurance to Trust Board that appropriate and effective clinical governance arrangements are in place throughout the organisation through receipt of exception reports from relevant Directors to demonstrate that they have discharged their accountability for parts of their portfolios relating to assurance of clinical quality. This covers the areas of practice effectiveness, drugs and therapeutics, infection prevention and control, diversity, information governance and clinical documentation, reducing restrictive physical interventions, medical education, safeguarding children and adults, research and development, regulatory compliance, and health and safety.
4. To provide assurance to Trust Board that the Trust is meeting national requirements for clinical quality, clinical governance and clinical safety.
5. To assure Trust Board that the Executive Management Team and Care Groups have systems in place that encourage and foster greater awareness of clinical quality, clinical governance and clinical safety throughout the organisation, at all levels.

Compliance

6. To monitor, scrutinise and provide assurance to Trust Board on the Trust's compliance with national standards, including the Care Quality Commission, the quality elements relating to NHS England (NHSE) and NICE guidance.
7. To provide assurance to the Trust Board that the Trust is compliant with relevant legislation.
8. To provide assurance that the Trust has effective arrangements for the prevention and control of infection, safeguarding adults and children, information governance and records management.

Clinical safety management

9. To provide assurance to the Trust Board that environmental risks, including those identified as a result of PLACE inspections or environmental audit, are addressed and monitor appropriate action plans to mitigate these risks.
10. To provide assurance to the Trust Board that robust arrangements are in place for the proactive management of complaints, adverse events and incidents, including scrutiny of quarterly and annual reports on incidents and complaints and implementation of action plans.
11. To provide assurance to Trust Board that there are robust systems for learning lessons from complaints, adverse events and incidents, and action is being taken to minimise the risk of occurrence of adverse events.
12. As delegated by Trust Board, to monitor implementation of action plans relating to reviews of complaints by the Health Service Ombudsman and of action plans identified through independent inquiry reports relating to the Trust.

Public and service user experience

13. To provide assurance that there are appropriate systems in place to enable the views and experiences of service users and carers, and clinicians to shape service delivery.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting wherever practical. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees. When a new Committee is formed it is incumbent upon all Committees to ensure that there are clear lines of accountability and that workplans / responsibilities are aligned and work is not duplicated. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

Reports being received as per the internet meetings governance framework

Ensure that the terms of reference template allows for the clear capture of information required by and reporting requirements into each committee

Next review due: April 2025

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Equality, Inclusion & Involvement Committee
Annual Work Programme
2024-2025

Agenda item/issue	Jun	Sept	Dec	Mar
Section 1 - Standing items				
Declarations of Interest	X	X	X	X
Minutes of previous meeting and action log	X	X	X	X
Actions from Trust Board	X	X	X	X
Consideration of items from the corporate/organisational risk register allocated to the Committee	X	X	X	X
Context report – national, regional & local	X	X	X	X
Section 2- Insight, feedback and programme updates				
Insight report (twice yearly)		X		X
Staff network report	X	X	X	X
Care group highlight report (previously called BDU report)	X	X	X	X
Patient/public story/campaign (film)	X	X	X	X
Sustainability reporting (twice yearly)	X		X	
Section 3 – Strategy & Policy				
Equality, inclusion & involvement annual action plans				X
Overview of equality inclusion & involvement policies as appropriate (review every 3 years)				X
Section 4- Performance Reports				
Performance dashboard	X	X	X	X
Equality & involvement action plan highlight report • Staff survey • Inclusive leadership and development programme	X	X	X X X	X
Equality Standard update (WRES & WDES)	X	X	X	X
Equality Delivery System 2 (EDS2) update		X		X
Internal audit reports as appropriate	X	X	X	X

Section 5 - Annual items				
Equality, involvement, communication and membership Annual Report for Trust Board (deferred to December)		~~X~~	X	
Workforce Disability Equality Standard (WDES) for Trust Board		X		
Workforce Race Equality Standard (WRES) for Trust Board		X		
Commitment to carers report			X	
Committee strategy session		X	X	
Section 6 Governance				
Committee annual report				X
Revised Committee membership & ToR as necessary				X
Annual review of Committee effectiveness				X
Section 7 – Standard Closing Items				
Agreement of Committee meeting dates and work programme for following year			X	
Items to bring to the attention of Trust Board	X	X	X	X
Review of risks	X	X	X	X
Work programme	X	X	X	X

NHS
South West Yorkshire Partnership
NHS Foundation Trust

EQUALITY, INCLUSION AND INVOLVEMENT COMMITTEE
Terms of Reference
To be approved by Trust Board 30 April 2024

The Committee is a Committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by the Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Equality, Inclusion Involvement Committee's prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through involvement and promoting the values of inclusivity and treating people with respect and dignity. The Committee will develop and oversee a strategy, including an approach to positive action, to improve access, experience and outcomes for people from all backgrounds and communities, including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities. On behalf of the Trust Board, it will have oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Equality, Inclusion and Involvement Committee is chaired by a Non-Executive Director. At least one other Non-Executive Director also sits on the Forum as well as relevant Directors of the Trust.

Membership as at 1 April 2024
Chair – Chair of the Trust – Marie Burnham
Non-Executive Director – Erfana Mahmood
Non-Executive Director – Mike Ford
Chief Executive – Mark Brooks
Dawn Lawson – Director of Strategy (Lead Director)
Chief People Officer – Greg Moores

Attendance
Technical support is provided by the Trust Marketing, Communication, Engagement and Inclusion Lead who is a regular attendee at Committee meetings. A Governor (appointed by the Members' Council), the staff side representative with lead for equality and diversity, a representative from each of the staff equality networks (when required), and a representative for each BDU equality forum, is also invited to attend meetings. Other directors and relevant officers attend the Committee by invitation. Administrative support is provided by the Personal Assistant to the Lead Director.

Quorum
The quorum will be half of the membership which must include one Non-Executive Director and one Director; however, members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of four times per year and be reviewed every twelve months.

Duties

- To promote the values of inclusivity, mainstreaming equality, diversity, involvement and inclusion across the Trust.
- To monitor, scrutinise and provide assurance to Trust Board that the Trust has a co-ordinated approach to promoting the values of inclusivity developed in partnership with other key stakeholders including service users, carers, staff and Members' Council.
- To monitor and provide assurance to Trust Board that the Trust is embedding diversity and inclusion and involvement in all its activities and functions.
- To provide assurance to Trust Board that the Trust is advancing equality of opportunity and fostering good relations with all communities that its serves
- To monitor, scrutinise and provide assurance to Trust Board that the Trust is compliant with legal and national guidance, including Equality Delivery System (EDS2), the Workforce Race Equality Standard (WRES), and the Workforce Disability Equality Standard (WDES).
- To agree an annual work plan that links to the Trust's strategic direction, workforce plan and the wider priority programmes and to monitor progress.
- To monitor implementation of strategic objectives relevant to sustainability, providing assurance to Trust Board that these are appropriately managed and resourced.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the approved minutes of Committee at the next Trust Board meeting following the Committee meeting at which they are approved. The Committee will also report to the Board annually on its work (see above).

All Trust Board committees have a responsibility to ensure they foster and maintain relationships and links between the Forums / Committees and Trust Board. Each committee also has a responsibility to ensure actions identified and agreed are placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.
Trust Board will receive bi-annual updates from the Committee about the management and resourcing of strategic objectives relevant to sustainability.

Reporting requirements into the Committee

The Equality Inclusion and Involvement Committee received regular performance reports on Equality Standards, Equality Delivery System and Equality Impact Assessments., plus feedback from staff networks and development programmes.

The Committee receives the annual reports on equality and diversity, Workforce Disability Equality Standard and Workforce Race Equality Standard before submission to Trust Board.

The Committee will receive an annual Equality Inclusion and involvement report.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

For review in April 2025

FIP Workplan 2024/25			April	June	July	September	October	November	January	March
Standard Items	Lead	Type								
Welcome & Apologies for absence	Chair	Verbal	X	X	X	X	X	X	X	X
Declarations of Interest	Chair	Verbal	X	X	X	X	X	X	X	X
Minutes of meetings	Chair	Paper	X	X	X	X	X	X	X	X
Matters arising & action log	Chair	Paper	X	X	X	X	X	X	X	X
Actions delegated to FIP from Trust Board	Chair	Paper	X	X	X	X	X	X	X	X
Finance										
Monthly Finance Report*	FD	Paper	X	X	X	X	X	X	X	X
West & South Yorkshire Collaborative Financial Updates	FD	Paper	X	X	X	X	X	X	X	X
Forecast Update	FD	Paper		X	X	X	X	X	X	X
Financial Sustainability	FD	Paper		X		X		X		X
Non-Recurrent expenditure update & tracker	FD	Paper			X				X	
Costing Update	FD	Paper		X		X		X		X
Annual Plan	FD	Paper	X						X	X
Investment										
Bids & Tenders	FD	Paper	X				X			
MHIS Investment Progress Report	FD	Paper		X		X		X		X
Capital Focussed Progress Report	FD	Paper	X		X		X		X	
Investment Requests	TBC	Paper	Ad-hoc							
Performance										
Monthly Performance Review	TBC	Paper	X	X	X	X	X	X	X	X
Risk Register	FD	Paper	X	X	X	X	X	X	X	X
Financial Benchmarking	FD	Paper		X		X		X		X
Performance Benchmarking	COO	Paper		X		X		X		X
Other										
Waiting List Report	COO	Paper	X		X		X		X	
Horizon Scanning	FD	Paper	Ad-hoc							
AOB	Chair	Verbal	X	X	X	X	X	X	X	X
Next Meeting Date	Chair	Verbal	X	X	X	X	X	X	X	X
Meeting Evaluation & confirmation of										
Effectiveness	Chair	Verbal	X	X	X	X	X	X	X	X
Alert, Advise, Assure - Items to report to Board	Chair	Verbal	X	X	X	X	X	X	X	X
Changes in level of assurance	Chair	Verbal	X	X	X	X	X	X	X	X
Agreed Actions	Chair	Verbal	X	X	X	X	X	X	X	X
Review Workplan	Chair	Paper	X	X	X	X	X	X	X	X
Items to redact from public facing minutes due to being commercial in confidence	Chair	Verbal	X	X	X	X	X	X	X	X

South West Yorkshire Partnership NHS Foundation Trust

FINANCE, INVESTMENT & PERFORMANCE COMMITTEE
Terms of Reference
To be approved by Trust Board 30 April 2024

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Finance, Investment & Performance Committee was established in 2019. The Terms of Reference of the Committee will be reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Finance, Investment & Performance Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Finance, Investment & Performance Committee's prime purpose is to provide oversight and challenge of the Trust's financial performance and financial plans to ensure the Trust and the services it provides remain financially sustainable. It will also review capital plans with particular focus on the scrutiny of major investments, including post evaluation reviews. The committee will also review the overall performance metrics of the Trust to identify key trends and issues. This may result in direction being given to other committees of the Board to carry out more detailed review and determine where corrective action needs to be taken. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors and three executive Directors. At least one Non-Executive member of the Committee should have recent and relevant financial experience.

Membership as at 1 April 2024
Chair – Non-Executive Director – David Webster
Non-Executive Director – Natalie McMillan
Non-Executive Director – Kate Quail
Director of Finance and Resources – Adrian Snarr (lead executive)
Chief Operating Officer – Carol Harris

Attendees as required.
Director of Nursing, Quality and Professions – Darryl Thompson
Interim Chief People Officer – Lindsay Jensen
Deputy Director of Finance – Robert Adamson
Deputy Director of Corporate Governance – Julie Williams

Attendance

The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Chair of the Trust, other Directors, and relevant officers attend the Finance, Investment and Performance Committee by invitation. The Director of Nursing, Quality and Professions will be asked to attend Committee when there are such items on the agenda that would warrant his attendance e.g. when discussing cost improvement projects or other measures to underpin our financial position. Administrative support is provided by the Personal Assistant to the Lead Director.

Quorum

The quorum will be two Non-Executive Director members and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The frequency of meetings was updated in March 2023 monthly meetings to 8 meetings per year.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Duties

<u>Finance</u>

The Committee will focus on the following in respect of the financial affairs of the Trust:

- Oversee and evaluate financial strategy;
- Seek assurance on delivery of financial and operational targets (through the integrated performance report);
- Consider forecasts for financial and operational information;
- Assess risks and seek assurance on mitigating action;
- Review proposed annual financial plan;
- Review proposed three and five year financial plans;
- Seek assurance on delivery of the cost improvement programmes (CIPs);
- Oversee delivery of the financial sustainability plan;
- Review Trust's service line financial reporting; and
- Consider the Trust's performance using benchmarking information including that included in the model hospital.

<u>Investment</u>

The Committee will focus on the following in respect of Trust investments:

- Approve business cases as required by Trust Standard Financial Instructions (SFIs) and oversee the post implementation review process for these; and
- Review the annual, three year and five year capital plans for the Trust.

Performance

The Committee will focus on the following in respect of Trust performance:

- Review areas of performance through deep dives into areas of focus and concern related to the integrated performance report. This will include reviewing issues and risks for corrective action.
- Provide information to other Trust committees on these key trends and issues which may require corrective action to be taken; and
- Receive and review NHS benchmarking reports.

In carrying out its work, the Committee will primarily utilise internal expertise. Where required it will seek reports and assurances from Directors and managers concentrating on the delivery of financial plans, investment criteria and over-arching Trust performance.

Relationship with the Members' Council

At the discretion of the Chair of the Committee and/or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Next review due: April 2025

South West Yorkshire Partnership NHS Foundation Trust

Mental Health Act Committee annual work programme 2024-25

Agenda item/issue	May 2024	Aug 2024	Nov 2024	March 2025
1. Standard opening Items				
Introductions, Apologies, Notice, Quorum, Declaration of interests	X	X	X	X
Actions delegated from Trust Board	X	X	X	X
2. Quality Improvement				
The Act in practice	X	X	X	X
CQC State of Care Report	X			
CQC Improvement plan – (when received)				
CQC monitoring the MHA report 2020/21	X			
Updates from Independent Hospital Managers	X	X	X	X
Service user engagement/experience	X	X	X	X
3. Key Clinical Risks				
Update on topical, legal and regulatory risks & Horizon Scanning	X	X	X	X
Focus on the clinical impact /risks relating to the use of the Mental Health Act/Mental Capacity Act/Deprivation of Liberty	X	X	X	X
Consideration of items from organisational risk register relevant to MHA Committee and any Exception Reports as required	X	X	X	X
4. Compliance and Assurance				
Quarterly Monitoring information – Mental Health Act statistics	X	X	X	X
Independent Hospital Managers' - Forum notes	X	X	X	X
Compliments, complaints and concerns in relation to the Mental Health Act	X	X	X	X
Noting the policies relating to the Mental Health Act and Mental Capacity Act agreed by Executive Management Team	X	X	X	X
MHA/MCA Code of Practice Oversight Group feedback	X	X	X	X
MHA/MCA/DoLs mandatory training update	X	X	X	X
Audit and compliance reports	X	X	X	X
Care Quality Commission MHA visit reports & outstanding action/progress reports	X	X	X	X
Cancellation of escorted S17 leave	X	X	X	X

Agenda item/issue	May 2024	Aug 2024	Nov 2024	March 2025
Contemporaneous record of capacity to consent to treatment	X	X	X	X
Record of RC providing outcome of SOAD review to service user	X	X	X	X
5. Standard Closing items				
Issues and items to bring to the attention of Trust Board & other Committees	X	X	X	X
Committee Work Programme	X	X	X	X
Annual items – Audits/ reviews				
Contemporaneous record of capacity to consent to treatment - review				X
RC responsibility to provide Second opinion reasons to service user - review				X
Section 132 (patients' rights) – MHA Office Deep dive	X			
Advocacy services report (Independent Mental Capacity Advocate / Independent Mental Health Act Advocate / general advocacy)	X			
Community Treatment Order review			X	
Annual review of Hospital Managers' arrangements			X	
Section 17 leave review				X
Annual CQC report		X		
Annual MHA Performance Report		X		
Mental Health Act Committee annual report to Trust Board				X

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MENTAL HEALTH ACT COMMITTEE
Terms of Reference
To be approved by Trust Board 30 April 2024

All Trust Board Committees are responsible for scrutiny and providing assurance to Trust Board on key issues allocated to them by the Board. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. It is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Mental Health Act Committee is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Mental Health Act Committee is chaired by a Non-Executive Director. Two other Non-Executive Directors also sit on the Committee as well as relevant Directors of the Trust.

Membership as at 31 March 2024
Chair – Non-Executive Director - Kate Quail
Non-Executive Director – Erfana Mahmood
Non-Executive Director – Mandy Rayner (Griffin)
Lead Director – Chief Medical Officer - Prof Subha Thiyagesh
Chief Nurse and Director of Quality & Professions – Darryl Thompson

Attendance
One Independent Associate Hospital Manager (the Chair of the Hospital Managers' Forum), is invited to attend each meeting. The Director of Services (Adults and Older Peoples Mental Health), the Associate Director of Legal Services; and Clinical Legislation Manager are in attendance at meetings. The Committee also has scope to invite other external individuals on an ad-hoc basis where it is felt expertise or specialist advice is required.

The Chief Executive, other Directors, and relevant officers attend the Mental Health Act Committee by invitation. Administrative support is provided by the Personal Assistant to the Chief Medical Officer.

Quorum

The quorum will be two Non-Executive Director members and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of four times per year to reflect availability of quarterly reports.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees and reporting requirements into the Committee

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-groups including but not limited to:

- Associate Hospital Managers' Forum
- MHA/MCA Code of Practice Oversight Group – workstreams include: 136 MHA Policy; Leave implementation group; Seclusion and Segregation and Reducing Restrictive Practice; and Section 132/132a and 131 patients' rights

The Committee receives regular reports on risk and assurance including statistical information on the use of the MHA 1983 and MCA 2005 in the form of the quarterly performance report.

Duties

1. To monitor the Trust's implementation of, and compliance with, current mental health legislation and proposed changes to such legislation, in particular the Mental Health Act 1983 and the Mental Capacity Act 2005, within the Trust taking into account best practice.
2. To consider the implication of any changes to legislation and regulations within a local context.
3. To receive reports from Associate 'Hospital Managers' in their role of hearing appeals and to scrutinise the processes for and outcome of appeals and tribunals.
4. To ensure there is an appropriate number of Hospital Managers in place with the appropriate skills and experience to fulfil their role.
5. To monitor trends in the application of the Mental Health Act 1983 (and any new Mental Health Acts or revisions to the existing Act) within the Trust and make recommendations where necessary.
6. To receive reports following Care Quality Commission (CQC) Mental Health Act visits for

information and comment and to ensure appropriate action is agreed and implemented within the organisation.
7. To scrutinise delivery against the Trust's action plan developed as a result of the Care Quality Commission's Annual Report as instructed by Trust Board.
8. To receive Trust policies relating to the Mental Health Act and Mental Capacity Act which have been approved by the Executive Management Team.
9. To receive policies reviewed/updated by the Trust's Policy Group.
10. To scrutinise the application of these policies throughout the Trust.
11. To address training issues in terms of delegation of responsibilities under the Mental Health Act 1983.
12. To address quality issues in terms of delegation of responsibilities under the Mental Health Act 1983.
13. To manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation.
14. To request specific reports relevant to the application of the Mental Health Act.
15. To undertake duties relevant to the Committee set out in the 'Duties of Hospital Managers' Policy.
16. To provide assurance that there are appropriate systems in place to enable the views and experiences of service users, carers and clinicians to shape service delivery in relation to the Mental Health Act 1983 and the Mental Capacity Act 2005.
17. To consider, in all its functions, the experience and views of service users, carers and families, with a particular focus on those from vulnerable groups, Black Asian and Minority Ethnic communities and all those who have protected characteristics.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting at which the minutes are ratified, wherever practical.
The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal working groups.

Next review due: April 2025

NHS
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NHS Foundation Trust

People and Remuneration Committee
Annual Work Programme
2024-2025

Agenda item/issue	May	July	Sept	Nov	Jan	Mar	Comments
Section 1 – Standing items							
Declarations of Interest	X	X	X	X	X	X	
Minutes of previous meeting and action log	X	X	X	X	X	X	
Actions from Trust Board	X	X	X	X	X	X	
Chief People Officer remarks / updates	X	X	X	X	X	X	
Staff Stories	X	X	X	X	X	X	
Section 2- Performance and Assurance							
Organisational Development Tactical Update	X		X		X		
Integrated Workforce Performance Report	X	X	X	X	X	X	
Agency Scrutiny Group	X	X	X	X	X	X	
Freedom to Speak Up Steering Group Update [FTSU Guardian required to attend PRC twice a year – January and July]	X		X	X		X	**Information included in FTSU Annual Review report in July and in the FTSU 6 monthly report in January on the Workplan**
Update on Disciplinary and Employment Tribunal cases and any high-profile disciplinary investigations	X	X	X	X	X	X	
Workforce Internal Audit Reports	X	X	X	X	X	X	
Guardian of Safe Working Report – Quarterly report (including Annual Report in May)	X		X	X		X	
Review of Off Payroll Appointments and IR35		X					
WRES Report and Action Plan			X				
WDES Report and Action Plan			X				

Staff Survey Results and Action Plan	X			X			
Wellbeing Annual Review		X					
Annual Review of Recruitment and Retention	X						
Annual Workforce Equality Report	X						
Mandatory Training Annual Report			X				
Section 3 – Strategy and Development							
Freedom to Speak Up Annual Review with 6 monthly update		X			X		
Operational Workforce Plan			X			X	**Workforce Plan actioned without National guidance being received**
Great Place to Work Strategy – Annual Review and Objective Setting			X				
Great Place to Work Strategy – Report on Delivery Plan	X	X	X	X	X	X	
Flexible Workforce Including Bank and Agency				X		X	
Gender Ethnicity and Disability Pay Gap Audits and Action Plan	X						
Section 4 - Risk							
Strategic Workforce Risks	X	X	X	X	X	X	
Section 5 - Governance							
Committee Annual Report including Effectiveness Review						X	
Review of Terms of Reference						X	
Agreement of Work Programme for following year						X	
Consultants Clinical Excellence Awards			X				
Review of Executive Directors' Pay			X				
Annual Review of Executive Directors' performance and objective setting		X					
Appointment of Executive Directors	X	X	X	X	X	X	
Directors' Remuneration	X	X	X	X	X	X	

Remuneration arrangements for senior management posts outside of Agenda for Change	X	X	X	X	X	X	
Approval of senior managers' redundancy / termination pay	X	X	X	X	X	X	
Reporting of any redundancy payments	X	X	X	X	X	X	
Section 6 – Standard Closing Items							
Items to bring to the attention of Trust Board/Corporate Trustee	X	X	X	X	X	X	
Work programme	X	X	X	X	X	X	
Agree redactions for minutes going to public board	X	X	X	X	X	X	
Any other business	X	X	X	X	X	X	

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PEOPLE AND REMUNERATION COMMITTEE
Terms of Reference
To be approved by Trust Board on 30 April 2024

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The People and Remuneration Committee (formerly known as Workforce and Remuneration Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role and revised membership.

The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose

The People and Remuneration Committee has delegated authority for developing and determining appropriate pay and reward packages for the Chief Executive and Executive Directors and a local pay framework for senior managers as appropriate that actively contribute to the achievement of the Trust's aims and objectives.

The Committee also has delegated authority to approve any termination payments for the Chief Executive and Executive Directors. Additionally, the Committee is responsible for ratifying Clinical Excellence Awards for Consultant Medical Staff.

The Committee also supports and monitors the Great Place to Work Strategy and considers issues and risks relating to the broader People strategy.

On behalf of Trust Board, it reviews in detail key workforce performance issues, and takes ownership of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, and giving assurance to the Board around the management of such risks.

The Committee will support the development of an organisational culture where staff feel free, safe and able to raise concerns at work without fear of suffering a detriment. This includes supporting the lead Freedom to Speak Up Guardian to actively encourage and promote the Trust's commitment to the principles of Freedom to Speak Up which ensures the safety and welfare of Staff, Service Users, Carers and Visitors.

In August 2022 a decision was taken to separate the people and remuneration aspects of the Committee and the terms of reference were amended to reflect this new structure.

Membership, attendance and duties for each part of the Committee are stipulated below.

The Committee will deal with people matters at all meetings. Should any remuneration matters arise, through update or as part of an annual process they will be added to the agenda. Remuneration must be discussed by the Committee at least once a year to approve the remuneration report as part of the Annual report and accounts.

Membership

Membership of the Committee is comprised of the Chair of the Trust, two Non-Executive Directors and the Chief Executive.

Membership for People and Remuneration items as at 1 April 2024
Chair – Non-Executive Director – Mandy Rayner
Non-Executive Director – Marie Burnham (Chair of the Trust);
Non-Executive Director – Nat McMillan;
Chief Executive (non-voting Committee member) – Mark Brooks.

Attendance

People items
The Chief People Officer is in attendance at meetings as lead Director and provides advice and support to the Committee. The Chief Operating Officer is also in attendance. Administrative support is provided by the Personal Assistant to the Chief People Officer. Also in attendance, at the request of the Committee will be members of the People Directorate, Senior Leadership team and the Deputy Director of Corporate Governance.

Remuneration items
The Chief Executive is a non-voting member of the Committee and will take no part in or be present for any items relating to his/her own personal remuneration or conditions of service. The Chief People Officer is in attendance at meetings as lead Director and provides advice and support to the Committee. Administrative support is provided by the Personal Assistant to the Chief People Officer.

Quorum

People and Remuneration
The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of the Chief Executive, the Chair of the Committee will decide whether it is appropriate for the Deputy Chief Executive to attend as a non-voting member.

Frequency of meetings

People
The Committee will meet no less than four times per year to discuss people matters.

Remuneration
The Committee will meet no less than once a year to discuss remuneration matters.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

People and Remuneration
The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent

professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

People

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees including but not limited to:

- Clinical Excellence Awards Panel.

Remuneration

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Duties

People

1. To approve recommendations of the Clinical Excellence Awards Panel for Clinical Excellence Awards to Consultant Medical Staff.
2. To support the strategic development of human resources and workforce development and consider issues and risks relating to the broader workforce strategy.
3. On behalf of Trust Board, to monitor progress of the Workforce Strategy and review in detail key workforce performance issues.
4. To have oversight of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.
5. To consider future national developments which could impact on the Trust's strategic workforce objectives.
6. To have oversight of the Trust's approach to Freedom to Speak Up including receiving at least 2 reports every year, one of which should be the annual report, from the lead Freedom to Speak Up Guardian.
7. On behalf of the Trust Board, to monitor progress of the Freedom to Speak Up Strategy and action plan and review in detail relevant performance indicators.
8. To listen to staff experience and stories at each meeting.
9. To receive regular reports from the Guardian of Safe Working.
10. To receive regular reports and updates from the Agency Scrutiny Group.

Remuneration

1. To develop and determine appropriate pay and reward packages for the Chief Executive, Executive Directors and other designated senior managers and other locally determined pay arrangements that actively contribute to the achievement of the Trust's aims and objectives, are affordable and are in line with the Trust's financial strategy. Specifically to:

   a) determine the remuneration arrangements for Executive Directors and to agree individual salary levels for Executive Directors;
   b) to determine any annual uplift, for example, cost of living, for the Chief Executive and Executive Directors;
   c) to ratify remuneration arrangements for senior management posts;
   d) to approve any annual uplifts in pay structures and any performance-related pay arrangements for senior posts;
   e) to approve any termination payments to the Chief Executive and Executive Directors and ensure these are properly calculated and reasonable with regard to probity and value for money;
   f) to receive a report from the Chief Executive of any proposed termination payments to be made to senior managers.

2. Under delegated authority from Trust Board as deemed appropriate for each circumstance, to agree and oversee the process for the appointment of the Chief Executive and Executive Directors of the Trust.
3. To receive an annual report from the Chief Executive documenting the performance of executive directors in relation to the achievement of the Trusts Strategic Objectives.

Monitoring

People and Remuneration

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

People and Remuneration

Trust Board will receive the minutes of the Committee at the next Trust Board meeting following the Committee meeting. Confidential personnel matters will go to the private session of Trust Board, if appropriate, and the decisions of the Committee in relation to specific salary matters are reported to the Non-Executive Directors of the Trust only. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

South West Yorkshire Partnership NHS Foundation Trust

Collaborative Committee
Annual Work Programme
2024-25

Agenda item/issue	April	June	Aug	Oct	Dec	Feb
Section 1 - Standing items						
Declarations of Interest	X	X	X	X	X	X
Minutes of previous meeting and action log	X	X	X	X	X	X
Actions from Trust Board	X	X	X	X	X	X
Consideration of items from the corporate/organisational risk register allocated to the Committee	X	X	X	X	X	X
Section 2- West Yorkshire Adult Secure Provider Collaborative						
Minutes of West Yorkshire Adult Secure Provider Collaborative Board	X	X	X	X	X	X
Minutes of West Yorkshire Mental Health, Learning Disability and Autism Programme Board	X	X	X	X	X	X
West Yorkshire Adult Secure Provider Collaboratives Assurance Report (including finance and activity, commissioning, quality, contracting and risks)	X	X	X	X	X	X
2025/26 Commissioning intentions					X	
Phase 2 Provider Collaboratives	X	X	X	X	X	X
Section 3 – South Yorkshire and Bassetlaw Adult Secure Provider Collaborative						
Minutes of Provider Collaborative Oversight Group	X	X	X	X	X	X
Minutes of South Yorkshire and Bassetlaw Adult Secure Provider Collaborative Board	X	X	X	X	X	X

South Yorkshire and Bassetlaw Assurance Report (including finance and activity, commissioning, quality, contracting and risks)	**X**	**X**	**X**	**X**	**X**	**X**
2025/26 Commissioning intentions					**X**	
Section 4 - Annual items						
Collaborative Committee Annual Report for Trust Board						**X**
Section 5- Governance						
Committee annual report						**X**
Revised Committee membership & ToR as necessary						**X**
Annual review of Committee effectiveness						**X**
Section 6 – Standard Closing Items						
Agreement of Committee meeting dates and work programme for following year						**X**
Items to bring to the attention of Trust Board	**X**	**X**	**X**	**X**	**X**	**X**
Review of risks	**X**	**X**	**X**	**X**	**X**	**X**
Work programme	**X**	**X**	**X**	**X**	**X**	**X**

South West Yorkshire Partnership NHS Foundation Trust

COLLABORATIVE COMMITTEE

Terms of Reference – *To be approved by Trust Board on 30 April 2024*

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Collaborative Committee was established in May 2022. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Committee is subject to an Effectiveness Review every 12 months.

The Collaborative Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

Purpose

The Collaborative Committee's purpose is to ensure delineation between provision and commissioning responsibilities (finance, contracting, planning and quality assurance) of the West Yorkshire Adult Secure Provider Collaborative, South Yorkshire Adult Secure Provider Collaborative and other specialised mental health provider collaboratives as appropriate where SWYPFT is the Co-ordinating Provider, and to seek assurance that the Trust's commissioning responsibilities as Co-ordinating Provider are being fulfilled.

The Collaborative Committee will seek assurance on behalf of Trust Board that contractual monitoring, financial, quality and performance management of the Provider Collaboratives are being undertaking and ensure information taken to Trust Board is sound, valid and complete. On behalf of the Trust Board, the Committee will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Day to day provision of patient care will continue to be the responsibility of Providers within the relevant collaborative.

This approach will ensure delineation between the provider and commissioning functions of the Provider Collaborative.

Membership

Taking guidance from Monitor (referred to as NHS England) and the Department of Health into consideration, neither the Chair of the Trust or the Chief Executive attends this Committee unless invited to do so. The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors.

Membership of the Committee is as follows:

Chair – Non-Executive Director – Mike Ford
Non-Executive Director- Chair of Finance, Investment and Performance Committee- David Webster
Non-Executive Director- Erfana Mahmood

Attendance

Representatives are also invited and expected to attend as follows.

- Executive Lead Director for Commissioning (Director of Finance and Resources)
- Chief Medical Officer
- Assistant Director of Corporate Governance, Performance and Risk
- Head of Commissioning (West Yorkshire Specialised Provider Collaborative Commissioning Hub)
- Provider Collaboratives Director (SYB Mental Health Provider Collaborative Commissioning Hub)
- Associate Director Provider Collaboratives and Planning
- Clinical Lead (West Yorkshire Adult Secure Provider Collaborative)
- Clinical Director (SYB Mental Health Provider Collaborative Commissioning Hub)
- Quality and Governance Leads (West Yorkshire Commissioning Hub)

The Chair of the Trust, the Chief Executive, other Directors, and relevant officers attend the Collaborative Committee by invitation. Administrative support is provided by Corporate Governance admin support team.

Quorum

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

Frequency of meetings

The Committee will meet a minimum of bi-monthly. The Chair of the Committee may request an additional meeting if they consider one is necessary.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference. The Committee work programme will be agreed at the beginning of each year and the commissioning risks facing the organisation, and agreed with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain external legal or other independent professional advice and to secure the attendance of external bodies or individuals with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

The Collaborative Committee will receive minutes and/or reports from the following groups and any other relevant groups as considered appropriate:

- West Yorkshire Adult Secure Provider Collaborative Board.
- South Yorkshire and Bassetlaw Adult Secure Provider Collaborative Oversight Group.
- West Yorkshire Specialised Mental Health Learning Disability and Autism Programme Board.
- South Yorkshire and Bassetlaw Provider Collaborative Partnership Board.

Duties

Financial assurance

The Committee shall receive updates on the financial performance of the Provider Collaboratives and seek assurance that effective financial governance systems and processes are in place. In particular, the Committee will:

- Maintain oversight of the financial position of the Provider Collaboratives, for which SWYPFT is the Co-ordinating Provider.
- Seek assurance from the Provider Collaboratives for which SWYPFT is the Co-ordinating Provider of the robustness of the risk assessments underpinning financial forecasts.
- Provide onward assurance to the SWYPFT Board that financial planning is effectively established and managed, and that risks to delivery of plans and any significant service impacts or risks are effectively managed or mitigated.
- Following review and recommendation from the relevant Provider Collaborative Oversight Group (e.g. WY Adult Secure Provider Collaborative Board and SYB Provider Collaborative Oversight Group), ratification of business cases (for both new service proposal and reduction of service delivery and investments and/or disinvestments).
- Seek assurance of in year performance against commissioned services and financial plans and examine the effectiveness of any remedial action plans.
- Seek assurance on the delivery of agreed improvement programmes to reduce cost and increase efficiency including assurance on benefits realisation and value for money.

The Committee will ensure that the systems for, and content of, financial reporting to Trust Board, are subject to review so as be assured of the completeness and accuracy of the information provided to Board.

Contracting

The Collaborative Committee will:

- Seek assurance that for Provider Collaboratives where SWYPFT is Co-ordinating Provider contracts are negotiated in line with standard procedures, and implemented enabling the Provider Collaborative to deliver its aims.
- Agree formal Commissioning Intentions.

Risk Management

The Collaborative Committee will:

- Receive Provider Collaborative risk registers, where SWYPFT is Co-ordinating Provider.
- Discuss and review any issue likely to require inclusion on, or modification to the risk register.
- Escalate risks to Trust Board where required.

Oversight of quality assurance and improvement

The Collaborative Committee will:

- Seek assurance from the relevant Provider Collaborative oversight group (e.g. WY Adult Secure Provider Collaborative Board and SYB Provider Collaborative Oversight Group) that the Provider Collaboratives have robust processes in place to monitor performance, including out of area placements.
- Seek assurance from the relevant Provider Collaborative oversight group that robust processes are in place to monitor the quality of provision of provider collaborative partners, and provider onward assurance to Trust Board.
- Seek assurance from the relevant Provider Collaborative oversight group that there are governance arrangements in place to manage quality concerns including those identified as a result of case manager reviews, incidents, or external review inspections are addressed and monitored, and appropriate action plans are in place to mitigate these risks, and provide onward assurance to Trust Board.
- Seek assurance that that there are robust systems for learning lessons from complaints, adverse events and incidents, and action is being taken to minimise the risk of occurrence of adverse events.
- To provide assurance to Trust Board that there are robust systems for learning lessons from complaints, adverse events and incidents, and action is being taken to minimise the risk of occurrence of adverse events.

Other Assurance Functions

The Collaborative Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the Provider Collaborative.

These will include any reviews by the Department of Health and Social Care, arms-length bodies, or regulators/inspectors (e.g. Care Quality Commission and NHS Improvement, NHS Resolution, etc) professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring

implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

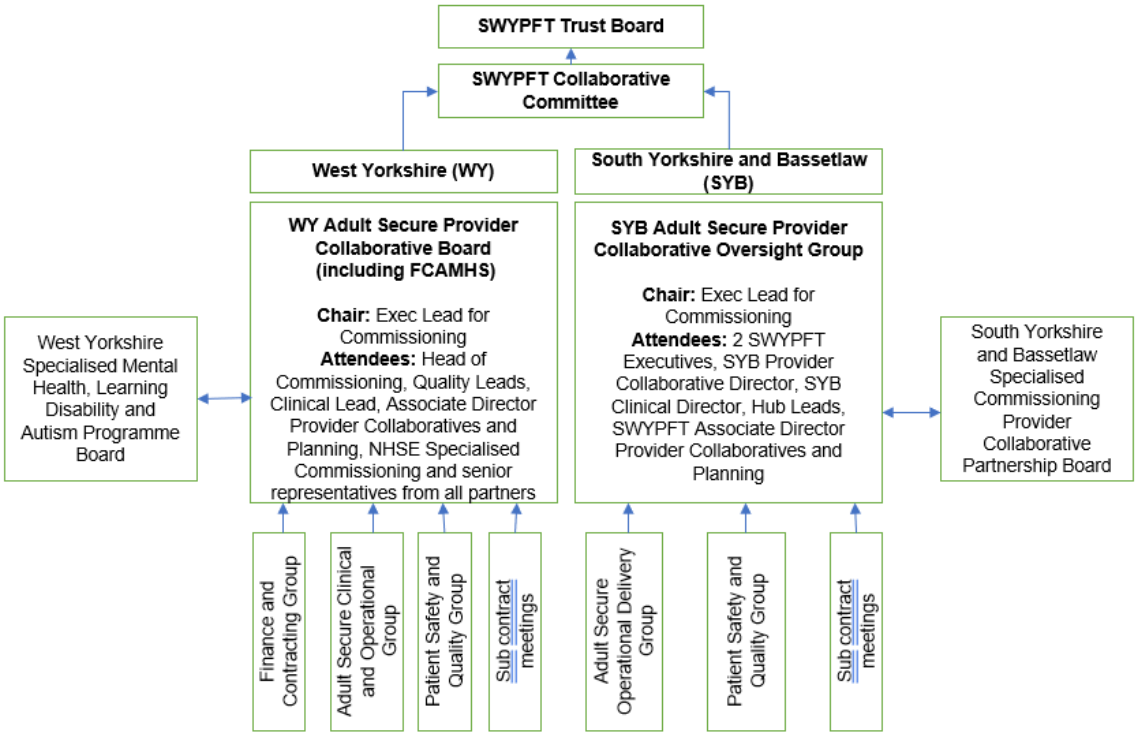
Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. Minutes will only being available to Private Board due to commercial sensitivity. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Next review due: 12 months

Appendix 1: Provider Collaborative Governance



South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 12.2

Private/Public paper:	**Public**		
Title:	**Going Concern Basis**		
Paper presented by:	**Adrian Snarr – Director of Finance, Estates and Resources**		
Paper prepared by:	Rob Adamson – Deputy Director of Finance		
Mission/values:	Use of resources		
Purpose:	To enable the Board to make a decision that the 2022/23 accounts and financial statements are prepared on a going concern basis.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work	✓	
BAF Risk(s):	Risk 3.1 - Increased system financial pressure combined with increased costs and a failure to deliver value, efficiency and productivity improvements result in an inability to provide services effectively		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	By confirming the 2023 / 24 accounts and financial statements are prepared on a going concern basis the Trust Board ensures the organisations effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnership and Integrated Care Board, and place-based partnerships.		
Any background papers / previously considered by:	Regular finance report provided at each Board meeting. Detailed finance and planning reports provided at the monthly Finance, Investment & Performance Committee.		
Executive summary:	• International Accounting Standard (IAS) 1 - Presentation of financial statements – Part of IAS 1 sets out one of the minimum requirements for concepts as “going concern”. It requires organisations to disclose issues that would affect longevity, if any, and also set out their confidence with resources being able to sustain the business for the foreseeable future. • There is a requirement for the directors of an organisation to confirm whether or not it is appropriate for the accounts of that organisation to be prepared on a “going concern” basis. • The auditors of the Trust are required to evaluate the management’s adoption of the going concern basis and their assessment of any material uncertainties that may require disclosure.		

	• In 2020, the Public Audit Forum updated and simplified guidance on assessing going concern in its publication 'Practice note 10'. It was determined that 'Practice Note 10' applied to the NHS. This means that the anticipated continued provision of service is a sufficient basis for going concern. • This remains supported in the updated NHS foundation trust annual reporting manual (FT ARM) and the HM Treasury Financial Reporting Manual (FReM). • The impact of this change is that the usual financial assurance will not be included in this paper. Instead, the focus will be on the evidence of an annual plan. • Despite continued changes to the NHS financial regime, the Trust has developed plans for the next financial year, in collaboration with relevant NHS partners. It is therefore expecting to continue to provide services for the foreseeable future. • A separate paper has been provided on the financial plan for 2024 / 25 and Board members have had the opportunity to engage with the submission of the plan and ratify it. The final financial plan for 2024 / 25 is for a break-even position, which looks achievable based on the assumptions made and recent financial performance.
Recommendation:	**Trust Board is asked to APPROVE the preparation of the 2023 / 24 annual accounts and financial statements on a going concern basis by adopting the following statement:** ***'After making enquires, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.'***

South West Yorkshire Partnership NHS Foundation Trust

Going Concern Basis

Introduction

There is a requirement for the directors of an organisation to confirm whether it is appropriate for the accounts of an organisation to be prepared on a "going concern" basis. The auditors of the Trust are expected to evaluate the management's adoption of the going concern basis and their assessment of any material uncertainties that may require disclosure.

In 2021/22 The Public Audit Forum updated and simplified guidance on assessing going concern.

"The Public Audit Forum issues guidance to auditors on how auditing standards should be applied in the public sector. Its publication 'Practice Note 10'1 was revised in late 2020. This updated guidance to auditors, approved by the Financial Reporting Council, explains that where the applicable financial reporting framework provides that the anticipated continued provision of services is a sufficient basis for going concern, then this should determine the extent of the auditor's procedures on going concern.

This remains the case in the NHS, with the DHSC Group Accounting Manual (GAM) and NHS foundation trust annual reporting manual (FT ARM) both based on the HM Treasury Financial Reporting Manual (FReM) where this definition applies."

The NHS foundation trust annual reporting manual still reflects this change. The main point is captured in the quote below.

"An NHS foundation trust's assessment of whether the going concern basis is appropriate for its accounts should therefore only be based on whether it is anticipated that the service it provides will continue to be provided with the same assets in the public sector. This is expected to be the case for NHS foundation trusts unless exceptional circumstances indicate otherwise."

The (FT ARM) goes on to clarify that

"Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept."

For the reasons given above, the Trust no longer has to provide evidence regarding financial sustainability, as has been the case in previous years. This is covered in in risk disclosures and other performance reports. The section below, will instead, focus on the organisation's planning process.

The Trust has submitted a breakeven financial plan for 2024 / 25 as approved by Trust Board in April 2024 and shared with West Yorkshire Integrated Care Board.

This plan is based on the assumption that services provided by the Trust will continue for at least the next twelve months. This meets the condition, outlined above, that the organisation is expected to deliver services for the foreseeable future.

Directors should consider all available information about the future when concluding whether the company is a going concern at the date, they approve the financial statements. Their review

should usually cover a period of at least twelve months from the date of approval of annual and half-yearly financial statements.

Directors should make balanced, proportionate and clear disclosures about going concern for the financial statements to give a true and fair view.

Directors should disclose if the period that they have reviewed is less than twelve months from the date of approval of annual and half-yearly financial statements and explain their justification for limiting their review.

It should be noted that as per section 2.1*3* of the foundation trust annual reporting manual there is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

Section 2.14 of the annual reporting manual does state 'The anticipated continuation of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern.''

Recommendation

Given the above it is considered appropriate the Trust continues to report on a going concern basis. It is therefore recommended the Trust Board approves the following statement for inclusion in the 2023 / 24 annual report:

'***'After making enquires, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.'***

[1] https://www.public-audit-forum.org.uk with link to Practice Note 10 document at bottom of page

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 30 April 2024
Agenda item 13.1

Private/Public paper:	**Public**		
Title:	**Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)**		
Paper presented by:	**Adrian Snarr - Director of Finance, Estates and Resources**		
Paper prepared by:	Andy Lister – Head of Corporate Governance (Company Secretary) Gemma Lockwood – Corporate Governance Manager		
Mission/values:	Policies and procedures covering core Trust systems and processes are a key part of the Trust's governance arrangements, supporting the Trust to achieve its mission and adhere to its values.		
Purpose:	To enable Trust Board to approve the Policy on Policies, a core policy for the Trust and reserved for Trust Board consideration and approval.		
Strategic objectives:	Improve Health	✓	
	Improve Care	✓	
	Improve Resources	✓	
	Make this a great place to work		
BAF Risk(s):	N/A		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Policies and procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust. A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that policies and procedures in use are current and reflect an organisational approach, including the Trust engagement with systems and partners.		
Any background papers / previously considered by:	The policy was previously approved by Trust Board on 25 April 2023. The policy on policies has been updated in April 2024 in line with recommendations following a policy management framework audit carried out by 360 Assurance. The audit received a significant assurance outcome, and all recommendations were all recorded as "low risk". The policy was reviewed by the Executive Management Team on 18 April 2024 and is submitted for approval by Trust Board.		
Executive summary:	The purpose of the Policy on Policies is: • to describe the approach to development and approval of policies and procedural documents • to provide a standard template for policy documents		

	• to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure • to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance • to describe the process for version control to ensure people have access and are operating to the most current version • to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements. Following review, the following changes have been made: • The process for procedures has been updated to mirror to the process for policies. • A proforma has been added for procedures to be approved through the Operational Management Group (OMG), to align to the policies process. • The section containing Barnsley Care Group policies has been removed and absorbed into Trustwide policy processes. • The equality impact assessment (EIA) process has been updated with clarification around EIA sign off for People/Employment policies.
Recommendation:	**Trust Board is asked to:** • **APPROVE** the updates to the policy on policies.

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South West Yorkshire Partnership
NHS Foundation Trust

Document name:	**Policy for the development, approval and dissemination of policy and procedural documents (728)** **(Policy on Policies)**
Document type:	Policy
What does this policy replace?	Update of previous policy
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	April 2024
Next review:	April 2027
Approved by:	Executive Management Team – 18 April 2024 Trust Board – on approval
Developed by:	Director of Finance, Estates and Resources Deputy Director of Corporate Governance
Director leads:	Director of Finance, Estates and Resources
Contact for advice:	Deputy Director of Corporate Governance Head of Corporate Governance (Company Secretary)

Table of Contents

Policy for the development, approval and dissemination of policy and procedural documents

1. Introduction

Policies and procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust.

A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that policies and procedures in use are current and reflect an organisational approach.

2. Purpose

The purpose of this document is:

- to describe the approach to development and approval of policies and procedural documents.
- to provide a standard format and content for policy and procedure documents.
- to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure.
- to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance.
- to describe the process for version control to ensure people have access to – and are operating to – the most current version.
- to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements.

3. Definitions

- A **POLICY** is a high level statement. Each policy should specify its purpose and may also include a procedure setting out how the policy will be achieved. A policy enables management and staff to make correct decisions, deal effectively and comply with legislation, Trust processes and good working practices.

- A **PROCEDURE** is often incorporated into a policy or can be a 'standalone' document. Procedures are the practical way in which a policy is translated into action. They explicitly outline how to accomplish a task or activity, giving detailed instructions. A procedure often allocates specific roles that specific individual must undertake.

4. Principles

The fundamental action points of this policy are to ensure all policies are developed and updated using a consistent approach, ensuring such documents are regularly reviewed to reflect current guidance, and following their approval that policies are disseminated so that staff are aware of their responsibilities.

5. Duties

It is the policy of the Trust that all policy documents and procedure documents will:

- have an identified Director lead
- have a designated contact for advice
- identify who is responsible for taking action

The following duties apply to this policy;

5.1 Trust Board
Trust Board is responsible for approving this policy for the approval, dissemination and implementation of policies and procedures as outlined in this document.

Policies that require Trust Board approval are outlined in the Trust's Scheme of Delegation. These include policies which are likely to be of major strategic or political significance, such as those relating to the appointment, remuneration and dismissal of staff, policies relating to the management of financial or clinical risk and policies for management of complaints and claims. Approval may also be delegated by the Trust Board for approval by a committee through their Terms of Reference and the Scheme of Delegation.

5.2 Executive Management Team (EMT)
The Executive Management Team (EMT) will approve all other policies (see 5.3 below). The EMT will be responsible for ensuring the policy document has been developed according to this policy.

5.3 Directors
Each policy will have an appointed Lead Director. This Lead Director is responsible for the development of new policies and timely review of current policies in accordance with this policy on policies.

The lead Director for each policy will be responsible for engaging relevant stakeholders in the development of the policy and ensuring appropriate arrangements are in place for managing any resource implications, including dissemination, training and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation.

It is the responsibility of the lead Director for a policy to ensure that the document is appropriately consulted on during the development process by key stakeholders (see section 6.2.3) and to agree the most appropriate way to undertake such consultation.

Multi agency policies will have a lead Director who will be responsible for ensuring the policy has gone through the necessary approval process.

Some policies are delegated to Committee for approval as detailed in the Trust's Scheme of Delegation.

In the case of policies relating to medicines management, with the exception of the overarching medicines management policy and the medicines code, approval is delegated to the Drugs and Therapeutics sub-committee of the Quality and Safety Committee (previously Clinical Governance and Clinical Safety Committee), and it is the responsibility of the lead Director to ensure that these policies adhere to this policy.

Other policies that are specific or relevant to local clinical arrangements can be approved locally by appropriate mechanisms within Care Groups; however, where there are implications across the Trust or a policy will have an impact on resources, staffing, Trust strategy, reputation, etc., approval remains reserved for the EMT. Directors should seek the advice of the Company Secretary or the Corporate Governance Manager if in doubt.

Procedures and guidance notes may be developed and issued by the lead Director using the principles included in this document. The lead Director is responsible for engaging

relevant stakeholders in developing the procedure or guidance note, communicating the procedure and ensuring its implementation.

5.4 Director of Finance, Estates and Resources
The Director of Finance, Estates and Resources supported by the Deputy Director of Corporate Governance will, on behalf of Trust Board, ensure this policy is implemented and that documents are controlled in accordance with non-clinical records management requirements.

5.5 Care Groups and Trust Action Groups (TAGs)
Directors may engage Care Groups (including the Operational Management Group (OMG) and TAGs in developing and implementing policies or procedural documents. They have no authority to approve policies.

5.6 Specialist staff
Specialist staff have a role in developing and implementing policies and procedures but have no authority to approve policies or procedures. Specialist staff include areas such as Safeguarding, Infection Prevention and Control, and Equality and Involvement Managers.

5.7 Service managers
Service managers have a role in developing and implementing policies and procedures but have no authority to approve policies or procedures.

5.8 Staff
All staff need to be aware of policies and how they impact on their practice. All new policies approved by Trust Board, its committees and / or EMT are communicated through the staff briefing and via the intranet and / or internet. Staff have an individual responsibility to seek out this information.

5.9. Duties for this policy
The Trust Board is responsible for approving this policy.

The lead Director is the Director of Finance, Estates and Resources.

All staff who write policies need to be aware of this policy.

The Deputy Director of Corporate Governance, supported by the Company secretary, is responsible for overseeing the administration of this policy. This includes ensuring policies for approval are included in the relevant Trust Board or EMT agenda in a timely way, maintaining a corporate record of all current and past policy and procedure documents, and notifying lead Directors when a policy or procedure is due for review.

6. Process of developing, approving and reviewing policies

6.1 Style and format
All policies and procedures should be written in a style that is clear, concise and unambiguous. Titles should be kept simple to assist easy identification of the document.

Policy and procedural documents should follow Trust branding guidance. The standard font is Arial 12 point. Uppercase and underlining should be avoided except in headings. Page numbers should be used.

A template showing the structure and mandatory sections to be included is provided in **Appendix D.**

Acronyms and technical language should be explained, or a glossary included.

A checklist, included at the end of the policy document, is to be completed and submitted to the EMT, committee or Trust Board at the time of final approval to ensure the policy includes all required contents.

6.2 Development process

6.2.1 Identification of need

The need for a new policy or procedure may be prompted by a change in national legislation, policy or guidance or it may be identified within the Trust either as a result of learning from experience, such as complaints or incidents, or as a result of a risk being identified by a specialist advisor or Task and Action Group (TAG). New policies may also be required as a result of the development of a new service or new way of working.

The first step should be to establish whether a new policy or procedure is required or whether the requirement can be met by amending an existing policy or procedure.

The aim should be to keep the number of policies to a minimum. The lead Director should be able to provide a clear justification for the development of any new policy.

This policy has been developed to minimise risks associated with policies and procedures being written without appropriate authority or consideration of the impact of the policy and to prevent inconsistent application of policies as a result of failure to effectively communicate or disseminate a policy or procedure. No other document already in existence in the Trust covers this subject.

6.2.2. Undertaking Equality Impact Assessments

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer.

An Equality Impact Assessment (EIA) must be completed prior to the revision of an existing Trust Policy or writing of a new Trust Policy. A toolkit to support this process is included in **Appendix Di** to this document and guidance can also be found at:

An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

As part of stakeholder involvement, Equality, Inclusion/ Engagement Leads should be involved in the development or review of the EIA to ensure all equality and diversity requirements are included, prior to the review of the policy. If any negative impact is identified, the policy should be amended or (if this is not possible) an action plan to mitigate the negative impact must be included.

6.2.3 Stakeholder involvement

Consultation with relevant stakeholders secures ‘buy in’ and provides an opportunity to identify and eliminate potential barriers to implementation.

Policy authors may wish to consider the Core20PLUS5. This is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies ‘5’ focus clinical areas

requiring accelerated improvement. Further information is available on NHS England website;

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Policy holders may also consider the Trust social responsibility and sustainability strategy (2022 – 2027) to reduce disadvantage and inequalities, improving our environmental impact and achieving the Trust's mission of helping people to reach their potential and live well in their communities.

https://www.southwestyorkshire.nhs.uk/documents/green-plan/

The lead Director is responsible for ensuring relevant stakeholders have been consulted during the development of the policy. The following identifies some of the individuals or groups who might be consulted with. This is not an exhaustive list. Consideration should be given to digitally enabled care.

Stakeholder	**Level of involvement**
Executive Management Team (EMT)	Approval – (may also be involved at the outset in confirming the requirement for a new policy or agreeing the development process)
Directors	Initiation, lead, development, receipt, circulation
Care Groups (Including the Operational Management Group (OMG)	Development, consultation, dissemination, implementation, monitoring
Specialist advisors	Development (including EIA), consultation, dissemination, implementation
Service user and carers	Development, consultation
Professional groups and leaders	Development, consultation, dissemination, implementation
Trust Action Groups (TAGs)	Development, consultation, dissemination, implementation
Staff side	Development, consultation, dissemination
Trust learning networks	Consultation
Local Authorities	Development, consultation
Police	Development, consultation
Other NHS Trusts	Development, consultation
Universities	Consultation

For this document, the clinical leads, People Directorate, staff side, and the EMT were consulted. The Trust Board agreed when developing the Scheme of Delegation that responsibility for determining policy approval arrangements should be a decision reserved for the Trust Board.

6.2.4. Trauma informed organisation

All documents should be written in a way that ensures they are underpinned by the key principles of Trauma-Informed Care in line with the Trust becoming a Trauma-Informed organisation. Further information can be found on the following link;

https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice

This guidance provides a definition of trauma-informed practice, its key principles and how it can be built into services and systems.

6.3. Process for review, approval and ratification

6.3.1 Policies

The EMT receive the Policy Register monthly for the lead Director to note when policies are due for review.

The Corporate Governance Team (for corporate policies) and Quality Improvement and Assurance Team (QIAT) (for clinical policies) are responsible for notifying policy authors and the lead director when policies are due for review.

On receipt of notification, policy authors should first update the EIA for the relevant policy **(Appendix Di).** On completion of the EIA, it should be sent to the Equality and Involvement team (InvolvingPeople@swyt.nhs.uk) to ensure sign off is complete prior to submission to the EMT with the appropriate policy. The exception being HR/People and Employment Policies which should be sent to the Diversity, Inclusion and Belonging Lead to ensure sign off is complete prior to submission to the EMT with the appropriate policy.

An EIA must be completed for all policies that have not previously been subject to EIA. For revised policies an update of the EIA needs to be undertaken. Guidance can be found on the Trust intranet – An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

The policy author will review the policy. If no amendment is required, this should be reported to the EMT (or Trust Board) for ratification including the updated EIA by the policy review date. Policies should be submitted to EMT with a completed proforma for approval of policies; for clinical policies please contact the Quality Improvement & Assurance Team (QIAT) on qiat@swyt.nhs.uk and for corporate policies the Corporate Governance Team on; corporategovernanceteam@swyt.nhs.uk

If the policy requires amendment, this should be done in consultation with the updated EIA prior to presenting the revised policy to the relevant sub-group; Corporate Policy, Procedure and Risk Group (corporate policies) or Clinical Policy, Procedure and Risk Group (clinical policies) for review.

The Corporate Governance Team (for corporate policies) and Quality Improvement and Assurance Team (QIAT) (for clinical policies) will then send the policy for peer review to the Executive Director prior to submission to EMT.

For submission to EMT the policy and signed off EIA need a completed proforma for approval **(Appendix F).**

It should be noted that, for services that came to the Trust as part of transformation, there may be a number of policies that, over time, will need to be aligned. Existing policies will continue to be followed until this work takes place.

Each appointed lead Director for a policy will need to ensure that reviews include all existing policies that have been produced by previous organisations and that new / updated polices are clear which policies they replace.

Should the review of a policy be delayed, a request for extension should be presented to EMT by submitting a completed proforma (**Appendix G**). At the time of approval, all policies should have a clearly defined review date (maximum of three years). This may be brought forward if earlier review is required, for example because of an identified risk or change in national policy.

Policies requiring approval by Trust Board will be subject to review at EMT prior to submission to Trust Board for sign off.

The Company Secretary will notify and track Trust Policies for approval by Trust Board.

Policies requiring approval by EMT should be presented by the lead Director.

6.3.2 Procedures

Procedures and guidance notes, due to their operational nature, are likely to require more regular updates.

Where a procedure requires update / review, the completion of an EIA is not mandatory, but is seen as good practice. Where a procedure already has an EIA, this should be reviewed prior to revision. Procedures should be submitted to the Operational Management Group (OMG) for approval, with oversight from the operational lead. The proforma for the approval of procedure through OMG can be found at **Appendix I**.

The checklist at **Appendix Eii** (Template - Checklist for review and approval of a document) should be completed by the reviewer.

6.3.3 Changing a policy to a procedure

It is the responsibility of the policy lead to identify and discuss with their Lead Director and appropriate professional advisors as to whether a policy can be changed to a procedure.

It should be noted that this CAN ONLY be applied if the policy is not required for compliance with legislation or regulatory standards.

Once a procedure has been agreed as a replacement the policy lead must contact the Corporate Governance Team for corporate policies or the Quality Improvement and Assurance Team (QIAT) for clinical policies.

The policy lead will be required to submit their proposal by completing the policy proforma (**Appendix H**), and the proposal will then be submitted to EMT for approval. The policy/procedure holder should liaise with the Involvement Team to determine if an EIA is required for a procedure.

6.3.4 Drugs and Therapeutic Documents

Drugs and Therapeutic (D&T) documents are approved at the Drug and Therapeutic group.

6.3.5 People directorate documents

All people directorate documents are subject to consultation with staff side at the employment policy group. Documents then proceed to the Trust partnership forum for final ratification (including staff side) before progressing to EMT for final approval.

6.4 Version control

All policies and procedures must have the version number, date of issue and the review date clearly marked on the front cover and as a footnote.

Draft policies should be marked v1 draft, v2 draft etc during the consultation phase. Once approved the document becomes Version 1. Each time the policy or procedure is updated the version number must be changed.

The introduction to the policy should make it clear whether a document replaces or supersedes a previous document, including the title(s) of any superseded or replaced documents.

6.5 Dissemination and implementation arrangements (including training)

Once approved, the Corporate Governance Team (for corporate policies) and Quality Improvement and Assurance Team (QIAT) (for clinical policies) will be responsible for ensuring the updated version is added to the document store on the intranet and is included in the weekly communication to staff.

Some Trust policies are required to be published on the external facing internet and these can be found at South West Yorkshire Partnership NHS Foundation Trust. The Corporate Governance and QIAT Team will inform the Trust Communications Team to ensure that all public facing policies are up to date.

The Corporate Governance Team (for corporate policies) and Quality Improvement and Assurance Team (QIAT) (for clinical policies) will also be responsible for ensuring previous documents are archived prior to the new version being uploaded.

Directors are responsible for ensuring that staff within their area of responsibility are aware of new or amended policies and procedures related to their work.

If local teams download and keep a paper version of procedural documents, the responsible manager must identify someone within the team who is responsible for updating the paper version when a policy change is communicated via the staff brief.

All policies and procedures must identify the arrangements for implementation, including:

- Any training requirements, including which staff groups this affects and the arrangements and timescale for delivering training.
- Any resource requirements, including staff, and how these will be met.
- Support available to assist implementation.
- Arrangements for ensuring the policy or procedure is being followed.
- Monitoring and audit arrangements.

6.6 Document control and archiving

Current policies and procedures will be available on the intranet in read only format.

For historic policies and procedures, a central electronic read only version will be kept as a corporate record (archive) in a designated shared folder to which all staff can request access.

Documents will be retained in accordance with requirements for retention of non-clinical records.

6.7 Monitoring compliance with the policy

All policies and procedure must identify the arrangements that are in place for ensuring and monitoring compliance. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission (CQC) standards, NHS Resolution frameworks and Monitor (or successor organisation) compliance.

Methods may include:

- Monitoring and analysis of incidents, performance reports and training records
- Audit
- Checklists
- Monitoring of delivery of actions plans through TAGS or Care Service Groups

The document should identify the methods that will be used to ensure timely and efficient implementation.

For this policy implementation:

- is the responsibility of the lead Director for individual policies to ensure that this policy is followed in the development and presentation of individual policies
- is monitored through presentation to EMT and / or Trust Board, evidenced by the minutes of meetings where policies are approved, or the appropriate ratifying body, again evidenced by the minutes of meetings where policies are approved
- is monitored by the ratifying body through the policies checklist
- is assured through occasional audit by the Trust's internal auditors (currently 360 Assurance).

7. Equality Impact Assessment (EIA)

An EIA has been completed for this policy with no negative impact identified (**Appendix A**).

8. Dissemination and implementation arrangements (including training)

The dissemination and implementation of this policy will be conducted in accordance with the processes outlined under section 6.5.

Support to assist the development of other policies is available by contacting the Corporate Governance Team (for corporate policies) and Quality Improvement and Assurance Team (QIAT) (for clinical policies).

9. Process for monitoring compliance and effectiveness

Compliance and effectiveness of this policy is reviewed through the approval of all other policies to ensure they comply with the requirements of this policy. Other methods may include review as part of Care Quality Commission (CQC) inspections and audit by the Trust's internal auditors.

10. Review and revision arrangements

A review and revision of this policy should take place at least every three years or if required earlier due to national guidance.

11. References associated documents and supporting references

This document has been developed in line with guidance issued by the NHS Resolution and with reference to model documents used in other trusts.

Appendix A

Equality Impact Assessment
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)

Date of EIA: November 2022 (final approval April 2023) Review Date: April 2026

Completed by: Asma Sacha, Corporate Governance Manager

	QUESTIONS	ANSWERS AND ACTIONS
1	**What is being assessed?** Prompt: what is the function of this document (new or revised)	This document is a revision of the EIA for the Policy for the development, approval and dissemination of policy and procedural documents approved on February 2020.
2	**Description of the document** Prompt: What is the aim of this document	This purpose of this policy is to guide staff of South West Yorkshire Partnership NHS Foundation Trust on the development and approval of policies and procedural documents. It aims to; - to provide a standard format and content for policy and procedure documents. - to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure. - to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance. - to describe the process for version control to ensure people have access to – and are operating to – the most current version. - to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements.
3	**Lead contact person for the Equality Impact Assessment**	**Asma Sacha** **Corporate Governance Manager**
4	**Who else is involved in undertaking this Equality Impact Assessment**	**Advice sought from Equality and Involvement Manager**
5	**Sources of information used to identify barriers etc** Prompts: service delivery equality data – refer to equality dashboards (BI Reporting - Home (sharepoint.com) satisfaction surveys, complaints, local demographics, national or local research & statistics, anecdotal. Contact InvolvingPeople@swyt.nhs.uk for insight **What does your research tell you about the impact your proposal will have on the following equality groups?**	**March 2022 Workforce Monitoring Report.** The fundamental aim of this policy is to ensure all policies are developed and updated using a consistent approach, ensuring such documents are regularly reviewed to reflect current guidance, and following their approval that policies are disseminated so that staff are aware of their responsibilities. The Trust currently employs approx.4,530 staff delivering a range of services including mental health, learning disability, forensic, some physical health and an extensive range of community services.
5a	**Disability Groups:** Prompt: Learning Disabilities or Difficulties, Physical, Visual, Hearing disabilities and people with long term conditions such Diabetes, Cancer,	• Potential barrier with access to the policy (use of technology) • The area reporting high numbers of staff with disabilities is Barnsley care group

	Stroke, Heart Disease etc. Accessible information standard	• The data shows 8.4% of staff consider themselves to have a disability, this is an increase from the 2020 figure of 6.4% • Staff can access this policy using the accessibility mode where the policy can be read out. • Staff can request using an interpreting service for deaf and hearing-impaired staff • We will use the service EIA to ensure we fully understand the nature of the disability so we can adjust and adapt our services according to need, remaining person centred throughout. • The policy has been sent to the staff Disability Network for consultation. • Policy holder to ensure staff disabilities and accessibility is considered during the writing of the policy or procedure/guidance.

Disability (March 2022)

Area	Yes	No or Unknown	Grand Total
Barnsley	91 *7.8%*	1,082 *92.2%*	1,173
Calderdale and Kirklees	84 *10.0%*	760 *90.0%*	844
Wakefield	31 *8.5%*	334 *91.5%*	365
Forensic Services	70 *11.2%*	557 *88.8%*	627
CAMHS	28 *8.6%*	299 *91.4%*	327
Inpatient Services	33 *9.8%*	304 *90.2%*	337
Support Services	38 *5.0%*	715 *95.0%*	753
Sub-total	**375** ***8.5%***	**4,051** ***91.5%***	**4,426**
Medical Staff	9 *5.4%*	159 *94.6%*	168
Grand Total	**384** ***8.4%***	**4,210** ***91.6%***	**4,594**

	QUESTIONS	ANSWERS AND ACTIONS
5b	**Gender:** Prompt: Female & Male issues should be considered.	This policy applies equally to all members of staff • Gender split of staff is 21% male 79% female – this is indicative of all NHS bodies. • No barrier identified by gender in accessing the policy • Gender neutral pronouns to be considered when forming a policy/procedure/guidance to avoid distinguishing roles according to people's sex or gender.

Staff in post by gender and area March 2022

Gender/Area	Barnsley	Calderdale and Kirklees Wakefield		Forensic Services	CAMHS BDU	Inpatient Services	Support Services	Medical Staff
Female	1,020 87.0%	689 81.6%	303 83.0%	464 74.0%	288 88.1%	261 77.4%	541 71.8%	68 40.5%
Male	153 13.0%	155 18.4%	62 17.0%	163 26.0%	39 11.9%	76 22.6%	212 28.2%	100 59.5%
Grand Total	1,173	844	365	627	327	337	753	168

5c

Age:

Prompt: Older people & Young People issues should be considered

This policy applies equally to all members of staff

- The highest number of Trust staff fall in the age bands 40 – 49 and 50 – 59 with just under 53% of total staff being between 40 and 59.
- Potential barrier with access to the policy (use of technology)
- The Trust is mindful that staff are choosing to work longer, and an older workforce may require consideration from a health and wellbeing perspective regarding initiatives and support to maintain them in employment.
- Policy holder to consider use of technology and appropriate training when forming new policies/procedures/guidance.

Age by area (March 2022)

Area	19 & Under	20-29	30-39	40-49	50-59	60-69	70+	Grand Total
Barnsley		118 *10.1%*	286 *24.4%*	291 *24.8%*	345 *29.4%*	124 *10.6%*	9 *0.8%*	1,173
Calderdale and Kirklees	1 *0.1%*	110 *13.0%*	205 *24.3%*	216 *25.6%*	231 *27.4%*	78 *9.2%*	3 *0.4%*	844
Wakefield	1 *0.3%*	32 *8.8%*	86 *23.6%*	83 *22.7%*	115 *31.5%*	45 *12.3%*	3 *0.8%*	365
Forensic Services	6 *1.0%*	145 *23.1%*	157 *25.0%*	141 *22.5%*	140 *22.3%*	34 *5.4%*	4 *0.6%*	627
CAMHS		57 *17.4%*	101 *30.9%*	77 *23.5%*	74 *22.6%*	18 *5.5%*		327
Inpatient Services	1 *0.3%*	94 *27.9%*	84 *24.9%*	57 *16.9%*	80 *23.7%*	20 *5.9%*	1 *0.3%*	337
Support Services		51 *6.8%*	120 *15.9%*	183 *24.3%*	277 *36.8%*	119 *15.8%*	3 *0.4%*	753
Sub-total	**9** ***0.2%***	**607** ***13.7%***	**1,039** ***23.5%***	**1,048** ***23.7%***	**1,262** ***28.5%***	**438** ***9.9%***	**23** ***0.5%***	**4,426**
Medical Staff		9 *5.4%*	38 *22.6%*	58 *34.5%*	50 *29.8%*	12 *7.1%*	1 *0.6%*	168
Grand Total	**9** ***0.2%***	**616** ***13.4%***	**1,077** ***23.4%***	**1,106** ***24.1%***	**1,312** ***28.6%***	**450** ***9.8%***	**24** ***0.5%***	**4,594**

5d	**Sexual Orientation:** Prompt: Heterosexual, Bisexual, Gay, Lesbian groups are included in this Category	This policy applies equally to all members of staff • The policy has been sent to the staff LGBT+ network group for consultation

Sexual Orientation (March 2022)

Area	Heterosexual	Gay or Lesbian	Bisexual	Unknown	Grand Total
Barnsley	1,005 *85.7%*	19 *1.6%*	8 *0.7%*	141 *12.0%*	1,173
Calderdale and Kirklees	701 *83.1%*	24 *2.8%*	11 *1.3%*	108 *12.8%*	844
Wakefield	300 *82.2%*	12 *3.3%*	3 *0.8%*	50 *13.7%*	365
Forensic Services	513 *81.8%*	24 *3.8%*	13 *2.1%*	77 *12.3%*	627
CAMHS BDU	291 *89.0%*	5 *1.5%*	10 *3.1%*	21 *6.4%*	327
Inpatient Services	271 *80.4%*	9 *2.7%*	6 *1.8%*	51 *15.1%*	337
Support Services	586 *77.8%*	10 *1.3%*	5 *0.7%*	152 *20.2%*	753
Sub-total	**3,667** ***82.9%***	**103** ***2.3%***	**56** ***1.3%***	**600** ***13.6%***	**4,426**
Medical Staff	138 *82.1%*	5 *3.0%*	1 *0.6%*	24 *14.3%*	168
Grand Total	**3,805** ***82.8%***	**108** ***2.4%***	**57** ***1.2%***	**624** ***13.6%***	**4,594**

5e	**Religion & Belief:** Prompt: Main faith groups and people with no belief or philosophical belief issues should be considered	This policy applies equally to all members of staff

Religious belief (March 2022)

Area	Atheism	Christianity	Islam	Other*	Unknown	Grand Total
Barnsley	193 *16.5%*	649 *55.3%*	10 *0.9%*	118 *10.1%*	203 *17.3%*	1,173
Calderdale and Kirklees	187 *22.2%*	353 *41.8%*	48 *5.7%*	95 *11.3%*	161 *19.1%*	844

Wakefield	65 *17.8%*	181 *49.6%*	5 *1.4%*	48 *13.2%*	66 *18.1%*	365
Forensic Services	159 *25.4%*	271 *43.2%*	24 *3.8%*	64 *10.2%*	109 *17.4%*	627
CAMHS BDU	94 *28.7%*	148 *45.3%*	5 *1.5%*	49 *15.0%*	31 *9.5%*	327
Inpatient Services	64 *19.0%*	143 *42.4%*	19 *5.6%*	44 *13.1%*	67 *19.9%*	337
Support Services	117 *15.5%*	364 *48.3%*	22 *2.9%*	82 *10.9%*	168 *22.3%*	753
Sub-total	**879** ***19.9%***	**2,109** ***47.7%***	**133** ***3.0%***	**500** ***11.3%***	**805** ***18.2%***	**4,426**
Medical Staff	20 *11.9%*	44 *26.2%*	36 *21.4%*	47 *28.0%*	21 *12.5%*	168
Grand Total	**899** ***19.6%***	**2,153** ***46.9%***	**169** ***3.7%***	**547** ***11.9%***	**826** ***18.0%***	**4,594**

5f	**Marriage and Civil Partnership** Prompt: Single, Married, Co-habiting, Widowed, Civil Partnership status are included in this category	This policy applies equally to all members of staff

Marital Status (March 2022)

Area	Civil Partnership	Divorced/Legally Separated	Married	Single	Widowed	Unknown	Grand Total
Barnsley	11 *0.9%*	125 *10.7%*	651 *55.5%*	366 *31.2%*	15 *1.3%*	5 *0.4%*	1,173
Calderdale and Kirklees	15 *1.8%*	85 *10.1%*	385 *45.6%*	337 *39.9%*	9 *1.1%*	13 *1.5%*	844
Wakefield	6 *1.8%*	38 *10.1%*	195 *45.6%*	120 *39.9%*	4 *1.1%*	2 *1.5%*	365
Forensic Services	9 *1.4%*	45 *7.2%*	245 *39.1%*	318 *50.7%*	4 *0.6%*	6 *1.0%*	627
CAMHS		36 *11.0%*	155 *47.4%*	132 *40.4%*		4 *1.2%*	327
Inpatient Services	3 *0.9%*	31 *9.2%*	122 *36.2%*	178 *52.8%*	2 *0.6%*	1 *0.3%*	337
Support Services	8 *1.1%*	77 *10.2%*	422 *56.0%*	233 *30.9%*	7 *0.9%*	6 *0.8%*	753
Sub-total	**52** ***1.2%***	**437** ***9.9%***	**2,175** ***49.1%***	**1,684** ***38.0%***	**41** ***0.9%***	**37** ***0.8%***	**4,426**
Medical Staff	2 *1.2%*	3 *1.8%*	127 *75.6%*	34 *20.2%*	1 *0.6%*	1 *0.6%*	168
Grand Total	**54** ***1.2%***	**440** ***9.6%***	**2,302** ***50.1%***	**1,718** ***37.4%***	**42** ***0.9%***	**38** ***0.8%***	**4,594**

5g	**Pregnancy and Maternity** Prompt: Currently pregnant or have been pregnant in the last 12 months should be considered	This policy applies equally to all members of staff

5h	**Gender Re-assignment** Prompt: Transgender issues should be considered	This policy applies equally to all members of staff
5i	**Carers** Prompt: Caring responsibilities paid or unpaid, hours this is done should be considered	This policy applies equally to all members of staff • The policy has been sent to the staff carers network for consultation
5j	**Race** Prompt: Indigenous population and BME Groups such as Black African and Caribbean, Mixed Heritage, South Asian, Chinese, Irish, new Migrant, Asylum & Refugee, Gypsy & Travelling communities.)	• The Trusts staff profile shows just under 89% consider themselves white. Of the remaining 11.3%, the largest group (5.1%) consider themselves of Asian origin. • Staff can request the policy is interpreted into a different language • The policy has been sent to the REACH (Race, Equality and Cultural Heritage) staff network for consultation

Workforce ethnicity

Area	Asian	Black	Chinese or Other	Mixed	White	Unknown	Grand Total
Barnsley	13 *1.1%*	12 *1.0%*	7 *0.6%*	9 *0.8%*	1,131 *96.4%*	1 *0.1%*	1,173
Calderdale and Kirklees	52 *6.2%*	34 *4.0%*	6 *0.7%*	14 *1.7%*	737 *87.3%*	1 *0.1%*	844
Wakefield	7 *1.9%*	6 *1.6%*	3 *0.8%*	7 *1.9%*	342 *93.7%*		365
Forensic Services	25 *4.0%*	44 *7.0%*	7 *1.1%*	11 *1.8%*	538 *85.8%*	2 *0.3%*	627
CAMHS BDU	9 *2.8%*	12 *3.7%*	2 *0.6%*	5 *1.5%*	299 *91.4%*		327
Inpatient Services	21 *6.2%*	31 *9.2%*		5 *1.5%*	280 *83.1%*		337
Support Services	27 *3.6%*	11 *1.5%*	13 *1.7%*	10 *1.3%*	688 *91.4%*	4 *0.5%*	753
Sub-total	**154** ***3.5%***	**150** ***3.4%***	**38** ***0.9%***	**61** ***1.4%***	**4,015** ***90.7%***	**8** ***0.2%***	**4,426**
Medical Staff	79 *47.0%*	9 *5.4%*	17 *10.1%*	5 *3.0%*	58 *34.5%*		168
Grand Total	**233** ***5.1%***	**159** ***3.5%***	**55** ***1.2%***	**66** ***1.4%***	**4,073** ***88.7%***	**8** ***0.2%***	**4,594**

6. Action Plan

EIAs are now reviewed using a grading approach which is in line with our Equality Delivery System (EDS). This rates the quality of the EIA. This means that the team can review the EIA and make recommendations only. The rating and suggested standards are set out below:

- **Under-developed** – red – **No data**. **No strands** of equality
- **Developing** – amber – **Some census data plus workforce**. **Two strands** of equality addressed
- **Achieving** – green – **Some census data plus workforce. Five strands** of equality addressed
- **Excelling** – purple –**All the data and all the strands** addressed

Potential themes for actions: Geographical location, built environment, timing, costs of the service, make up of your workforce, stereotypes and assumptions, equality monitoring, community relations/cohesion, same sex wards and care, specific issues/barriers.

Who will benefit from this action? (tick all that apply)		Action 1: This is what we are going to do	Lead/s	By when	Update -outcome	RAG
Age	x	The Trust will ensure that staff of all backgrounds, identities and ages in their present circumstance will receive information to provide direction to develop policy, procedure and guidance documentation.	Corporate Governance Team	March 2026 (every 2 years)	Involve the staff networks (LGBT, REACH (formerly BAME), carers network and Disability)	Achieving
Disability	X					
Gender reassignment	X					
Marriage and civil partnership	X					
Race	X					
Religion or belief	X					
Sex	X					
Sexual Orientation	X					
Pregnancy maternity	X					
Carers	X					

Who will benefit from this action? (tick all that apply)		Action 2: This is what we are going to do	Lead/s	By when	Update -outcome	RAG
Age	x	There is a statutory duty to carry out Equality Impact Assessments and policy authors to ensure they are considering the impact on those with protected characteristics throughout the policy/procedure or guidance development.	Policy authors	Ongoing	To ensure the most up to date national data is available to compare to our Trust workforce data.	**Developing**
Disability	X					
Gender reassignment	X					
Marriage and civil partnership	X					
Race	X					
Religion or belief	X					
Sex	X					
Sexual Orientation	X					
Pregnancy maternity	X					
Carers	X					

Grading the EIA
Undertaken by: Aboobaker Bhana, Equality and Involvement Manager

Date: 6 December 2022

Rating: Developing
EIAs are now reviewed using a grading approach which is in line with our Equality Delivery System (EDS). The team have reviewed and rated the EIA using the following:

- **Under-developed** – red – **No data**. **No strands** of equality
- **Developing** – amber – **Some census data plus workforce**. **Two strands** of equality addressed
- **Achieving** – green – **Some census data plus workforce. Five strands** of equality addressed
- **Excelling** – purple –**All the data and all the strands** addressed

Comments:
Overall a good EIA
Needed some specific examples in the involvement section- You Said -We Did
Would have been good to include the description of CPRG group and its function
In the action plan -The new census 2021 demographic data for ALL areas needs to be added as soon as available
Include examples any other related work programmes led by the Corporate Governance team to support this policy
Include any SI/SUI's/complaints or concerns related to CQC Guidelines, that may have had an impact one of the equality groups, that led to learning lessons and positive outcomes

7. Involvement & Insight: New or Previous (please include any evidence of activity undertaken in the box below) An integral element of the policy to write and develop policies, procedures and guidance is to involve the various groups and support networks, i.e., LGBT+, Race, Equality and Cultural Heritage (REACH) staff network group (formerly BAME), carers and Disability networks to ensure there continues to be no unintended consequences to individuals. Policy authors need to ensure key consideration is given to external stakeholders and those who use our services; service users and carers when developing policies, procedures and guidance. The policy authors can take insight from the Friends and Family Test, Complaints, Compliments and Carers Groups.
8. Publishing the Equality Impact Assessment This is available on the Trust intranet and via Freedom of Information request.
9. Methods of Monitoring progress on Actions The policy will be reviewed by the Corporate Policy, Procedure and Risk Group (Chair, Head of Corporate Governance/ Company Secretary)
10. Signing off Equality Impact Assessment: Adrian Snarr, Director of Finance, Estates and Resources – Approved 16/12/2022 Julie Williams, Deputy Director of Corporate Governance, Performance and Risk – Peer review – Approved 16/12/2022 Asma Sacha, Corporate Governance Manager – Approved 06/12/2022

Andrew Lister, Head of Corporate Governance/ Company Secretary – Approved 06/12/2022

Aboobaker Bhana – Equality and Involvement Manager – Approved 06/12/2022

Once approved, you must forward a copy of this Assessment/Action Plan by email to:
InvolvingPeople@swyt.nhs.uk

If you have identified a potential discriminatory impact of this policy, please refer it to the Equality & Engagement Development Managers together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Equality & Engagement Development Managers.

Appendix B

Checklist for review and approval

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	YES	Staff networks, corporate policy, procedure and risk group and EMT
	Is there evidence that a trauma-informed 'lens' has been applied? e.g. through use of language etc.	YES	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	

6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint People Directorate /staff side committee (or equivalent) approved the document?	YES	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	Trust Communications Team
	Does the plan include the necessary training/support to ensure compliance?	N/A	Equality Impact Assessment training available
8.	**Document Control**		
	Does the document identify where it will be held?	YES	Intranet document store
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	N/A	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

Appendix C

Version control sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	June 2008	Director of Corporate Development	Final	Final version approved by Trust Board
2	March 2009	Director of Corporate Development		Changes made to ensure clarity on superseded or replaced documents and to reflect change in guidance for 2009/10
3	March 2010	Integrated Governance Manager	Final draft	Changes made following review and subsequent recommendations made during NHS LARMS review
4	Decemb er 2010	Integrated Governance Manager	Final	Inclusion of Equality Impact Assessment
5	July 2011	Integrated Governance Manager	Final	Changes made to accommodate comments made during NHS LARMS review and transfer of services from NHS Barnsley
6	October 2012	Integrated Governance Manager	Final draft	Changes made to meet requirements of NHS LARMS
7	October 2013	Integrated Governance Manager	Final	Revised equality impact assessment added (approved by lead Director 3 October 2013)
8	July 2014	Integrated Governance Manager	Final	Review by Lead Director; agreed no changes required. Approval of review date extension for further two years
9	January 2017	Integrated Governance Manager	Final	Reviewed with minor amendments and approved by Trust Board.
10	January 2019	Company Secretary Corporate Governance Manager	Final	Reviewed with minor amendments. Approved by EMT and Trust Board.
11	January 2020	Company Secretary	Draft	Reviewed with minor amendments. Approved by EMT and Trust Board.
12	March 2020	Corporate Governance Manager	Final	Approved by EMT and Trust Board.
13	April 2023	Director of Finance, Estates and Resources, Deputy Director of Corporate Governance Head of Corporate Governance and Corporate Governance Manager	Final	Full review undertaken and completion of the new Equality Impact Assessment proforma. Approved by EMT and Trust Board.

Appendix D
Policy Template - style and format

Document name:	**Name of the policy**
Document type:	Policy
What does this policy replace?	New policy / Updated version
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet and / or Internet
Issue date:	Month Year
Next review:	Month Year
Approved by:	Executive Management Team on (date) Trust Board on (date)
Developed by:	Job title
Director leads:	Job title
Contact for advice:	Job title

Contents

1. Introduction

This section should include a brief explanation of the reason for the policy.

2. Purpose and scope of the policy

This section should include why the policy needed, the rationale for development, what will it cover and an outline of the objectives and intended outcomes.

3. Definitions

This section should include a list and / or description of the meaning of terms used in the context of the policy or procedure.

4. Principles

This section should include the fundamental action points of the policy or procedure to be adopted.

5. Duties

This section should include the following:

- who is responsible for developing and implementing the policy
- who in the organisation is required to do what
- who is responsible for communicating the policy
- who is responsible for consultation with stakeholders
- who is responsible for approving the policy/procedure

6. Equality Impact Assessment

This section should include a new or updated Equality Impact Assessment to be completed.

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer.

An Equality Impact Assessment (EIA) must be completed prior to the revision of an existing Trust Policy or writing of a new Trust Policy. A toolkit to support this process is included in the appendices to this document and guidance can also be found at:

An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

As part of stakeholder involvement, Equality and Engagement Managers should be involved in the development or review of the EIA to ensure all equality and diversity requirements are included, prior to the review of the policy. If any negative impact is identified, the policy should be amended or (if this is not possible) an action plan to mitigate the negative impact must be included.

7. Dissemination and implementation arrangements (including training)

This section should describe the methods that will be used to ensure timely and efficient dissemination and implementation arrangements including training. This should include:

- any training requirements, including which staff groups this affects and the arrangements and timescale for delivering training;
- any resource requirements, including staff, and how these will be met; and
- support available to assist implementation;

Directors are responsible for ensuring that staff within their area of responsibility are aware of new or amended policies and procedures related to their work and the change is communicated in The Headlines. If local teams download and keep a paper version of documents, the responsible manager must identify someone within the team who is responsible for updating the paper version.

8. Process for monitoring compliance and effectiveness

This section should identify the arrangements for compliance and effectiveness, responsibility for conducting any audit, review or monitoring, the methodology to be used for audit, review or monitoring, its frequency, the process for reviewing the results and monitoring of key performance indicators. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission (CQC) standards, and Monitor / NHS Improvement compliance. Methods may include:

- monitoring and analysis of incidents, performance reports and training records
- audit by the Trust's internal auditors
- checklists
- monitoring of delivery of actions plans through TAGs or Care Groups.

9. Review and revision arrangements

This section should identify the arrangements for the review and revision of the policy. If an update to a policy has taken place it should describe the process undertaken.

10. References

This section should list any other documents referenced within the policy.

11. Associated documents

This section should list any other documents to be read in association with the policy. This could include other policies, procedures and guidance documents.

12. Appendices

Appendix A: Equality Impact Assessment (EIA)
Appendix B: Checklist for the review and approval of policy document
Appendix C: Version control sheet

TEMPLATE Di
Appendix A - Equality Impact Assessment (EIA) Toolkit

To be completed and attached to any policy document when submitted to the Executive Management Team and / or Trust Board for consideration and approval.

Document author to download the most up to date form from the Trust intranet (sharepoint)

Guidance and forms
An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

TEMPLATE Dii
Appendix B - Checklist for the review and approval of policy document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
	Is it clear in the introduction whether this document replaces or supersedes a previous document?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Is the method described in brief?		
	Are people involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
	Is there evidence that a trauma-informed 'lens' has been applied? e.g. through use of language etc.		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		

	Are supporting documents referenced?		
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint People Directorate Human Resources/staff side committee (or equivalent) approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8.	**Document Control**		
	Does the document identify where it will be held?		
	Have archiving arrangements for superseded documents been addressed?		
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?		
	Is there a plan to review or audit compliance with the document?		
10.	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so is it acceptable?		
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?		

TEMPLATE Diii
Appendix C - Version control sheet for policy document

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes

Appendix E

Procedure Template - Style and format

Document name:	**Name of the procedure / document**
Document type:	Procedure guidance/ Guidance/ Standard Operating Procedure? (please choose)
What does this procedure replace?	Update of previous procedure New procedure / Updated version
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet and / or Internet
Issue date:	Month Year
Next review:	Month Year
Approved by:	Operational Management Group on (date)
Developed by:	(name and job title)
Director lead:	(name and job title)
Contact for advice:	(name and job title)

Contents

Procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust.

A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that procedures in use are current and reflect an organisational approach.

Equality Impact Assessment (s) for procedures are not mandatory, but guidance should be sought from the Equality and Inclusion team if in doubt. If there is an EIA in place for the procedure you are writing, this may require an update including equality data for staff, and people who use our services or population data. Please contact the Equality and Involvement Team **before you develop the procedure.**

1. **Introduction**
   Set out the context for the procedure, why is it required and background information. Refer to polices that staff may need to make reference to with respect to this procedure.

2. **Purpose and scope**
   What is the aim of the procedure and which groups of people does it apply to.

3. **Definitions**
   Define any terms that are required, i.e. in a care plan SOP we may want to define what we mean by a ‘care plan’.

4. **Principles**
   Outline the key principles that underpin the procedure.

5. **Procedure / Process**
   Outline the procedure in sufficient detail for staff to follow.
   Include flowcharts where applicable.

6. **Duties**
   Outline key duties of staff who will be using the procedure.

7. **Dissemination and implementation arrangements**
   Identify how the implementation and effectiveness of the procedure will be monitored.

8. **Training needs**
   Identify any training needs relevant to the procedure.

9. **Process for monitoring compliance and effectiveness**
   This section should identify the arrangements for compliance and effectiveness, responsibility for conducting any audit, review or monitoring, the methodology to be used for audit, review or monitoring, its frequency, the process for reviewing the results and monitoring of key performance indicators.

10. Review and revision arrangements (to include document control and archiving)

This section should identify the arrangements for the review and revision of the procedure. If an update to a procedure has taken place it should describe the process undertaken.

11. References

This section should list any other documents referenced within the procedure.

12. Associated documents (if applicable)

Appendix A Equality Impact Assessment (EIA) (If applicable, not mandatory)
Appendix B Checklist for review and approval
Appendix C Version control sheet

Template Ei

Appendix A - Equality Impact Assessment (EIA)
If applicable, document author to consult the Equality and Involvement Team.

Document author to download the most up to date form from the Trust intranet (sharepoint).

Guidance and forms
An Introduction to Equality Impact Assessment (EIA) (sharepoint.com)

Template Eii

Appendix B - Checklist for the review and approval of a procedure

To complete and attach to the document

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, procedure, protocol or standard?		
	Is it clear in the introduction whether this document replaces or supersedes a previous document?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Is the method described in brief?		
	Are people involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
	Is there evidence that a trauma-informed 'lens' has been applied? e.g. through use of language etc.		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		

	Are the references cited in full?		
	Are supporting documents referenced?		
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint People Directorate Human Resources/staff side committee (or equivalent) approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8.	**Document Control**		
	Does the document identify where it will be held?		
	Have archiving arrangements for superseded documents been addressed?		
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?		
	Is there a plan to review or audit compliance with the document?		
10.	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so is it acceptable?		
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?		

Template Eiii

Appendix C - Version control sheet for a document

This control sheet should provide a history of previous versions of the procedure and changes made

Version	Date	Author	Status	Comment / changes

Appendix F

PROFORMA FOR APPROVAL OF POLICIES BY THE EXECUTIVE MANAGEMENT TEAM (EMT)

This form should be completed to support submission of policies for approval to EMT.

Policy name and reference number	
Review deadline *(month/year)*	
Has this policy been considered as a procedure instead?	
Name of policy author (s)	
Name of executive director lead and date of review	
Name of peer review executive director and date of review	
Has Equality Impact Assessment (EIA) been completed and signed off (Y/N)	
EMT submission date	
Purpose of the policy	
Note what has changed and why *(highlight any changes in the policy document)*	
Policy / policies it replaces or updates, if any *(please state version)*	

Confirm that the policy has been developed / updated in accordance with the 'Policy for the development, approval and dissemination of policy and procedural documents' (Policy on Policies).	
Provide evidence of consultation with appropriate stakeholders - (who, how and when). For clinical documents this must include the Clinical Policies and Procedures Group. For corporate documents this must include the Corporate Policy, Procedure and Risk Group.	
Identify any risks:	
Note any implications for directorates. • **People** • **Finance** • **Clinical safety and Quality** • **Corporate Governance** • **Training** • **Other**	
Date document approved by EMT	
Proposed date of next review *(month/year)*	

Appendix G

PROFORMA FOR EXTENSION OF POLICIES BY THE EXECUTIVE MANAGEMENT TEAM (EMT)

This form should be completed to support submission of policies for extension to EMT.

Policy name and reference number	
Name of policy author (s)	
Name of executive director lead and date of review	
Name of peer executive director lead and date of review	
EMT date *(Corporate Governance Officer to complete)*	
Review deadline *(month/year)*	
Length of extension required	
Purpose of the Policy	
Details of any previous extension requests	
Reason for extension	
Identify any risks (including safeguarding children and adult)	
How will the risks be managed?	

Appendix H

PROFORMA FOR APPROVAL OF CHANGING A POLICY TO A PROCEDURE BY THE EXECUTIVE MANAGEMENT TEAM (EMT)

This form should be completed by the policy lead.

Policy name and reference number	
EMT date *(Corporate Governance Officer to complete)*	
Name of policy author (s)	
Purpose of the Policy	
Reason for changing a policy to a procedure	
Confirm that the policy Lead Director has been consulted (Name of Lead Director and date consulted)	
Identify any risks (including safeguarding children and adult)	
How will the risk be managed	

Appendix I

PROFORMA FOR APPROVAL OF PROCEDURES BY OPERATIONAL MANAGEMENT GROUP (OMG)

The following should be completed to support submission of procedures for approval to OMG.

Procedure name	
OMG date	
Review deadline	
Proposed date of next review	
Purpose of the procedure	
Policy the procedure is linked to	
Note what has changed and why	
Policy(ies) it replaces or updates, if any	
Confirm that the procedure has been developed / updated in accordance with the 'Policy for the development, approval and dissemination of policy and procedural documents' (Policy on Policies). Refer to the intranet page: 728.docx (sharepoint.com)	e.g. correct Trust logo, font is Arial 12pt, stakeholder consultation completed (see below), EIA completed / updated (see below), checklist for the review and approval of procedural document completed, version control appendix updated, hyperlinks are updated/working correctly.
Provide evidence of consultation with appropriate stakeholders (who, how and when). For clinical procedures this must include the Clinical Policies and Procedures Group (if applicable).	
Provide the date that the related policy Equality Impact Assessment (EIA) was completed / updated in consultation with an Equality & Engagement	

Manager. Refer to the intranet page: Completing a policy EIA (sharepoint.com)	
Identify any risks	
Note any implications for: • **Finance** • **Governance** • **Training** • **Other**	

Appendix J

Acronym buster

Text	Acronym
Executive Management Team	EMT
Care Groups	CGs
Trust Action Groups	TAGs
Equality Impact Assessment	EIA
Operational Management Group	OMG
Quality Improvement & Assurance Team	QIAT
Care Quality Commission	CQC

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2024-25

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✘	Item deferred

Note that some items may be verbal

Agenda item / issue	30 Apr	21 May	2 July (June)	30 July	20 Aug	1 Oct (Sept)	29 Oct	26 Nov	17 Dec	28 Jan	25 Feb	25 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	30 Apr	21 May	2 July (June)	30 July	20 Aug	1 Oct (Sept)	29 Oct	26 Nov	17 Dec	28 Jan	25 Feb	25 Mar
Chief Executive's Report	✘		✘	✘		✘	✘	✘		✘		✘
Questions from the public (item 3)	✘		✘	✘		✘	✘	✘		✘		✘
Any other business (public and private)	✘		✘	✘		✘	✘	✘		✘		✘
Risk and Assurance												
Board Assurance Framework	✘			✘			✘			✘		
Corporate / organisational risk register	✘			✘			✘			✘		
Strategic overview of business and associated risk											✘	✘
Review of Risk Appetite statement												✘
Complex Incidents update (private session)	✘		✘	✘		✘	✘	✘		✘		✘
Serious Incidents quarterly report (public)			✘			✘		✘				✘
Risk assessment of performance targets, CQUINS and System Oversight Framework and agreement of KPIs (when published)			✘									
Assurance from Trust Board committees and Members' Council	✘		✘	✘		✘	✘	✘		✘		✘
Guardian of safe working hours annual report			✘									
Workforce Equality Standards						✘						
Medical appraisal / revalidation annual report						✘						
Ligature Annual Report								✘				
Freedom to Speak Up Annual report (July Annual report and January 6 monthly update)				✘						✘		
Medical Education Annual Board report								✘				

Agenda item / issue	30 Apr	21 May	2 July (June)	30 July	20 Aug	1 Oct (Sept)	29 Oct	26 Nov	17 Dec	28 Jan	25 Feb	25 Mar
Data Security and Protection toolkit	✘ (update)		✘									
Annual report and accounts (including Quality Account for 2022)		✘										
Annual Governance Statement	✘											
Equality and diversity annual report										✘		
Incident management annual report			✘									
Health and safety annual report			✘									
Patient Experience annual report			✘									
Sustainability annual report						✘						
Premises Assurance Model (new annual report 2021)			✘									
EPRR Compliance report						✘						
IPC BAF				✘								✘
Integrated Care Systems and Partnerships												
South Yorkshire update including the South Yorkshire Integrated Care System (SY ICS)	✘		✘	✘		✘	✘	✘		✘		✘
West Yorkshire update including the West Yorkshire & Health & Care Partnership (WYHCP)	✘		✘	✘		✘	✘	✘		✘		✘
Provider Collaboratives and Alliances	✘		✘	✘		✘	✘	✘		✘		✘
Performance reports												
Integrated Performance Report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
Safer Staffing report			✘							✘		
System Oversight Framework (when released)			✘									

Agenda item / issue	30 Apr	21 May	2 July (June)	30 July	20 Aug	1 Oct (Sept)	29 Oct	26 Nov	17 Dec	28 Jan	25 Feb	25 Mar
Care Group Performance report	✘		✘	✘		✘	✘	✘		✘		✘
CQC action plan updates			✘			✘		✘				✘
Strategic Direction												
Board Development		✘			✘				✘		✘	
Horizon Scanning – Focus On		✘			✘				✘		✘	
Investment Appraisal Framework (private)	✘							✘				
Strategic Objectives												✘
Trust Board Annual Work Programme												✘
Operational Plan (private)										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
Five-year plan												
Finance updates for longer term planning					✘						✘	
Governance												
Constitution (including Standing Orders) and Scheme of Delegation (if required)							✘					
Compliance with NHS provider licence conditions and code of governance			✘									
Going Concern Statement	✘											
Assessment against NHS Constitution				✘								
Audit Committee annual report including committee annual reports and terms of reference	✘											
Use of Trust Seal			✘			✘		✘				✘
Internal governance structure review												✘
Strategies and Policies												

Agenda item / issue	30 Apr	21 May	2 July (June)	30 July	20 Aug	1 Oct (Sept)	29 Oct	26 Nov	17 Dec	28 Jan	25 Feb	25 Mar
Digital strategy (including IMT) **update**							✘					
Estates strategy **update**				✘						✘		
Policy on Policies *(April 2024)*	✘											
Trust strategy refresh *(July 2024)*				✘								
Equality, Involvement, Communication and Membership Strategy (TBC*)*												✘
Learning from Healthcare Deaths Policy *(June 2024)*			✘									
Workforce strategy/organisational development strategy *(to follow Trust Strategy refresh 2024)*												✘
Digital Strategy (full) *(to follow Trust Strategy refresh 2024)*												✘
Trust Board declaration and register of fit and proper persons, interests and independence policy *(March 2025)*												✘
Clinical Strategy *(to follow Trust strategy refresh 2024)*												

Policy / strategy review dates:

- Trust Strategy *(July 2024)*
- 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 2024) (or as required)
- Equality, Involvement, Communication and Membership Strategy (TBC)
- Emergency Preparedness Resilience and Response Policy (November 2025)
- Customer Services Policy *(September 2026)*
- Digital Strategy *(to follow Trust strategy refresh)*
- Clinical Strategy *(to follow Trust strategy refresh*
- Estates Strategy *(July 2033)*
- Learning from Healthcare Deaths Policy *(next due for review in June 2024)*
- Organisational Development Strategy *(to follow Trust Strategy refresh)*
- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(April 2026)*
- 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 2027)*
- Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in September 2026)*
- Workforce Strategy *(to follow Trust Strategy refresh)*
- Research and Development Strategy *(October 2025)*